
KPMG
Ministry of Health
and Long-Term Care
MOHLTC-LHIN
Effectiveness Review
FINAL REPORT
September 30, 2008
AUDIT ▪ TAX ▪ ADVISORY

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1 Executive Summary

In a 2004 speech on Ontario's health system, the Honorable George Smitherman, Minister of Health and Long-Term Care (MOHLTC), said:

Our vision is of a system where all providers speak to one another in the same language, where there are no longer impenetrable and artificial walls between stakeholders and services: a system driven by the needs of patients, not providers.

The Local Health Integration Networks (LHINs) are integral to that vision. They were established to bring about an integrated health system that would enable local communities to make decisions about their local health systems. The government recognized:

- That communities and health service providers needed to work together to reduce duplication, better co-ordinate health service delivery, and integrate services to improve access to health care.

- That Ontario needed to move toward a health care organizational model that devolved authority to local bodies. In other provinces, this regionalization move took the form of Regional Health Authorities that essentially combined system planning with the direct management of health care delivery.

The Ontario model took a different approach to local decision-making. The LHINs were established with the authority to engage their communities, proactively plan an effective service system, facilitate integration and system transformation, and manage the overall funding of the health system within their devolved authority. Under the LHIN model, local service providers retain their focus on service delivery, their individual corporate identities, and their local Boards. LHINs are Crown Agencies with their own Boards of Directors appointed through an Order in Council (OIC). The MOHLTC is the steward, providing overall health system direction.

Under the Ministry/LHIN Accountability Agreement (MLAA) (Schedule 1 Part D) both parties must work together to evaluate the ***effectiveness of the transition and devolution of authority***. This review does that. It should be noted that this review is not an examination of the effectiveness of the LHINs, individually or collectively, or a review of the MOHLTC.

The Effectiveness Review found that the transition and devolution of authority to the LHINs has been effective and an overall success. LHINs have been devolved the authority necessary to discharge their core functions: Planning, community engagement, funding, and integration activities. The development of 14 LHINs and the transition and devolution of authority was a significant undertaking. Not surprisingly, the review found some issues facing both the MOHLTC and the LHINs in managing this devolved authority. These issues fall into three categories:

- Relationships and trust
- Clear communications
- Effective processes and structures

The review found that challenges related to these core issues impact the overall effectiveness of the system and should be addressed through the supportive changes identified in the Recommendations. It

should be noted that these challenges are consistent with – and are to be expected in – a system transformation of this magnitude.

The Effectiveness Review consisted of two phases. Phase 1 focused on creating an operational map of the overall vision for the LHIN model in order to fully understand the scope, functions, and authority that were expected to be devolved to the LHINs. Phase 2 focused on assessing the state of effectiveness in the new MOHLTC/LHIN environment. KPMG conducted extensive consultations to understand the current situation. These included:

- Two-day site visits with each LHIN that allowed LHIN staff, including Board Chairs, to inform the Review, interviews and focus groups with MOHLTC senior staff, a cross section of Health Service Providers (HSP) and representatives from several provincial health service provider associations
- A workshop with LHIN and MOHLTC participants to discuss and validate emerging themes

Overall, about 250 people contributed to the interviews and discussions. They provided a rich body of qualitative data from which to assess the effectiveness of the processes and structures supporting the LHIN model.

In many ways, the development of the LHINs was a *classic change management story*. It began with an innovative idea. As the concept became operational, many issues common to new ventures arose. From a change theory perspective, many of these issues were to be expected as the LHINs – new organizations with new relationships and processes – evolved. It is vital to this report's overall context to bear in mind that the MOHLTC and the LHINs have created a new system, one that has never existed in Ontario, or in fact, in Canada.

From inception, the LHIN model has been different than other provincial models designed to regionalize health care. Thus, it presented new challenges for organizational design planners. LHINs are not health service providers. While their functions most closely resemble government, unlike most government departments they clearly were established to operate in a flexible, locally focused manner. Absent existing models to study, designers had to visualize an ideal LHIN organizational structure, corresponding processes, and resources. By necessity, this could only have been done with a broad brush. The details would be worked out as the LHINs evolved. Consequently, it is no surprise this review identified some need to realign processes and resources within the system.

As the LHIN model developed, 14 Chairs and CEOs were appointed. With the facilitation of the Health Results Team, the CEOs and Chairs worked collaboratively to further develop the LHIN model and begin the process of hiring staff and creating organizational identities. Thus, as individual LHINs took shape, the level of collaboration began to diminish. Building these new organizations took a tremendous effort – engaging their communities and spending countless hours meeting with stakeholders across their catchments – and required most of the attention of their CEOs and Chairs.

At the same time, the MOHLTC was transforming – moving from managing the health care system to providing strategic leadership, planning, and central oversight as Ontario's health system steward.

While the LHINs participated on the various committees developing new provincial processes, the MOHLTC supported some committee secretariat work since the LHINs did not have sufficient staff or time. As the LHINs further developed, it became apparent that ensuring an effective health system would require significant cross-LHIN collaboration. At the time of this writing, the MOHLTC and the LHINs were under significant pressure, helping to maintain more than 93 working groups and

committees. The existing collaboration processes are not sustainable unless a collaborative mechanism or structure is put in place.

As the LHINs developed further, their cultures began to evolve. The LHIN Boards and staff strongly believe the original LHIN vision that they should be the leaders of their local health systems, implementing the new structures and processes to enable an evolving health system. Over time, friction grew between the LHINs and the MOHLTC. While a foundation of goodwill remained, the new and old cultures began to clash. From a change-management perspective it appeared the LHINs were taking on their new authority while the MOHLTC, in some instances, was holding on to its traditional role. This initial period, in which both sides figured out a new way of working, was to be expected, given the unique nature of the LHIN model. The system must provide further opportunities to build relationships and trust to enable the LHINs and the MOHLTC to learn how to work together as partners.

Heavy workloads also featured prominently in the LHIN development. From day one, the LHINs were actively engaged in building their organizations, while implementing their new functions of community engagement, performance/financial management, planning, and systems integration. Their workloads – greater than originally anticipated – became even more so as the MOHLTC gave them new requirements. It is apparent that many LHINs could use more resources to produce more efficient and effective system outcomes.

As of April 1, 2007, LHINs began managing the funds for their local health systems. This was generally well managed and demonstrated that they could provide the leadership and fiscal responsibility envisioned in the model. However, this transfer also accentuated the lack of clarity around LHIN, MOHLTC, and Ministerial roles. This lack of clarity results from the intrinsic balance between local and provincial authority. Certain authority grey areas were cited by interviewees who noted it is not always clear where provincial authority ends and local authority begins. There was also some lack of clarity within the LHINs' governance. Many LHIN Chairs continued to work full time on LHIN business even after the initial year of development. This led to some organizational confusion with the Chairs and CEOs having to work out their respective roles and relationships. This report recommends ways to clarify these grey areas.

As previously mentioned, the MOHLTC/LHIN experiences, are normal in this scale of system change. New organizations often go through the stages of forming, storming, norming and performing (Bruce Tuckman 1965). At the time of writing, the LHINs and the Ministry are at the creating-norms stage. This should lead to improved effectiveness, especially if LHINs and MOHLTC work together to agree on these norms. A comprehensive understanding of where the system is in its journey to vision state will lead to a greater appreciation of the pressures on both the MOHLTC and LHINs and should result in more effective working relationships.

As mentioned, the core issues are:

- Relationships and trust
- Clear communications
- Effective processes and structures

This report's recommendations all relate to these core issues and can be summarized as:

- Increasing the clarity of decision making processes
- Reviewing and aligning resources

- Enhancing collaboration processes and partnerships
- Refining accountabilities and processes
- Governance

The full report presents recommendations to address these issues.

Conclusion

The Effectiveness Review found positive progress. Although the LHIN model is unprecedented, the challenges are similar to those faced by other new systems. LHINs have:

- Managed their authority successfully with few problems
- Created and executed local decisions
- Significantly engaged their local catchments
- Developed and implemented processes

Many LHINs also have been involved in integration activities.

LHINs are moving in the right direction, but will require some significant changes to reach the intended vision. Each of this report's proposed recommendations is achievable and will increase the effectiveness of the system. Finally, there has been a constant forward movement of the system and there remains continued goodwill among the MOHLTC, LHINs and HSPs, all of which expressed a firm belief in this model for Ontario.

Recommendations

The first set are operational recommendations; the second governance recommendations.

Operational Recommendations

Authority

Recommendation 1

The MOHLTC and the LHINs should work collaboratively to develop a framework that clearly identifies who has decision-making authority over processes, functions, and the decision-making process for which there is currently a lack of clarity. At a minimum there needs to be clarity around:

- *New initiatives*
- *Roles and purpose in identifying legal and policy compliance*
- *Financial authorization*
- *Funding approvals*

The MOHLTC and the LHINs should develop an understanding of their shared authority over certain types of decisions.

Recommendation 2

The Minister and the Board Chairs should work collaboratively to create processes to guide Ministerial and broader government interaction and communication to support the desired authority and autonomy of the LHINs.

Recommendation 3

The Minister and the MOHLTC should recognize and engage LHINs as partners in the health system transformation. This would require that the MOHLTC create increased opportunities to meet with LHIN CEOs early on to seek their input and solve problems together.

Recommendation 4

The MOHLTC should continue providing training and education to the MOHTLC divisions and branches to support a move towards stewardship, emphasizing that the MOHLTC and LHINs are partners in the delivery of health care services. The MOHLTC should also provide guidance to staff on the new LHIN environment and how to best partner and communicate with LHINs.

Accountability

Recommendation 5

The MOHLTC and LHINs should continue to work to refine the MLAA process to assess whether its obligations are being met to mutually-agreed-upon standards, performance measures, and outcomes.

Recommendation 6

Shift the current accountability framework from a focus on process measures to a focus on system performance indicators with a strong focus on outcomes.

Focusing on outcomes will provide clear direction on provincial strategic goals and desired objectives. More importantly, an outcomes emphasis will enable LHINs to more effectively focus on system management and transformation.

Additional considerations include:

- *MOHLTC and the LHINs should continue to work collaboratively to develop MLAA performance measures that will track system and strategic outcomes*
- *Ensuring performance indicators are clear, measurable, and tied to the actions of the LHIN*
- *Further develop indicators that track the LHIN strategic directions of:*
    - *Access and Equity*
    - *Integration and Coordination*
    - *Quality*
    - *Sustainability*
- *Continue to refine the system scorecard*

Recommendation 7

The MOHLTC and LHINs should work collaboratively to develop financial and other incentives to reward the LHINs for achieving and surpassing outcome targets. These incentives should provide high-performing LHINs with the resources to seed health system innovations and celebrate excellence.

Strategy and Direction

Recommendation 8

The MOHLTC should release publicly the Provincial Strategic Plan, including clear, achievable measures.

Recommendation 9

The MOHLTC and the LHINs should strengthen existing structures (e.g., the LHIN CEO/MMC meetings) and consider developing new mechanisms (e.g. strategy workshops) to ensure early and on-going LHIN input into provincial strategy development and implementation. This would enrich policy and strategy development by bringing the LHINs' understanding of local health systems, including integration opportunities. Being informed of MOHLTC strategies in development also would enable LHINs to more effectively plan local policy initiatives.

Recommendation 10

The MOHLTC in consultation with LHINs – within the implementation process of Recommendation #1 – should create and provide tools to guide LHIN-MOHLTC interaction. This could include clarification of MOHLTC and LHIN respective roles and responsibilities in a variety of potential scenarios in which they have to collaborate.

Process and Program Devolution

Recommendation 11

The MOHLTC and LHINs should create standardized processes to guide the devolution of programs and responsibilities to the LHINs. This should include up-front policy work and planning to align with the LHIN model.

Recommendation 12

The MOHLTC and the LHINs should continue to develop more comprehensive ongoing knowledge transfer processes that use a variety of adult learning and knowledge management tools and strategies. The MOHLTC and the LHINs should jointly:

- *Undertake a knowledge transfer needs assessment*
- *Apply adult learning principles*
- *Stagger the training*
- *Train on different modalities*
- *Provide a website and a contact person*

Reporting and Information Management

Recommendation 13

The MOHLTC should align the reporting requirements of the LHINs more closely to the principles of a stewardship model and the vision for the LHIN model. The MOHLTC should continue to simplify the quarterly reporting process and plan to:

I. Restructure the quarterly reports removing all details of operating activities so they only include financial and performance updates.

II. Identify a materiality threshold for variance reporting so LHINs do not have to follow-up on all financial forecasts.

III. *Create a method to provide the LHINs with feedback on their reports and to share any best practices identified through review of reports.*

IV. *Monitor the volume of reporting requests submitted to the LHINs*

V. *Create a protocol for all ad-hoc reporting requests that will guide the MOHLTC when requesting information from the LHINs.*

Recommendation 14

The MOHLTC and LHINs should find more effective and timely ways to meet the information requirements of the LHINs.

Collaboration

Recommendation 15

The LHINs should work collaboratively to develop a LHIN Joint Operations and Strategy Office (JOSO is a suggested name). When the LHINs were created, it was expected they would work together as a team. However, without the tools and structures to enable these partnerships it is difficult for 14 separate organizations to work together. JOSO would support inter-LHIN initiatives, develop consistent methodologies, provide project management support, training, and liaison with the MOHLTC Communications Information Branch, support the proposed MOHLTC-LHIN-HSP collaborative structures, and house LSSO and LHIN Legal services.

To enable this, MOHLTC should:

- *Increase LHIN operational budgets to enable them to support JOSO. It is anticipated that JOSO would have a small core staff and would engage a combination of LHIN secondees and external resources on a project basis.*

Capacity

Recommendation 16

LHINs should develop processes and/or structures to facilitate more effective points of integration within their organizations, particularly between the Planning, Integration and Community Engagement (PICE) and Performance, Contract and Allocation (PCA) teams. Some LHINs have already begun this process, developing project teams, new process flows, and staff whose responsibilities cross these functions.

Recommendation 17

LHINs should re-evaluate how they accomplish their work in order to appropriately manage and deliver on their objectives. This will require LHINs to prioritize or eliminate certain planning and community engagement activities in order to focus their resources and more effectively facilitate health system integration and transformation activities.

Recommendation 18

LHINs should review their needs for basic operational tools such as wireless connectivity, meeting-scheduling packages, contact-management systems, electronic HR functions, etc., and provide LHIN Shared Services Office (LSSO) with the resources to provide these tools.

LHINs should also change the composition of the LSSO Governing body to include only senior LHIN staff.

Recommendation 19

Many LHINs will require more resources in order to effectively manage their responsibilities. The LHINs should be required to go through a systematic process to document their resource requirements as per the following recommendations:

- *LHINs should, if they have not already done so, undertake an organizational review using a consistent work-load methodology. Part of this review should include an assessment of the current LHIN skill requirements and competencies. The needs across the LHINs will differ depending on their characteristics (numbers of HSPs etc.)*
- *LHINs should collate all organizational reviews and identify gaps and the funding increase necessary to address these gaps*
- *The MOHLTC should flow increases to operational funds, for human resources and space requirements, mid-year. If this is not possible, by fiscal year 2009/10 based on the approval of the submitted proposal*

Recommendation 20

The MOHLTC should complete the budgeted staffing-up of LHIN support divisions and branches – especially those that provide critical functions for the LHINs – as soon as possible. These should include, but are not limited to, Health Analytics Branch, Strategic Investment Planning Branch, and the Health Program Policy and Standards Branch.

LHIN Liaison Branch

Recommendations 21

The MOHLTC should review and refine the structure of the LHIN Liaison Branch (LLB) to enable it to continue its evolution towards providing a comprehensive link between the MOHLTC and LHINs.

- *LLB should continue to provide the MOHLTC's oversight of the LHINs. In addition, it should enhance its role to assist the MOHLTC to ensure that policy, strategy, and standards development are aligned within the LHIN model.*
- *LLB should coordinate policy support to the LHINs on strategy implementation and special initiatives during the development of submissions by working with the LHINs to review legal and policy constraints prior to Board approval. This may negate the need for LLB staff to review LHIN allocations after they have been approved by the LHIN Boards.*
- *Senior Management of LLB should continue to review the organization structure and roles of LLB staff to align them with their mandate. It is anticipated that there will be a need to shift resources from the liaison function to other mandate areas*

Governance

Recommendation 22

The Minister should ensure the political arm of government receives ongoing training on the mandate of the LHINs and the authority granted to LHIN Boards.

Recommendation 23

The Minister should review the OIC processes to:

- *Improve timeliness of both new appointments and reappointments. This should include development of a competency model that identifies quality standards for the selection and review of Board appointees' skills and experience.*
- *Modify the appointment process so that the Board terms are staggered to reduce the number of appointments ending at the same time.*

Recommendation 24

Board Chairs should work together to create shared recruitment strategies to attract community members to sit on LHIN Boards.

Recommendation 25

The Minister, with input from Board Chairs, should develop a Provincial Evaluation Framework with a shared set of standards that outlines the roles, responsibilities and desired behaviours of the LHIN Board as a whole, as well as individual members. This should include a specific focus on the performance expectations of the Chairs.

Recommendation 26

The Minister should contract one external party to conduct Board and Chair evaluations annually to;

- *Provide each LHIN Board with an assessment of the performance of individual members and the Board as a whole*
- *Prepare a confidential performance evaluation report on each Board and Board Chair for the Minister.*
- *Based on the annual evaluation report, the Minister should take appropriate action to provide remediation, training, or to replace Board members and Chairs not performing to Provincial Standards. This would include providing governance coaches for Chairs who request assistance or who require it based on performance reviews.*

Recommendation 27

LHIN Chairs should create common tools to guide their Boards in assessing their progress towards strategic governance and ensuring that a consistent provincial governance orientation is delivered to all LHIN Board members at least annually.

Implementation Considerations

Recommendation 28

The MOHLTC/LHIN Effectiveness Review Steering Committee (MLERSC) should continue to function and oversee the implementation of the Effectiveness Review recommendations.

The MLERSC should contemplate, within two years, the need for a further third-party review of the effectiveness of the MOHLTC/LHIN model.

2 Introduction

LHINs were created in 2005 by the Ontario Ministry of Health and Long-Term Care to enable local health system planning and management, as a way to achieve the province's overarching goals to increase access and equity, system integration and coordination, quality, sustainability and the overall health status of the population. Unlike other provinces, which have moved away from independent health service provider governance to regional governance, in Ontario the MOHLTC has devolved authority and funding for health system planning and management to LHINs – 14 new organizations, which are expected to improve services for their local population, within a MOHLTC provincial stewardship framework. Health service providers continue to operate with their own Boards and management. The development of the LHINs and the shift in role of the MOHLTC from health system manager to health system steward was an enormous undertaking. It required significant culture change within the MOHLTC, and presented a considerable learning curve for the new LHINs.

This review evaluates the ***effectiveness of the transition and devolution of authority***. It should be noted that it is not an examination of the effectiveness of the LHINs – individually or collectively – or a review of the MOHLTC.

LHINs have been in place for almost three years and only now are being held accountable for funding, thus, this is an opportune time to assess their operational effectiveness. As could be expected for an undertaking of this magnitude, LHINs still are in a transition period. As LHINs and the MOHLTC continue the transition, they can benefit from this report's recommended changes to move them closer to their goals and the vision for health care in Ontario.

This report lays out the findings of the Effectiveness Review. The recommendations take into account the significant progress that has been made, the work that is currently ongoing, and beyond that, the changes that will be required to move the LHINs and the MOHLTC towards the full transition of authority and accountability.

Project Scope

This review was mandated to assess the effectiveness of the devolution of authority to LHINs, as the MOHLTC undertakes a significant transformation in the way health care services are managed in Ontario.

The catalyst for this Review was an agreement between the MOHLTC and the LHINs to undertake a capacity review by the spring of 2008. The scope and purpose were first described in the MOHLTC LHIN Accountability Agreement (MLAA) and then more fully in supporting documents.

The MLAA states:

- Both parties will work together to complete by spring 2008 an evaluation of their effectiveness in carrying out the transition and devolution of authority contemplated by this Agreement.

Five principle focus areas for the review were identified. These related to different aspects of the design and implementation of the devolution process. They are to:

- Review progress to date on implementing the independent and interdependent roles and responsibilities of the MOHLTC and LHINs
- Evaluate the capacity of the MOHLTC and LHINs to execute the transition and fulfill their roles as set out in the Local Health System Integration Act (LHSIA) 2006, the MOHLTC LHIN Accountability Agreement, and the Memorandums Of Understanding (MOU)
- Identify gaps in capacity and areas that need attention to fulfill the devolution/transition
- Review and assess the operational design assumptions of LHINs and
- Develop constructive recommendations to further strengthen the devolution and transition as the MOHLTC and LHINs continue to evolve in their new roles

It is also important to establish that this Effectiveness Review was not:

- An examination of outcomes (health or otherwise) as a measure of MOHLTC/LHIN effectiveness
- An examination of the relationship between LHINs and individual health service providers
- An examination of the original LHIN model

Ultimately, this review was to assess how well the implementation of the new LHIN model was handled to determine if the resources and processes of the MOHLTC and the LHINs were sufficient to enable the LHINS to accomplish their mandates.

This review was guided by the Effectiveness Review Steering Committee comprised of:

- Debbie Fischer, ADM, Transition (Co-Chair);
- Gary Switzer, CEO, Erie St. Clair LHIN (Co-Chair);
- John McKinley, ADM, Health System Information Management and Investment Division;
- John Magill, Chair, Mississauga Halton LHIN;
- Kathy Durst, Chair, Waterloo Wellington LHIN;
- Bill MacLeod, CEO, Mississauga Halton LHIN;
- Carrie Hayward, Director, LLB; and,
- With support from Kathryn McCulloch, Manager West Unit, LLB and Nellie Manley, Senior Program Consultant, LLB.

Approach and Methodology

The review was carried out in two phases. Phase 1 focused on creating an operational map of the overall vision for the LHIN model, in order to fully understand the scope, functions, and authority that were expected to be devolved to the LHINs. This provided a framework to guide the assessment of effectiveness that took place in the second phase of the project.

Phase 2 focused on collecting and analyzing information to assess the current state of effectiveness in the new LHIN environment. KPMG conducted extensive consultations to understand the current situation. These included two-day site visits with each LHIN that provided an opportunity for more than 150 LHIN staff, including Board Chairs, to inform the review. KPMG held:

- Interviews and focus groups with more than 60 MOHLTC senior staff, a cross section of Health Service Providers (HSP), and representatives from a sample of provincial health service provider associations
- A workshop with more than 120 LHIN and MOHLTC participants to discuss and validate emerging themes

All of these meetings provided a rich body of qualitative data from which to assess the effectiveness of the staffing, processes, and structures supporting the LHIN model.

In addition to the consultations KPMG reviewed many documents to provide both historical perspective and data on current processes. These documents included:

- Ontario health system strategic planning documents
- Cabinet meeting minutes
- MOHLTC – Original LHIN planning documents and meeting minutes
- LHIN Think Tank Documents (Planning, Health System Integration, Funding, Governance and Ethics)
- LHIN Management Directives, Summer 2005
- Original LHIN Orientation Sessions, June and August, 2005
- LHIN Governance Manual and July 2005 Governance session materials
- LHIN Communications protocols
- LHIN Community Engagement methodology documents
- Local Health System Integration Act, 2006
- MOHLTC-LHIN Accountability Agreement
- Memorandum of Understanding
- MOHLTC-LHIN Performance Agreements
- LHIN Business Operating Manuals
- LHIN Bulletins
- MOHLTC New Directions Newsletter
- LHIN Board Meeting Minutes and supporting documentation
- Formal requests for information from the MOHLTC and letters of correspondence

KPMG's analysis of the data focused on identifying consistent themes emerging from across all of the consultations and document reviews and assessing the data against the intended operational vision for the LHINs.

A Framework for Measuring the Devolution

LHINs were established to drive health care decision making down to the local level. It was envisioned that LHINs would guide improvements in the health care system to enable better health for the people of Ontario. In a 2004 speech on Ontario's health system, the Honorable George Smitherman, Minister of Health and Long-Term Care, said:

Our vision is of a system where all providers speak to one another in the same language, where there are no longer impenetrable and artificial walls between stakeholders and services: a system driven by the needs of patients, not providers.

The LHINs were the vehicle to achieve that vision. Ontario recognized the need to move toward an organizational model that devolved authority to local bodies. In other provinces, this regionalization move took the form of Regional Health Authorities that essentially combined the roles of system planning and the direct management of health care delivery. The Ontario model took a different approach to local decision-making. The LHINs were established as planning bodies with the authority to engage their communities, proactively plan an effective service system, facilitate integration and system transformation, and manage the overall funding of the health system within their devolved authority. Under the LHIN model, local service providers retain their focus on service delivery, their individual corporate identities, and their local Boards. LHINs were established with their own Boards of Directors appointed through an Order in Council (OIC). The MOHLTC was to be the steward of the system providing overall health system direction.

Stewardship requires the Ministry to:

- Guide and direct the health system through strategy development, planning, and evaluation;
- Set the directions and enable the choices needed to improve the health system;
- Ensure the system is driven by the needs of citizens of Ontario; and,
- Partner with health care providers.

(Source: MOHLTC: A New Direction)

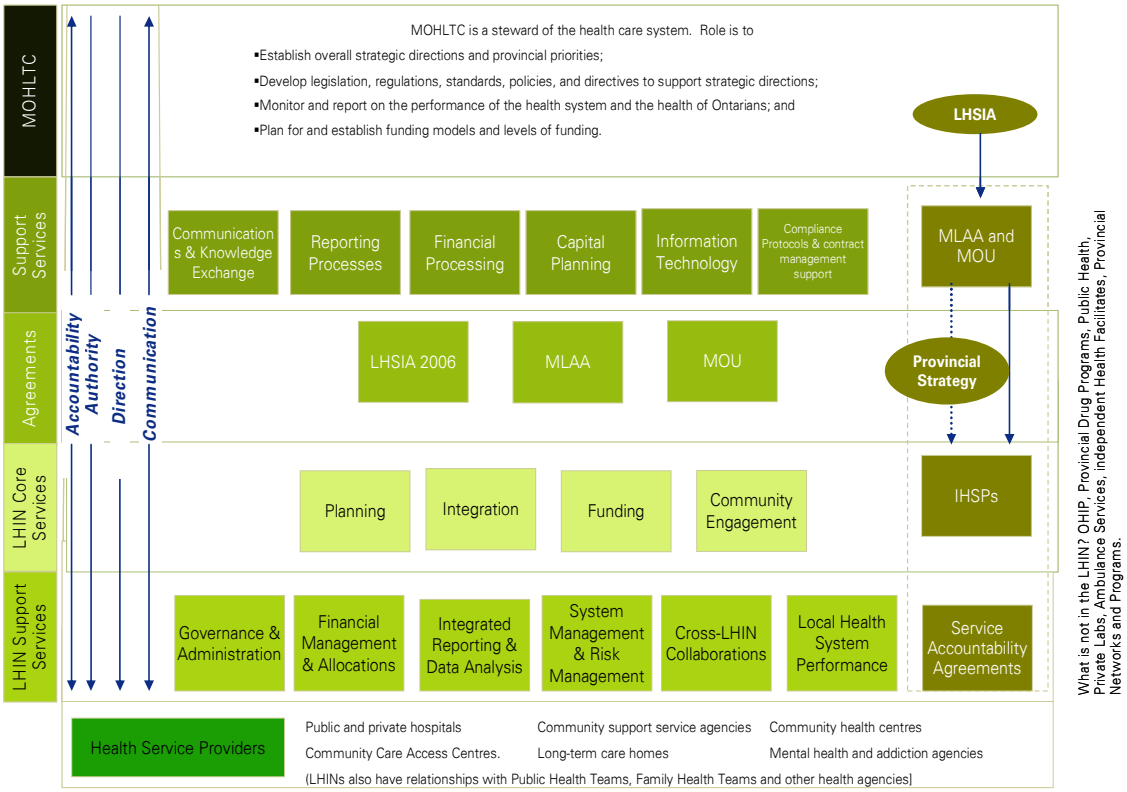
LHINs are Crown Corporations, the key features of which are that:

- Crown Corporations are given a mandate by the Government;
- Government appoints and removes directors of Crown Corporations;
- Crown Corporations are distinct legal entities wholly owned or controlled by government, and,
- Government has the authority to intervene in the management of a Crown Corporation by directing the Board to follow a particular course.

(20 Questions Directors Should Ask About Crown Corporation Governance"; The Canadian Institute of Chartered Accountants, 2007)

The Local Health System Integration Act, 2006, states that LHINs are agents of the Crown *as well as* being controlled and managed by their own Boards.

At the onset, it was envisioned that LHINs would be small and smart, requiring only a small staff to accomplish their role. On average each LHIN had 23 staff. The following diagram is an operational map of the expected roles and functions of both the MOHLTC and the LHINs in the new model. The map was developed through reviews of foundation documents and information obtained through interviews with key leaders involved in the initial conceptualization of the LHIN model.



The map depicts the various functions retained by the MOHLTC and those that were devolved to the LHINs. It also captures the legislation and various agreements that guide the relationship between the MOHLTC and the LHINs. At the bottom of the diagram, there is a list of the Health Service Providers (HSPs) that have been devolved to the LHINs.

KPMG reviewed the effectiveness of the current LHIN operational model using the map as a guide. The map represents the intended alignment and organization of work functions deemed necessary for the overall effectiveness of a LHIN. A key focus of this review is whether the current operations are sufficiently resourced and managed to enable the LHINs to fulfill their roles. The individuals interviewed and focus groups consulted by the review team explored all areas of the operational model.

How to Read this Report

This Report contains the findings and recommendations of the MOHLTC-LHIN Effectiveness Review. The document is organized through several key themes that have impacted the ability of the MOHLTC and the LHINs to be effective organizations. It is recommended that the reader begin with the Executive Summary which provides a background discussion of the historical and change management context that shaped the development of the LHINs. It also describes the project methodology and original operational vision of the LHINs to provide the context of the review.

Following these sections, findings are presented with the key themes of Authority and Accountability, Strategy and Direction, and a series of themes associated with supporting Infrastructure. We provide a set of recommendations that addresses each theme at the end of each section.

Further, the report is focused on recommendations in those areas that appear to have a material impact on the future functioning of the LHINs, or those areas that consistently arose throughout interviews, focus groups and data collection. The report also tries to recognize the ongoing work to address some of the identified issues, such as the development of a collaborative infrastructure. The final section of the report presents considerations for implementing the recommendations.

3 Authority

A founding principle of the Ontario LHIN model is that LHINs have the authority to make decisions on the management of local health systems. The rationale is that devolution of authority to the LHINs will ensure that local decision-making is more effective, within a guiding provincial strategy, than a centralized decision-making model. At the heart of LHIN and MOHLTC effectiveness is the appropriate understanding of – and execution of – their authority and how they enable their respective (provincial and local) authority.

The Local Health System Integration Act, 2006 (LHSIA) provides the LHINs with the authority to manage the local health system by planning, funding, and integrating services[1], in order to achieve better access to high quality services and coordinated health care. LHSIA defines the role of the LHINs as: *to identify and plan for the health service needs of the local health system in accordance with provincial plans and priorities and to make recommendations to the Minister about that system (LHSIA, 2006 Objects 5 (b)).* In addition to managing local health systems, LHINs must carry out this authority within the provincial context, and are responsible for implementing provincial priorities at the local level. This dual role for LHINs in implementing local and provincial priorities leads to a balancing act between provincial interests and local authority. This has resulted in some tension which we explore in this chapter.

Evolution of the Devolution

In their first two years, as the LHINs built their new organizations, their attention was focused on building new processes, developing relationships with their providers, and planning. Their role at this time was limited to the development of integration priorities through the wide-scale engagement of their communities, and the translation of these priorities along with provincial strategic directions into Integrated Health Service Plans (IHSPs). Individuals consulted for this report did not express any concerns about their authority in these areas. In fact, there was consensus that the LHINs had been very effective during the IHSP development, and created a base of community involvement and trust to enable future endeavors.

The funding and integration authority transitioned to the LHINs in fiscal 07/08. It is clear that overall, the LHINs have been actively exercising their authority in a number of ways, including:

- Making funding and reallocation decisions
- Negotiating the Hospital Service Accountability Agreements (H-SAAs)
- Approving voluntary and facilitated integrations of service providers

That there have been no material issues with these processes underscores the effectiveness of this transition and demonstrates that authority has been transferred to the LHINs.

As this was the first time that LHINs had funding authority, it was to be expected that there would be a period of learning. Further, as mentioned, there is a natural tension in the design of the system as authority resides both with the MOHLTC (provincial) and LHIN (local). This tension has been attributed in some degree to a lack of common understanding of who has authority, who should have authority, or

[1] LHSIA 2006, Part III, IV and V

where the MOHLTC authority ends, and the LHINs' begins. Examples of tension were cited by both LHIN and MOHLTC interviewees, particularly when they discussed the roll-out of special provincial initiative funding, such as LHIN Urgent Priority, and Aging at Home funding. In these situations, the MOHLTC allocates funds earmarked for these priorities to the LHINs. Under Urgent Priority, the MOHLTC provided LHINs with funding towards their IHSP priorities and under Aging at Home, funding to enhance services for seniors.

It was intended that the LHINs would make local decisions about which programs should be funded, but that the MOHLTC would still play a role in determining that the program funds were going to be allocated within certain criteria. These examples demonstrate that there was insufficient clarity over the process as well a lack of understanding of the continuing role of the MOHLTC in these initiatives. More specifically, there was a lack of clarity about the aspects of authority and decision making that rested with the LHINs and those which remained with the MOHLTC. Some LHINs believed that all the authority rested entirely with them and acted accordingly. This led to a variety of practices across the LHINs.

At a high-level, the process for both Urgent Priority and Aging at Home funding involved the MOHLTC providing the LHINs with guidance/criteria on how these funds were to be allocated. This was followed by the LHINs submitting proposals to the MOHLTC for review and the corresponding flow of funding. Both LHINs and MOHLTC agreed that issues over authority arose at this point. Some LHINs perceived that their LHIN Board approval was the final approval; some also approved the submissions in public board sessions. During the MOHLTC review, a small percentage of submissions were rejected as not fitting with the criteria provided, or policy and legislative requirements. In this minority of cases, the LHINs involved felt that their authority was being challenged since their Board already had approved the submission. Other LHINs stated that it was not the role of the MOHLTC to review LHIN proposals but to fund those as requested. As the system steward, the Ministry does have a continued role in reviewing these submissions against both the specified criteria and legislative and policy requirements. The latter review was especially significant in the first rounds of funding initiatives when the LHINs may not have known about all the legislative and policy requirements. LHINs will gain this knowledge with experience and as they increase their work with health providers.

These examples highlight some of the challenges in early devolution as the MOHLTC and LHINs adapted to their new roles. Many of these challenges are understandable especially since both the MOHLTC and LHINs were undergoing significant change. These examples also highlight the need for MOHLTC and the LHINs in many instances to share authority, and that a lack of understanding of this shared authority contributed to the problems identified in this chapter. Addressing this tension will be important to enable both the MOHLTC and the LHINs to exercise their shared and individual authority effectively.

In a system transformation of this size, it is important for the MOHLTC to:

- Engage LHINs as early on in the process as possible
- Clearly explain the process and rationale for any review

This will allow for LHIN and MOHLTC staff to have a comprehensive understanding of the process. If the review process and expectations of all parties had been discussed and agreed to in advance in the above examples, both authority and process would have been clear.

Participants explored these issues in the MOHLTC/LHIN workshop held in June as part of this review, during which there was significant recognition that further work is required to clarify the details of authority and the processes around it. Participants also recognized that, in many instances, the MOHLTC and the LHINs have a shared authority and that clarifying processes to recognize these situations could improve decision making. The MOHLTC has the right and responsibility to ensure the criteria set out are met. LHIN Boards should feel comfortable that when recommendations are brought to them for approval, their decisions are final. While both of these expectations do not seem unreasonable, the challenges encountered over the past year demonstrate the need to develop clear, agreed-upon processes for funding allocations and to fully integrate them into all aspects of LHIN and MOHLTC practice.

Recommendation 1

The MOHLTC and the LHINs should work collaboratively to develop a framework that clearly identifies who has decision-making authority over processes, functions, and the decision-making process for which there is currently a lack of clarity. At a minimum there needs to be clarity around:

- *New initiatives*
- *Roles and purpose in identifying legal and policy compliance*
- *Financial authorization*
- *Funding approvals*

The MOHLTC and the LHINs should develop an understanding of their shared authority over certain types of decisions.

Political Environment

Due to the realities of the political environment in which both the MOHLTC and LHIN staff work, there will be occasions when the Minister/ Minister's Office will have to change or intervene in processes. The Minister retains this right to set and/or revise direction. This can lead to tension at many levels, between political, MOHLTC and LHIN staff. Some of this tension is natural and to be expected in a political environment. However, there have been examples, when a lack of understanding of processes or limited LHIN engagement in processes has raised this tension above a reasonable level. The Minister's Office interface with the LHINs has not necessarily reflected some of the characteristics of the LHIN model. For example, the LHIN Boards and LHINs' authority to allocate and announce local funding. These interactions have impacted some LHINs and created challenges in terms of how LHINs are perceived by their HSPs and local communities. It appears that the political arm of the MOHLTC may not fully understand the impact that changes in processes have on the LHINs or always consider the LHIN environment.

While it should be expected that governments will refine strategies as circumstances require, there should be clearer communications and consideration for the repercussions. The following recommendation addresses this issue:

Recommendation 2

The Minister and the Board Chairs should work collaboratively to create processes to guide Ministerial and broader government interaction and communication to support the desired authority and autonomy of the LHINs.

Partnership

The size of this transformation is extensive and the MOHLTC has made – and continues to make – significant strides towards changing its culture. A common theme underlying all the issues previously addressed, is one of organizational culture and its impact on the relationships among the MOHLTC, the Minister/Minister's Office, and the LHINs. The vision for the LHINs is as partners in the conceptualization, development, and implementation of strategy and policy. The LHINs were created to be more than regional offices, with a much broader role. LHINs were also envisioned to be much more than typical transfer payment agencies in their role and relationship with the MOHLTC.

Many of the process issues that have been identified reflect two cultures that have not yet found effective ways to communicate and understand each other. The LHINs are small, locally focused organizations that strive to not act bureaucratically. LHINs have identified local priorities they are passionate about achieving. When the MOHLTC is perceived as pushing back on LHIN submissions and funding requests, the LHINs feel disempowered and that the tools they were given to meet their priorities are ineffective. A mutual understanding of regulatory policy and program parameters will begin to address this challenge.

The MOHLTC has identified the need to change its culture as a key priority. There has been significant training provided to MOHLTC staff on the transition to stewardship, the role of the LHINs, and how to work with the LHINs. In a transition of this scope, it will take time for this education to filter through all levels of the MOHLTC. It is recommended that further change is required to accommodate and enable the LHINs to fulfill their role as envisioned. To address these issues, the MOHLTC needs to consciously shape its culture to reinforce to MOHLTC staff that the LHINs are local authorities.

Recommendation 3

The Minister and the MOHLTC should recognize and engage the LHINs as partners in the health system transformation. This would require that the MOHLTC create increased opportunities to meet with LHIN CEOs early on to seek their input and solve problems together.

Recommendation 4

The MOHLTC should continue providing training and education to the MOHTLC divisions and branches to support a move towards stewardship, emphasizing that the MOHLTC and LHINs are partners in the delivery of health care services. The MOHLTC should also provide guidance to staff on the new LHIN environment and how best to partner and communicate with LHINs.

Summary

Overall, stakeholders feel that authority has been successfully devolved to the LHINs. LHINs have successfully taken on funding authority and been able to reallocate funds across their local systems. LHINs have successfully engaged their communities and are implementing their IHSPs. The challenges identified in this chapter are related to clarity of decision-making processes and in particular how the MOHLTC and the LHINs work together. The proposed recommendations are intended to provide clarity and definition around processes so that both the LHINs and the MOHLTC have a concrete framework to refer to and mutual understanding of how processes should work.

The effectiveness of the accountability mechanisms established by the MOHLTC and the LHINs are discussed in the following section.

4 Accountability

For the MOHLTC to effectively grant LHINs the authority for managing $20 billion in public funds, there must be appropriate measures and tools in place to hold them accountable for their actions and decisions. In addition to funding, LHINs also have a role and accountability for managing a public good that contributes to the well-being of Ontarians.

LHINs are accountable for spending allocations, managing the health system, maintaining quality, overseeing improvements to the health system, contributing to the overall improvement of health status, and realizing the government's strategic objectives.

The MOHLTC and the LHINs have established instruments to provide a measure of accountability. These include legislation and regulations, a memorandum of understanding, and performance agreements. Performance is understood as the ability of LHINs to:

- Conform to legislative and regulatory requirements
- Manage within the parameters established by the government
- Implement plans and priorities and achieve outcomes

The MOHLTC-LHIN Accountability Agreement (MLAA) is the main performance tool used by the MOHLTC and the LHINs. LHINs are required to report their financial and performance accountabilities against the agreement quarterly and support this information with an annual report. The MLAA lays out the LHINs' authority for planning, funding, integration, and system management. The agreement defines accountabilities for each LHIN and for the MOHLTC in supporting the LHIN. Significant work has been completed on building the MLAA, through negotiation between the MOHLTC and the LHINs. A working group of both parties – the Agreement Development Team – was created to manage the MLAA. Its mandate is to develop and amend specific schedules, to manage the performance indicator refresh and to communicate updates and changes to the Ministry and the LHINs.

The current MLAA contains 11 schedules and defines the specific roles and responsibilities of both the MOHLTC and the LHINs for:

- The transition of authority
- Supporting the devolved authority of the LHINs

All 11 schedules include obligations for either or both the MOHLTC and LHINs. Schedule 10 also sets out, "performance indicators for the local health system to improve local health system performance.[2]" The indicators are reported by the LHINs and monitored by the MOHLTC. The obligations of the MOHLTC are monitored by LLB. Obligations are assigned to a MOHLTC division and the status of each of these obligations is reported to a Ministry Committee (represented by MOHLTC Directors) and ultimately to the Ministry Management Committee (MMC). MOHLTC and LHIN staff have indicated that the agreement has been very useful in defining the obligations of each party and, indeed, the MLAA is their reference for all LHIN or MOHLTC processes or queries.

[2] MLAA Schedule 10

While the MLAA has been effective, there is some question whether there is sufficient granularity within each obligation to determine if they have been implemented (this is not in reference to schedule 10 and the current performance indicators.) While it is clear who is accountable and responsible for achieving a specific task, the desired outcomes are not always measurable. In some cases, this has led to differing expectations of outputs. For example, in Schedule 4, on Information Management Supports, the MLAA specifies that the MOHLTC will, "develop a repository of data and information to support health system needs and provide access to that repository to the LHINs." It is difficult to use the MLAA to establish whether this repository has been successfully developed and put in place to the anticipated level either by LLB when monitoring the MLAA or by the LHINs and the MOHLTC when implementing or accessing the repository. This is partially due to a lack of specificity in the MLAA wording and the absence of an agreed-upon process to mutually assess whether MLAA accountabilities have been achieved.

It is important to note that there are also examples within the MLAA where obligations are clearly written and provide clear guidance on determining whether/when they have been accomplished to the extent envisioned. Typically these process indicators contain a deadline, such as the integrated reporting calendar in Schedule 8.

A focus on the measurability of the MLAA contents is only the first step toward an adequate performance management system. A more formal evaluation framework would provide the MOHLTC and the LHINs with the tools to evaluate the achievement of their respective obligations under the MLAA.

Recommendation 5

The MOHLTC and LHINs should continue to work to refine the MLAA process to assess whether its obligations are being met to mutually-agreed-upon standards, performance measures and outcomes.

In addition, the few system performance measures built into the MLAA for the current year are, for the most part, tied to specific strategic outcomes such as wait times but without measures for tracking other system performance indicators such as equity. While the MOHLTC recognizes the need to develop benchmarks and continue to move towards the development of system performance indicators, this work should become a higher priority. Enhancing existing performance indicators will enable the measurement of success of the LHIN model and comparability across the LHINs. Identification of higher performing LHINs will also more readily allow for the identification and dissemination of best practices amongst the LHINs.

The MOHLTC has created the Ontario Health System Scorecard that provides information that can be used to measure and guide strategic health system performance improvement initiatives. The scorecard reports on 30 indicators that measure the performance of the health system under 14 strategic objectives or performance dimensions. This system scorecard approach could be used to provide a balance of measures across the Ministry's strategic directions and clarity to the LHINs on the specific objectives they are expected to achieve. The current performance measures are insufficient to provide assurance to the MOHLTC that the LHINs are meeting their strategic objectives. There are ongoing efforts to improve data collection and performance measurements across the health system. Many of the indicators are available at the LHIN level, and can be used to guide the development of strategic plans and priorities at the local level. Improvement in data collection and dissemination will support the development of performance measures and targets for LHIN accountability agreements with the Ministry of Health and Long-Term Care.

Recommendation 6

Shift the current accountability framework from a focus on process measures to a focus on system performance indicators with a strong focus on outcomes.

Focusing on outcomes will provide clear direction on provincial strategic goals and desired objectives. More importantly, an outcomes emphasis will enable the LHINs to more effectively focus on system management and transformation.

Additional considerations include:

- *MOHLTC and the LHINs should continue to work collaboratively to develop MLAA performance measures that will track system and strategic outcomes*
- *Ensuring performance indicators are clear, measurable, and tied to the actions of the LHIN*
- *Further develop indicators that track the LHIN strategic directions of:*
    - *Access and Equity*
    - *Integration and Coordination*
    - *Quality*
    - *Sustainability*
- *Continue to refine the system scorecard*

Once the current system scorecard is refined, accountability can be strengthened by the addition of performance tied to financial and other rewards. Accountability is not just a question of responsibility, but also should be used to move the system forward. There are currently no concrete incentives for LHINs to achieve desired outcomes. Rewarding achievement of outcomes will facilitate and may enhance system performance. It will also help in identifying and disseminating best practices that will enable system improvements across all LHINs. LHINs do have the authority to reallocate funding between their providers but this is dependent on there being identified surpluses in the system. Some LHINs said they are able to identify innovations since they are close to their local communities but noted they do not have seed funding to put towards these innovations. Innovation incentives also can include recognition awards, innovation conferences, publications and other approaches that acknowledge excellence and support dissemination of proven practices. To enable LHINs to achieve their expected outcomes and to provide LHINs with some incentives, KPMG recommends:

Recommendation 7

The MOHLTC and LHINs should work collaboratively to develop financial and other incentives to reward the LHINs for achieving and surpassing outcome targets. These incentives should provide high-performing LHINs with the resources to seed health system innovations and celebrate excellence.

Summary

The recommendations in this section focus on strengthening of the accountabilities between the MOHLTC and the LHINs. It is evident that there are some schedules in the MLAA that do not provide sufficient detail on the obligations of the two parties. To this end, we recommend refining some of the schedules. Further, we note that LHINs are not measured against all of their core objectives. While health outcomes are difficult to identify and measure, a focused move towards measuring against outcomes will allow the MOHLTC and the LHINs to assess the level of change the new model is achieving and where any changes need to be made. It is also recommended, that to provide incentives

for the LHINs to achieve their outcomes and to support innovative/best practice solutions, they should be provided with financial and other incentives as reward for achieving and surpassing outcome targets.

Strengthening the accountability framework between the MOHLTC and the LHINs will clarify mutual expectations, provide feedback, and enable government to be confident that public funds are being managed effectively while the health of the province's population is improving. Achieving these expectations requires clear vision and a well-communicated strategy. These aspects are discussed in the next section.

5 Strategy and Direction

The vision for Ontario's devolution model establishes the MOHLTC as system steward responsible for setting strategic directions, policy, and standards, while LHINs are tasked with setting local priorities that are aligned with provincial priorities. The LHINs are required under the legislation to produce an integrated health service plan (IHSP) that "shall be consistent with a provincial strategic plan". Under the MLAA, the MOHLTC is responsible for releasing the provincial strategic plan, and the LHINs are responsible for updating their IHSPs within six months of its release.

These defined roles allow the MOHLTC to conduct provincial planning and develop policy that is consistent within a strategic framework to improve the overall health of Ontarians. This oversight role requires the MOHLTC to provide the LHINs with strategic direction in order for the LHINs to align local system priorities with provincial direction.

In the first year of operations, each LHIN set out to facilitate community meetings to determine its integration priorities. In year two, after the legislation received royal assent, the LHINs were asked to develop Integrated Health Service Plans (IHSPs) for their LHIN and determine priorities for the next three years. This was done without a thorough provincial framework, since the 10-year Strategic Plan has not been publicly released. The LHINs relied on several key pieces of information to inform and build their IHSPs:

- Previous work that identified local priorities
- Renewed engagement of the community
- Data analysis on the health status of their LHIN from the IHSP
- High level strategic directions received from the Minister of Health
- Stated priorities from the MOHLTC

At that time, the MOHLTC's strategic directions were:

- Renewed community engagement and partnership
- Health status – access and equity
- Quality and sustainability

The MOHLTC priorities at the time were: keeping Ontarians healthy, reducing wait times, and improving access to healthcare providers

Once the IHSPs were approved by LHIN Boards and launched in the fall of 2006, the MOHLTC announced several additional key strategies including Aging at Home, and Emergency Department wait times/Alternate Levels of Care (ALC). The government's actions in releasing the Aging at Home strategy were consistent with the strategic directions, but had not been foreseen entirely by the LHINs. Half of the LHINs had not identified seniors as a priority, and as a result had not established seniors advisory networks, leaving them feeling "behind the eight ball" compared to the LHINs who were already working with seniors groups and providers. Furthermore, it was difficult for these LHINs to explain to their communities why resources were being committed towards a priority that had not been identified during their extensive community consultations. The issue here is clearly one of process and timing, not whether the strategy was the right one. Many interviewees said they felt Aging at Home

was an excellent strategy that for the first time allowed the LHINs to plan and fund local initiatives while addressing a provincial priority. While there were some difficulties in its implementation, the majority of interviewees agreed it demonstrated the strengths of the Ontario model.

Since the election (October, 2007), the MOHLTC has established two new key priorities. These priorities – Access to Care (particularly emergency department wait times, under which Aging at Home and Chronic Disease Management fall) and Family Care for All, including the government's initiative to fund more family health teams and provide access to more nurses, replace the previous three. The launch of these priorities provided some clarity for the LHINs on current priorities, but also created some ambiguity as to the province's long term planning and in particular, how the IHSPs will be implemented.

Without the big picture from an overall MOHLTC Strategic Plan, and with new priorities launched by the MOHLTC without much notice or consultation with the LHINs, it has been challenging for the LHINs to align local and provincial priorities. Without advance knowledge of MOHLTC strategies about to be released, the LHINs will continue to be reactive. This is contrary to the vision for the LHINs. The release of the Strategic Plan, particularly due to its 10-year time horizon, certainly will enable the LHINs to be more effective and efficient in aligning their local planning with the provincial view.

The following recommendation addresses these issues:

Recommendation 8

The MOHLTC should release publicly the Provincial Strategic Plan, including clear, achievable measures.

Engaging LHINS in Strategy Development

When the LHINs were created, the Ministry retained the role of leading strategy and policy development for health care in Ontario. While the MOHLTC has not yet released the Strategic Plan, it has been generating significant new strategies that communicated the government's health care objectives. However, KPMG has found that these strategy development initiatives do not always – or effectively – engage the LHINs at various stages of strategy development

The perception from the LHINs is that the MOHLTC is passing the strategy "over the fence" with little input into implementation planning and that the MOHLTC is not being fully transparent in its strategy conceptualization and development. LHINs said they have a lot of local knowledge that would be useful for the MOHLTC when developing provincial strategies, and are eager to be involved in the conceptualizing of strategies. Conversely, MOHLTC staff have noted that there have been instances where LHINs were invited to take part in consultation sessions on strategy and chose not to. While it is apparent there is willingness to engage from both sides, the challenge may be finding the most effective way to involve the LHINs in a meaningful way.

Many interviewees at the MOHLTC cited a lack of knowledge or clarity regarding how to work with, or engage, the LHINs. Specifically, some MOHLTC staff do not understand how, practically, to reach out to the LHINs as a team, since they are 14 different organizations, sometimes with different structures and processes. While there is an enormous amount of work underway in the current environment, LHINs expressed a real desire to be involved. The behaviour of the MOHLTC appears to be cautious – wanting to have a well-planned strategy before the LHINs become involved. This results in a culture that treats LHINs as if they are typical transfer payment agencies, whereas LHINs are planning and funding bodies that conduct needs assessments for their local areas and can bring their understanding

of local best practices and requirements to respond to specific strategies. As a result, there is a real risk that the MOHLTC may be duplicating work that LHINs have done in identifying needs and solutions.

To begin to address this issue, in practice, the MOHLTC could release their plans to the LHINs, which in turn could use this information in their operational planning. The MOHLTC also needs to involve LHINs in early strategy conceptualization and the development of strategy. This leads to the following recommendation.

Recommendation 9

The MOHLTC and the LHINs should strengthen existing structures (e.g., the LHIN CEO/MMC meetings) and consider developing new mechanisms (e.g. strategy workshops) to ensure early and on-going LHIN input into provincial strategy development and implementation. This would enrich policy and strategy development by bringing the LHINs' understanding of local health systems, including integration opportunities. Being informed of MOHLTC strategies in development also would enable LHINs to more effectively plan local policy initiatives.

In addition, tools could be developed to facilitate MOHLTC strategy and policy development to guide how the MOHLTC would involve the LHINs. As mentioned earlier, MOHLTC staff currently are sometimes uncertain about how to plan and implement programs within the LHIN environment. This has led to actions that were not aligned with LHINs. The development of tools to guide staff in their interactions with the LHINs and the development of policy and strategy would help facilitate an ongoing, mutually beneficial relationship.

Recommendation 10

The MOHLTC in consultation with the LHINs – within the implementation process of Recommendation #1 – should create and provide tools to guide LHIN-MOHLTC interaction. This could include clarification of MOHLTC and LHIN respective roles and responsibilities in a variety of potential scenarios in which they have to collaborate.

6 Program Devolution

This section describes the effectiveness of processes in place to devolve the authority for provincial programs to the LHINs. These processes include devolution of provincial programs – typically programs evolved from MOHLTC priorities to address specific needs. These processes require an exchange of information between the MOHLTC and the LHINs. The MOHLTC has a responsibility to transfer programs and program knowledge in a manner that enables program continuity. The LHINs' role is to maintain both program funding and service coordination.

Numerous programs and processes have been devolved to the LHINs while others remain the responsibility of the MOHLTC. The process to devolve these programs and processes was an immense task for the MOHLTC, especially in the face of the internal transformation the MOHLTC is going through. This effort must be acknowledged. Processes, such as hospital funding, re-allocations of funds, and targeted programs were devolved to the LHINs. In addition to the devolution of hospital funding, the LHINs also assumed specific program responsibilities. The responsibilities are captured in LHSIA and the MLAA, Schedule 3: Local Health System Management. Many hospital programs (which included 18 programs with specific parameters) were specifically devolved within the base budgets in the MLAA. Examples include Cardiac Surgery, Permanent Cardiac Pacemaker Services, and Chronic Kidney Disease. The LHINs role is to maintain the provincial or regional service delivery models and to maintain service coordination[3]. The Provincial Programs Branch was commissioned with the responsibility for the coordination of specific retained provincial programs.

In general, the devolution of a majority of programs was effective, even more so considering the magnitude of the system transformation and budgets involved. The MOHLTC reviewed the existing programs, aligned the current funding structures with the LHIN boundaries, and provided the LHINs with guidance on program content. However, many MOHLTC, LHIN and HSP interviewees expressed concern that specific hospital programs (for example, chronic kidney disease and trauma) were not effectively transitioned to the LHINs. LHINs said the knowledge transfer was inadequate to support ongoing management of these programs and they were not provided with sufficient guidance/protocols. LHIN staff were concerned that they lacked the program knowledge to adequately plan and manage these programs. Some MOHLTC staff corroborated the view that knowledge transfer to the LHINs required more forward planning and protocols for the LHINs, but also said that the knowledge transfer was not adequately managed at the LHIN end. Since the LHINs were focused on setting up their organizations, they could not fully absorb the detailed information provided. It is apparent that both realities of the MOHLTC and the LHINs impacted the effectiveness of program devolution. Within the MOHLTC, the transition resulted in many staff who had previously managed these programs (some from Regional Offices) being mapped to other divisions and branches within the MOHLTC or to the LHINs, taking with them their program knowledge. The programs were divested at a time in the LHINs' evolution when significant change was underway, and the knowledge transfer sessions that did occur may require repeating or "just-in-time" access.

Since these were the first programs devolved to the LHINs, it is expected that this transition would have provided lessons learned for future program transfers. To improve the existing processes, the MOHLTC

[3] MLAA Schedule 3 8 (a) and (b)

and the LHINs have established a Provincial Program Working Group to look at the role of the LHINs and the MOHLTC in managing programs in a provincial context. The Provincial Programs Branch is providing training for the LHINs on certain programs. The importance of discussing these processes is that it identifies what the MOHLTC and the LHINs need to consider going forward to ensure effective devolution of programs and processes.

As mentioned, there has been significant work in considering of the ongoing supports LHINs will require as these programs become their responsibility. To ensure ongoing effectiveness, standardized processes to devolve programs should be developed that include careful planning in collaboration with the LHINs. It is necessary to consider the skills required to manage these programs and to ensure that a full transfer of knowledge has taken place.

Recommendation 11

The MOHLTC and LHINs should create standardized processes to guide the devolution of programs and responsibilities to the LHINs. This should include up-front policy work and planning to align with the LHIN model.

Knowledge Transfer

Knowledge transfer includes activities to transfer the program and process knowledge from within the MOHLTC to the LHINs. This transfer is intended to provide the LHINs with the appropriate skills to manage these programs on an ongoing basis. To devolve authority effectively, the MOHLTC must effectively transfer program knowledge.

The MOHLTC planned and executed a significant number of knowledge transfer sessions throughout the 2006 and 2007 early stages of the transition. The LHINs attended concentrated knowledge transfer sessions, sometimes lasting up to three days. This was a significant task for which the MOHLTC had planned through collaboration with the regional offices and the LHINs. Most LHINs expressed that they found these sessions useful. Others, however, did not, explaining that although well intended and well structured, they found it difficult to conceptualize without having had the experience of oversight of these programs. LHIN staff also felt that knowledge transfer was limited by the use of single sessions to convey so much information and the heavy workloads at the time of the knowledge transfer sessions.

A challenge cited by those in the MOHLTC was the constantly changing environment of the LHINs, in particular high LHIN staff turnover. Some staff who attended the initial knowledge-transfer sessions, left, leading to a loss of knowledge within certain LHINs. LHINs were also not set up to effectively collaborate to share some of the knowledge that was transferred. The MOHLTC itself was another issue, with staff moving to other branches and divisions, often taking with them knowledge of the program within the MOHLTC.

Many LHIN staff believe they did not received sufficient knowledge about their HSPs and some of their core tasks. As a result, some LHINs believe they lack the complete picture of their local regions.

As mentioned, the MOHLTC was fully aware of the necessity and significance of a robust knowledge transfer process and executed this as planned. However, due to changes in the MOHLTC and LHIN environments and challenges that are inherent in a transformation of this size, there have been some gaps. To address these issues, it is important that more rigorous knowledge transfer processes be put in place. This process should recognize the working environment of the MOHLTC and the LHINs. The MOHLTC has been using principles of adult learning to transfer this knowledge and should continue to

further consider the principles of adult learning – including adapting the learning modality to the learners' style – conducting multiple learning sessions, providing after-learning follow-up, and refresher courses.

Recommendation 12

The MOHLTC and the LHINs should continue to develop more comprehensive ongoing knowledge transfer processes that use a variety of adult learning and knowledge management tools and strategies. The MOHLTC and the LHINs should jointly:

- *Undertake a knowledge transfer needs assessment*
- *Apply adult learning principles*
- *Stagger the training*
- *Train on different modalities*
- *Provide a website and a contact person*

Summary

The overall devolution of programs and knowledge transfer has been effectively managed. KPMG's analysis demonstrates the need for the MOHLTC and the LHINs to more effectively plan for the future transfer of programs to the LHINs. Frequent issues with these programs can be attributed to the lack of planning prior to devolution and the transfer of knowledge between the MOHLTC and the LHINs. It is important to note that the MOHLTC has recognized this gap and has taken steps that begin to address the issue. However, a more rigorous, standard practice could help to further address issues identified along with appropriate knowledge transfer processes.

7 Reporting and Information Management

To enable accountability, the MOHLTC as system steward requires information from the LHINs that links their performance with their objectives. The ability of the LHIN to effectively plan and manage their local health system is dependent on timely access to information. This section describes the effectiveness of the reporting processes that have been established, and the information management processes that have been put in place to enable LHIN operations and reporting.

Reporting

Both LHSIA and the MLAA define reporting as a LHIN obligation and view reporting as an important step in being accountable to the Minister. LHINs report to the MOHLTC through quarterly reports, an Annual Service Plan, and an Annual Report. Throughout 2007/08, there also have been reporting requirements that are not specified within the MLAA. For example, emergency department capacity reports or daily reports on Hospital Service Accountability Agreement (HSAA) negotiations. Within this section, the quarterly reporting process and any ad-hoc reporting requests are reviewed.

Quarterly reporting process

LHINs must report to the MOHLTC on the last day of every quarter in order for their financial status to be incorporated in MOHLTC reports submitted to the Ministry of Finance. As previously described, this requirement is written into the MLAA. In an effort to meet this requirement, LHINs currently request HSPs to manually report their financial condition several weeks in advance of the deadline. Data is reported through the Web-Enabled Reporting System (WERS) to the MOHLTC 30 days after the end of the Quarter. This additional reporting requirement allows the LHINs to assess any future financial risks on the horizon.

The quarterly reporting process is mandatory and LHINs must complete the reports. It is apparent that, for most LHINs, this reporting duty is a workload pressure. In most cases, the Boards of the LHINs review these reports, creating additional workload for LHIN staff in manual report preparation since operational staff need to allow ample time for report preparation and Board review and approval.

Once approved by LHIN Boards, the reports are sent to LLB. LLB and Financial Management Branch (FMB) review the reports and the forecasts to assess financial expenditures and risk. The financial aspects of the reports are forwarded to the Ministry of Finance. Approximately two to four weeks after quarter end, HSPs upload their actual financial data into WERS. This data then is compared with the reported forecasts. Any material variances are reviewed with the LHINs.

This process is resource intensive for the LHINs and results in significant work for the MOHLTC and the HSPs. If there are large variances, LHINs likely will have to contact their HSPs to identify the variance source (therefore the LHINs may have to contact their HSPs twice – once to gather information on any forecast and budget variances and then on any variances between the actuals and the budget). LHINs are required to develop an understanding of the reasons for variances between budget and forecast and between budget and actuals.

It is apparent that the financial aspects of the quarterly reporting process are a resource intensive process for many of the LHINs. It is expected that the resources needed for the preparation of these reports will diminish as LHINs gain further experience with their local system. Previously, regional office staff employed historical knowledge and ongoing dialogue with the HSPs to provide these estimates. Typically, they did not require estimates from HSPs in advance of reported actuals. If the LHINs can rely on their growing knowledge of the HSPs to highlight any financial pressures to the MOHLTC and do not have to request information from each HSP, this will reduce the time required to prepare these quarterly reports. Further, if LHINs only report to the MOHLTC on possible material financial variances, then this may also reduce the time required to manage the financial reporting processes.

Quarterly Reports also include updates on LHIN activities. These reports are sent to LLB, which has a review process in place. The Quarterly Reports are also sent to other areas in the Ministry. For example a section on in-year financial risk reporting requires comments from the FMB. LLB's process is to schedule individual teleconferences with the LHINs to provide feedback. In interviews the LHINs noted that they often do not receive feedback on these reports, and that they would be interested to know how the information is used, and to share any best practices identified in the reports that might help them. The MOHLTC explained that there is a process to feed back information to the individual LHINs and more broadly to all the LHINs, whenever relevant.

Although it is necessary for the LHINs to report quarterly on their financial performance to the MOHLTC, it is questionable whether the operational updates the LHINs provide to the MOHLTC are necessary to fulfill the MOHLTC's role as a steward. These reporting requirements were necessary for the MOHLTC during the early transition phase. Now that the LHINs have authority for the majority of their health service providers and have produced two annual reports on their activities, the requirement for the LHINs to report any operational achievements should be minimized or eliminated. This should have a positive impact on LHIN workload pressures without reducing accountability.

Ad-Hoc Reporting

Ad hoc reporting includes reports or information the LHIN is expected to provide the MOHLTC that are not part of the regularly scheduled reports in Schedule 8 of the MLAA. Examples of these reports include:

- Requests for information on Cardiac Services and Pacemakers in hospitals
- Information on CKD programs
- Weekly Emergency Department staffing capacity reports
- Daily H-SAA negotiations reporting, etc.

Many LHINs said they were expected to provide substantial ad-hoc reporting, often with quick turn-around times. LHINs, in general, understood that there sometimes was a need for this reporting but were frustrated when the processes for these reporting requests were unclear or were incomplete. As system steward, the MOHLTC is required to evaluate the performance of the LHINs and one way to do this is through reporting processes. In turn, the MOHLTC said there are occasions when the LHINs need to understand the political realities of the MOHLTC and that information may be needed to support government decision-making processes. There should be standardization and clarity around the purpose of – and timelines for – these processes to ensure they are effective for both the LHINs and the MOHLTC.

Reporting is predominantly the responsibility of the PCA division, which has voiced concern over already constrained capacity for regularly scheduled events and the financial management of their HSPs. Furthermore, in some LHINs, the Board attempts to review all reports that are sent to the MOHLTC. This further increases the workload as Board papers have to be created. These pressures on workload act as a distraction for the LHINs and do not allow them to focus on their priorities. Going forward, the MOHLTC and LHINs should evaluate reporting processes to understand their value and to reduce any inefficient use of LHIN resources. The MLAA states that the MOHLTC and the LHINs will evaluate reporting processes on an annual basis. This review should also include a thorough evaluation of all reporting, including ad hoc reporting. While some improvements have been made, future streamlining of the quarterly reporting and ad-hoc processes would have a significant positive impact on the LHINs.

Recommendation 13

The MOHLTC should align the reporting requirements of the LHINs more closely to the principles of a stewardship model and the vision for the LHIN model. The MOHLTC should continue to simplify the quarterly reporting process and plan to:

I. Restructure the quarterly reports removing all details of operating activities so they only include financial and performance updates.

II. Identify a materiality threshold for variance reporting so LHINs do not have to follow-up on all financial forecasts.

III. Create a method to provide the LHINs with feedback on their reports and to share any best practices identified through review of reports.

IV. Monitor the volume of reporting requests submitted to the LHINs

V. Create a protocol for all ad-hoc reporting requests that will guide the MOHLTC when requesting information from the LHINs.

As described, the requirements of the MLAA are that the LHINs provide the necessary information to the MOHLTC to enable its oversight role. The information flow in this case is from the LHINs to the MOHLTC. Conversely, there are also supports that the MOHLTC has agreed to provide to the LHINs, so a process flows from the MOHLTC to the LHINs. The following section discusses the information management processes and tools required to support the LHINs and the MOHLTC in their roles.

Information Management

To enable the key LHIN functions of reporting, planning, and system management, LHINs require access to adequate information management tools. In the MLAA, the MOHLTC's obligation is to develop a repository of data and information to support health system needs, and provide repository access to the LHINs. The MLAA also states that the LHINs will be provided with timely access to data and information tools. Further, in Schedule 10, the MLAA states that both parties will work to develop a performance dashboard to monitor local health system performance. The MOHLTC Health System Information Management Investment Division (HSIMID) was set up with the mandate to build data and information management tools and the processes for the LHINs to access these tools. Information requests are directed to the LHIN Support Team at the MOHLTC, within HSIMID.

Many interviewees said the LHINs have not been provided with the necessary tools to enable them to be effective planners, to make decisions based on evidence, and to analyze their local regions health

data. The MOHLTC has provided the LHINs with an information desk but the service on LHIN information requests has been inconsistent. The MOHLTC is actively involved in producing tools for the LHINs, such as the Health-Based Allocation Model (HBAM) and has created the dashboard. The former is still in development and testing and is not yet ready for wide-scale use by the LHINs. The dashboard, however, has been created and rolled out to the LHINs. Further information on the dashboard is included in the chapter on Accountabilities.

Data Requests

Within HSIMID, there is an Access and Release team. It is the first point of contact for LHIN information requests. LHINs contact this group with data requests. These data requests range from basic population demographics to service utilization patterns and other health planning information. There are two people on this team. They receive the request and pass it on to the most relevant person. MOHLTC staff cannot always respond to the LHIN requests in a timely manner since they do not have the resources (HSIMID has not been operating at full staffing levels in 2007/08). In addition, many of the MOHLTC divisions are transitioning and there sometimes are difficulties in tracking down information.

Additionally, there sometimes are recurring requests. One of HSIMID's objectives is to make this information available on a knowledge-exchange website, to standardize reports and tools and to provide methods and modeling functions. Standardization will be important to ensure that there are not 14 different ways of tracking information. Within the LHINs, data and information management has been managed differently across the Province. There are a variety of approaches that have been taken to recruit decision support specialists and epidemiologists. Some LHINs have analysts with significant health sector experience while others have analysts with little health sector experience. As a result, there is inconsistency in the information that LHINs can access and understand. This is a capacity issue and is discussed further within the chapter on capacity.

Interviews with LHINs highlighted the need for the following tools for the LHINs to be effective in executing their mandate.

Identified Tool	Analysis
MIS data • MIS data provides detailed information on HSPs • CSS Agencies are being trained to use MIS • Some LHINs expressed that they require full access to MIS data.	• There was inconsistency between the LHINs on whether or not they had access to MIS data. MOHLTC staff confirmed that LHINs did have access but not to all the detail because, under PHIPPA rules, LHINs are not to be holders of personal information. • It would be useful for LHINs to be provided with an update on the tools they do have access to and provided with the rationale for the levels of detail they can access.
LHIN Dashboard/Balanced Scorecard • A tool to review the performance of the LHINs	• Tool has been provided to the LHINs (see Accountability)
HBAM The Health Based Allocation Model	• LHINs are to be provided with HBAM which LHINs require to enable them to be effective planners and to

Identified Tool	Analysis
(HBAM) is a tool that is being developed by the MOHLTC. This model will include both population-based indicators and direct measures of health status, to provide a more accurate measure of local health needs. The Health-Based Allocation Model determines each LHIN's appropriate share of funding based on: • Direct measures of health status • Population-based factors such as age, gender, socio-economic status, rural geography and patient flows • Provider characteristics	assess needs. • The MOHLTC is still finalizing the tool and plans to provide this tool to the LHINs in 2009. • LHINs have expressed a need to receive more complete information on the assumptions and internal algorithms of HBAM. • Numerous orientation sessions have been provided to the LHINs on the purpose and use of HBAM.

The above table demonstrates that there are currently a variety of information management tools under development for use by the LHINs, but yet there is a continuing expectation for the LHINs to perform at a level "as if" they already had access to these tools. HSIMID is moving to fill the new roles identified as necessary in the transformation of the MOHLTC. This is one of the reasons cited for the delays in providing the LHINs with access to the information tools. As new roles are brought on, the MOHLTC will be able to provide the LHINs with a more effective service. The LHINs and the MOHLTC should develop interim processes to enable each to execute their mandates.

Recommendation 14

The MOHLTC and LHINs should find more effective and timely ways to meet the information requirements of the LHINs.

Summary

Many of the issues discussed so far highlight the overriding theme of capacity and the matching of the work required of the LHINs with their skills and staff levels. Examples of skill gaps and workload pressures were touched on in the section on the devolution of programs, the role of LHINs as program managers, and the processes through which LHINs report to the MOHLTC. The previous section also touched on the capacity strains within the MOHLTC which impact its ability to meet the obligations in the MLAA. Capacity pressures also impact the ability of the LHINs and the MOHLTC to collaborate, the next section explores these issues further.

8 Collaboration

The vision for the LHINs was that they would work together with the MOHLTC on processes and programs that require consistency, innovative thinking, or a Provincial perspective. This was a vision consistently expressed in the consultations with the LHINs and the MOHLTC. There are, however, few formal agreements or mechanisms that define inter-LHIN collaborative mechanisms. For example, each LHIN signed its own MLAA with the MOHLTC. These MLAAs do not contain provisions related to inter-LHIN obligations. This review has also identified that many of the existing collaboration mechanisms require improvement.

There are many areas where LHINs can benefit from inter-LHIN collaboration. These include:

- Standard practices
- Dissemination of best practices
- Implementation of provincial initiatives
- Interfacing with Provincial HSP Associations
- Interfacing with HSPs that provide service across LHIN boundaries
- Coordination of LHIN-MOHLTC interactions
- Training

A key observation of the review is that the LHINs have had difficulties in managing their internal workloads. The strain on LHIN capacity (as described in detail in Chapter 9) has had an impact on their ability to collaborate, not only among the LHINs but also with the MOHLTC and their HSPs. One approach that could strengthen collaboration would see the LHINs establish a central mechanism. This would facilitate collaboration across the 14 LHINs. This section provides information and analysis on the successes and difficulties LHINs have had collaborating. The section is split into five themes. Each is followed by an overall recommendation to increase collaboration effectiveness.

LHIN and MOHLTC Collaboration

The new model for Ontario's health care system is built on the assumption that there will be collaboration and partnerships. There are four primary types of collaboration that must occur to create effective processes and support ongoing change in the LHIN model. These include collaboration between the LHINs and the MOHLTC (LHIN-to-MOHLTC), between MOHLTC branch and divisions (MOHLTC-to-MOHLTC) and among the LHINs (LHIN-to-LHIN). There is also a need for collaborations between LHINs and HSPs. Each of these is discussed in this section.

LHIN-to-LHIN Collaboration

LHINs currently collaborate through regular meetings across all LHINs or with their immediate boundary neighbours. For example, LHIN Chairs meet monthly as do LHIN CEOs. The LHINs need to collaborate with one another to develop common processes, share information and best practices, agree on how to manage provincial programs, participate in provincial policy work, and interact with provincial associations and bodies. Most importantly, the LHINs need to agree on policies, processes, and decision-making criteria that must be consistent across the LHINs. Currently, the guidelines for LHINs to make collective decisions are unclear. In some decisions, LHIN Chairs have to agree to a two-thirds majority before they take collective action. However in practice this has meant that Boards have been involved in decisions that have been more operational in nature. There needs to be clearer guidance to inter-LHIN collective decisions. Though LHINs need the flexibility to respond to the local needs of their particular catchment areas, there is considerable work that is consistent, resulting in efficiencies and common understanding across HSPs. For example, similar proposal submission processes, approvals of end-of-year surplus, and performance monitoring processes.

MOHLTC-to-MOHLTC Collaboration

Within the MOHLTC there is a requirement to collaborate to produce effective policy and strategy. This is amplified with the recent realignment of the MOHLTC in a functional manner to support the LHINs. Cross-functional teams now are required to conceptualize strategy and policy and bring that conceptualization to development. Further collaboration is required with implementation teams who bring the strategy and policy to fruition.

As the transformation of the MOHLTC has been underway, the MOHLTC and LHINs indicated that this internal MOHLTC coordination of strategy has not always functioned as planned to effectively support the roll-out of strategy and policy in the LHIN environment (refer to the chapter on Strategy for further detail). Lessons can be learned from recent experience in the Aging at Home Strategy launch. As described later in this chapter a common issue of concern was communication, especially as messages and role expectations traveled up and down the line from the senior MOHLTC levels to the branches in executing work tasks.

MOHLTC-to-LHIN Collaboration

The LHINs and the MOHLTC are required to collaborate to ensure that the LHINs are involved in provincial strategies, planning for the devolution of programs, and in ensuring that MOHLTC-LHIN shared processes work effectively. There are currently various mechanisms for the MOHLTC and the LHINs to collaborate. For example, the MOHLTC-LHIN working capital group, which is co-chaired by MOHLTC and LHIN representatives, or the joint Ministry Management Committee-CEO monthly meetings.

While these structures exist, and many, such as the Agreement Development Team, function well, in interviews the MOHLTC and the LHINs have said that a number of these working groups have not been effective. Meetings typically have full agendas and can lack focus on strategic issues. The effectiveness of the working groups was raised on numerous occasions and is explored in more depth below.

Working Groups

Working groups are set up to manage certain processes, for example Aging at Home or the MLAA indicator refresh. Working groups can be LHIN only, or MOHLTC and LHIN groups. There is usually a Chair and representatives from across the LHINs. Currently, one CEO is responsible for identifying working group representatives from across the LHINs.

As at April 2008, there were more than 93 working groups set up to provide expertise, guide implementation, negotiate agreements, lead performance improvement initiatives, and evaluate outcomes. It is a credit to the MOHLTC and the LHINs that they have been able to create so many groups. It is also a reflection of all the work that the LHINs and the MOHLTC had to do to establish operations and the new processes of the LHINs. Many LHIN and MOHLTC staff suggested that the sheer number of these working groups was an indication that there needed to be a better process to collaborate. Upon examination, it became clear that these groups were not as effective as they should be.

One of the concerns about these working groups was that there are no consistent formal processes to:

- Establish these working groups
- Manage the agendas for these groups
- Communicate to the necessary staff on discussions and outcomes
- Confirm shared decisions
- Get cross-LHIN representation and representation from LLB
- Agree on measures to implement next steps

It is not our contention that all 93 working groups have had these issues. Many said that that there have been many successful collaborations between the MOHLTC and LHINs, such as the Agreement Development Team, which is responsible for the development and refresh of the MLAA.

Observing the current state of LHIN and MOHLTC collaborations has led to the conclusion that the LHINs do not have effective mechanisms through which to collaborate with each other and that a shared central function is required to coordinate and support LHIN collaborations. Another aspect of collaborations is the need for effective lines of communications between the MOHLTC, LHINs, the HSPs, and the Provincial Associations.

Lines of Communication

Lines of communication are the processes through which the MOHLTC, LHINs, and other stakeholders communicate among themselves and with each other. The LHIN model was established with some clear horizontal lines of communications. Channels of communications were envisaged between the Minister and LHIN Chairs, as well as the Deputy Minister and CEOs. Horizontal lines of communications do not always work as effectively as planned. Furthermore, the majority of interviewees said that vertical internal communications within the LHINs and the MOHLTC also are not consistently effective. There are examples of LLB and LHIN staff not hearing the same messages as their managers or

receiving messages some time after their managers had received the information. There are few formal mechanisms to ensure that all staff are provided with the necessary information. One of the reasons cited for this ineffective process was that the LHIN and MOHLTC senior staff have high workloads and the volume of communication is sometimes overwhelming. The LHINs and the MOHLTC need to filter and prioritize the flow of information and communications such that the volume of communication is reduced and the relevant people can receive important communications in a timely manner.

Lines of communications between MOHLTC communicators and LHIN communicators

Within the Communications Information Branch, there is the LHIN Communications Team (LCT). The LCT was structured as a time-limited, one-window approach to communicate with and support the LHINs with media procedures, annual reports, visual identity, etc. The LCT has been the main conduit for sharing communications with the LHIN communicators. Generally, respondents described the LCT as an effective coordination mechanism for overall communications. Since the LCT is to be disbanded at the end of fiscal year 2008/09, the services provided by LCT will no longer be provided through the MOHLTC.

LHIN-HSP-Provider Association communications

Interviews with a sample of Health Service Providers and Health Service Provider Associations revealed a common concern that there are ineffective lines of communications with the LHINs as a provincial group. Note that the majority of HSPs interviewed felt that they had effective and open lines of communications with their individual LHINs. The issue is how to communicate with more than one LHIN and ensure consistent communications. An example cited was the ineffective communication processes to deal with HSPs that cross LHIN boundaries. HSPs stated that LHINs are not consistent in their practices. This can impact the HSPs workloads. In these cases, the HSPs have to communicate with multiple LHINs although they do not have a means to do so. These findings were corroborated with representatives of Provider Associations, who also said they do not have means to communicate with multiple LHINs. There are no formal mechanisms for the LHINs to speak with one voice or for the LHINs to be contacted through one channel.

A related area that requires collaboration and consistency is the sharing and disseminating of best practices.

Best practices

Under the LHSIA, LHINs are required to disseminate best practices but do not always have the resources to identify best practices or mechanisms to share them. LHINs indicated that it would be useful to have one central function that can:

- Provide the LHINs with research information
- Act as a library to hold best practices information (such as the LHIN intranet site) on behalf of the LHINs.

LHIN Shared Services Office (LSSO) and Legal Services

LSSO and legal services are examples of how LHINs have collaborated to provide shared services. Currently, this function resides within the Toronto Central LHIN and reports to a Management Committee. The role of LSSO is described in the section on Capacity. If a structure is created to

coordinate all LHIN collaborations, it seems reasonable that the LSSO, training and legal services should be housed in this structure.

Training

The variability of staff skill sets across LHINs is reflected within the chapter on Capacity. Some working groups mentioned that they spend a large proportion of their time educating staff. Currently, the LHINs have not established professional development as a budget line and there is no process in place to ensure LHIN staff have consistent, on-going training. There has also been no recent needs assessment of the LHINs training requirements.

LHINs require a resource that can provide them with professional-development training as well as training on specific competencies, such as negotiation skills.

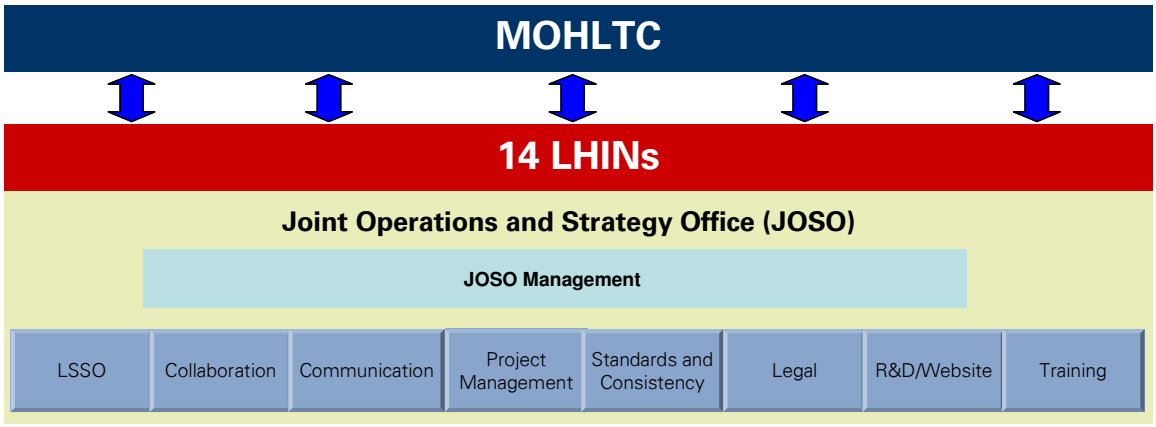
Currently, there is no process for LHINs to be provided uniform training unless the MOHLTC provides it or one LHIN manages the training for all LHINs. LHINs are not organized, nor do they have resources or mechanisms, to consistently provide this type of inter-LHIN coordination.

Summary

LHIN effectiveness would benefit from more formal collaboration mechanisms. It is apparent the LHINs also require an overall project-management function to coordinate and provide administrative support to working groups, shared projects, and other collaborations. To enable their effectiveness, LHINs also require coordination to effectively support their communication with the MOHLTC, HSPs, and Provider Associations. The following section proposes a Joint Operations and Strategy Office (JOSO) as a new structure to facilitate increased inter-LHIN collaboration activity.

Joint Operations and Strategy Office

Analysis of the current state of LHINs and MOHLTC demonstrates that both have been very active in trying to work together through the creation of working groups, using cross-LHIN meetings and LLB as a conduit to pass information through the MOHLTC to the LHINs and vice versa. However, it has become apparent that the LHINs would benefit from a shared mechanism that enables collaboration and communication that would provide a common voice to identify standards and consistency. There also needs to be better guidelines for inter-LHIN decision making. To address this issue, we propose a Joint Operations and Strategy Office (JOSO) illustrated below.



Proposed functions of JOSO:

- *Communications and Collaboration*

The secretariat/collaborative structure illustrated above would provide the LHINs with a mechanism to collaborate on joint projects with the MOHLTC and communicate progress back across the LHINs. JOSO would also provide a base for interaction with health service provider associations, or those health service providers with services or locations that span several LHINs (e.g. Academic Health Science Centres, Long Term Care Home operators etc.)

The MOHLTC and LHINs are establishing a collaborative structure to create mechanisms, through which LHINs and HSPs and Associations can collaborate, for example on policy and strategy. It is recommended that this structure sit within JOSO.

- *Project Management*

The structure would provide a shared project management office for provincial strategies and initiatives that require consistency.

- *Best Practices (Research & Data /website) and Standards and Consistency*

The structure would enable the sharing of best practices, act as a resource centre, and be a source for training. The structure would enable LHIN-wide identification of necessary standards and processes that should be consistent.

- *Training*

The structure would provide LHIN-wide training following completion of a training needs assessment across the LHINs

- *The LHIN Shared Services Office (LSSO) and LHIN Legal Services.*

LSSO and Legal services already exist in the LHIN model to provide some shared services to the LHINs. It is recommended that all cross-LHIN functions reside in one structure, and that LSSO and the Legal Services function be incorporated into JOSO.

It is envisioned that a management committee will provide oversight to the Joint Office, consisting of a small core staff, supplemented by secondees from within the LHINs, and contract resources, to provide project management support for provincial initiatives. LHINs would be required to fully analyze their needs with respect to each of these functions to accurately determine staffing levels and how the office would function and operate. It is expected that JOSO would enable the overall LHIN system to more effectively deploy and use its existing resources.

The functions listed above are not exhaustive A full capacity needs assessment of a Joint Operations and Strategy Office should be completed by the LHINs and MOHLTC. JOSO is to serve the LHINs' shared needs and to enable the LHINs to focus on their core local functions of planning, community engagement, funding, and integrating. It is likely that each function of JOSO will not need dedicated staff, that staff can be seconded to JOSO as required, and that some staff may be able to handle several functions, such as Research and Development and Standards and Consistency.

Recommendation 15

The LHINs should work collaboratively to develop a LHIN Joint Operations and Strategy Office (JOSO is a suggested name). When the LHINs were created, it was expected they would work together as a team. However, without the tools and structures to enable these partnerships it is difficult for 14 separate organizations to work together. JOSO would support inter-LHIN initiatives, develop consistent methodologies, provide project management support, training, and liaison with the MOHLTC Communications Information Branch, support the proposed MOHLTC-LHIN-HSP collaborative structures, and house LSSO and LHIN Legal services.

To enable this, MOHLTC should:

- *Increase LHIN operational budgets to enable them to support JOSO. It is anticipated that JOSO would have a small core staff and would engage a combination of LHIN secondees and external resources on a project basis.*

Throughout this report, reference has been made to the capacity pressures in the system and recommendations, such as the implementation of JOSO and a refinement of reporting processes, have been identified to ease some this pressure. The following section provides a detailed review of LHIN and MOHLTC capacity.

9 Capacity

Capacity represents the ability of the LHINs and the MOHLTC to respond to the demands of their expected roles efficiently and effectively. Throughout this report we have identified factors that impact the capacity of the system. During the review it was clear that both the LHINs and the MOHLTC face capacity pressures,. These pressures add further weight to the achievements of both the LHINs and the MOHLTC in making extensive progress towards the vision state. Going forward, there is a risk that the LHINs will not be able to fulfill their mandate due to inadequate staff numbers, skills levels and, in many cases, ineffective resource deployment. A great deal of the workload experienced by LHINs is created by the MOHLTC and is not seen as being under the control of LHIN management. There is also a risk that while the MOHLTC itself is in transition, the internal organizational gaps will impact on the effectiveness of the MOHLTC-LHIN model.

This chapter aims to understand why these pressures exist and how they could be alleviated to improve the effectiveness of Ministry/LHIN transition.

LHIN Capacity

During the planning for the LHINs, the functions and scope of the LHINs and the MOHLTC as system steward were mapped out at a high level. It was difficult, without evidence from other jurisdictions, to determine what the most effective organizational design should be to support the planned LHIN functions. Ontario was the first province to put in place a model that focused heavily on community engagement as a key tenet. As a result, once the functions began to be put into operation in the LHINs, it was apparent that the current organizational structure was not aligned with the workloads of the LHINs. To some extent, this is to be expected since the MOHLTC did not have any comparative organizations.

It was intended that the LHINs, as small and smart organizations, would be able to provide quick responses and implement solutions within their local environment. After some consideration of different models, LHINs were established with one constant organizational structure. There was a high-level capacity review to align the expected work of a LHIN with the expected skill requirements. Job descriptions were provided to the LHIN to match the organizational structure. At the time of conception, it was difficult to map the detailed functionality of the LHINs to the required numbers of FTEs and skill sets.

In general, LHINs were provided with the following positions:

- A Board Chair and eight Board members;
- A CEO who reports to the Board;
- Two Senior Directors who report to the CEO, one to manage the Planning, Integration and Community Engagement (PICE) division and another to manage the Performance, Contracts and Allocations (PCA) division. Within each division, there are approximately eight consultants reporting to their Senior Director.
- Approximately two-three administrators and a corporate coordinator.

With these resources, the LHINs have been successful at engaging their stakeholders and their communities. HSPs indicated LHINs have been successful at bringing together different sectors within their local regions. With some LHINs, the PICE and PCA teams have significant points of integration with programs and projects seamlessly moving from one division to another. Some LHINs have changed or refined their original structures to more effectively manage the demands of their work. This reorganization is analyzed further in this section.

The LHINs have a relatively small number of resources to manage what is in many cases a significant workload. Some quick facts:

- The average LHIN has 23 FTEs; the range is 18 to 30.
- Each LHIN has to manage the performance and finances of, on average, 157 HSPs; the range is 49 to 265;
- Two LHINs cover more than 400,000 sq. km.

More detailed analysis of LHIN characteristics can be found in Appendix A. The two LHINs with the largest geographic span are also the LHINs with the largest numbers of HSPs. This has a significant impact on the workloads since community and stakeholder engagement can involve a great deal of travel time.

The majority of LHIN staff said they were overwhelmed with the amount of work. It was also the perception of many MOHLTC staff that LHIN workloads were quite high and that this explained why LHIN attendance at working groups was variable and why messages and to-do actions were not always communicated effectively within the LHINs. HSP interviewees said LHIN staff are extremely busy and perceived the LHIN environment as high-stress. All parties said the LHINs seemed to have significant capacity pressure.

A number of factors impact the capacity constraints of the LHINs, including:

- Reporting
- Access to information
- Collaborative Structures
- Organizational structures
- Priority and Engagement models
- Basic office systems
- Resources

The first three of these have been analyzed within the chapter on Reporting and Information Management and Collaboration. Each of the other factors is reviewed in this chapter. Each factor relates to recommendations that are premised on the LHINs and the MOHLTC taking steps to improve the effectiveness of the other areas highlighted so far in this report. For example, that the reporting requirements of the LHINs will be more streamlined. It is anticipated that LHINs will be able to better manage their capacity issues by increasing the effectiveness of the factors discussed below.

Organizational Structures

In addition to the capacity constraints just mentioned, the original organizational structure of some LHINs has led to the development of silos that separate the PCA and PICE teams. In reality, many tasks

require input from the skill sets within each division. Some LHINs noted that these silos lead to ineffective working processes. For example, the Aging at Home initiative, in which the PICE division was responsible for putting together all the proposals and identifying the performance measures of each proposal without input from the PCA team. The PCA team has specific staff with performance indicator skills and experience that could have provided an overview of all the indicators being used in the local health system.

In this example, had the PCA team worked more closely with the PICE team the process would have been more efficient and effective. Some LHINs have identified these silos and created new organizational structures to address and increase the points of integration. One LHIN has created a Chief Operating Officer post plus three divisions. Another LHIN is proposing a matrix structure, such that each LHIN priority is supported by PICE and PCA staff. The objectives of these new structures include enhancing the integration between the two divisions in the LHINs. An analysis of the effectiveness of these new structures has not been completed; however, the need for closer working relations between PCA and PICE teams has been identified as an area for improvement and leads to the following recommendation.

Recommendation 16

The LHINs should develop processes and/or structures to facilitate more effective points of integration within the organizations particularly between the Planning, Integration and Community Engagement and Performance, Contracts and Allocations teams. Some LHINs have already begun this process, developing project teams, new process flows, and staff whose responsibilities cross these functions.

Priority and Engagement Models

Additionally, LHINs have been very active in planning through the creation of their IHSPs and different planning structures in their local health regions. In implementing the IHSPs, LHINs have created a multitude of planning networks, advisory groups, councils, planning areas, and so on. LHINs use these networks to varying degrees. Some have decision-making authority, some have finite time schedules and terms of reference to deliver recommendations, while others are ongoing and are used for advice and feedback.

An observation is that the LHINs have been very involved in planning but due to the delayed release of the Provincial Strategy, and because LHINs are still getting to know the needs of their regions, there has not been sufficient prioritization of the planning function and planning bodies. LHINs need to prioritize their activities and balance provincial priorities with local priority needs. This should allow them to also focus more resources on system transformation

Recommendation 17

LHINs should re-evaluate how they accomplish their work in order to appropriately manage and deliver on their objectives. This will require the LHINs to prioritize or eliminate certain planning and community engagement activities in order to focus their resources and more effectively facilitate health system integration and transformation activities.

Basic Office Systems

The LHIN Shared Service Office is mandated by the government. The vision of LSSO is to provide common services to the LHINs, efficiently and effectively. LSSO is responsible for information technology services (IT) and IT enabled services, which include Human Resources (HR), Payroll and Finance & Accounting. The IT network is outsourced to an external party. The LSSO charges the LHINs for additional services which include Legal and Audit services, but the delivery of these services is managed separately from the LSSO. The Shared Services Agreement from April 2006 defines the arrangements between the LHINs for sharing the services.

In 2007/08, LSSO had six staff members. LSSO is accountable to the Toronto Central LHIN Board and also reports to a Management Committee which is represented by both LHIN CEOs and Chairs. This Management Committee approves budget requests, new contracts and extensions to contracts.

Generally, LHINs had mixed reactions to the service provided by LSSO. LHINs understood that LSSO had the same amount of time to set up its initial processes as the LHINs. LSSO has created many new processes from scratch with limited resources and the LHINs have been provided with IT systems, a payroll function and HR processes. Some LHINs expressed that there have been issues with processes that are under the mandate of LSSO. Their concerns were largely focused on the adequacy of the information technology and human resources supports provided by a contracted third party. The majority of interviewees acknowledged that the main issues were not within LSSO's direct control. Recently some significant steps have been taken to strengthen service contract controls.

LHIN staff expressed frustration at having to spend their time on these issues when they already have high workloads. Many of the issues identified by the LHINs were acknowledged by LSSO. LSSO staff added further weight to the issues by expressing that the overall infrastructure provided to the LHINs is not as comprehensive as needed. For example, LHINs have not been provided with electronic HR systems, facilities to book meetings across LHINs, adequate phone systems, wireless systems, collaboration space, and so forth.

There appears to be a disconnect between the role LSSO has been asked to perform and the resources and authority provided to it to provide this service. A comprehensive assessment of the capacity of LSSO has not been completed as part of this review. However, it appears from the majority of LHIN interviews that there is a gap in service.

The current governance arrangement for LSSO may be contributing to these service gaps. LSSO has had several funding requests declined. It is unclear whether the majority of the LHINs had a good understanding of how the requested funds were to be applied to address the service problems. Information from LHIN interviews suggest that some LHIN Boards are reluctant to support a shared service and do not understand the value proposition provided by LSSO. The LSSO governance committee membership includes both LHIN CEOs and Chairs. Given the operational nature of the LSSO services, it would be more appropriate to have a governance committee that consisted only of LHIN CEOs and possibly some office managers.

A thorough review of the required outputs and levels of service is also required to assess the necessary service arrangement provided by LSSO. Since the LHINs have been in place for a few years, there is more of an understanding of their business needs. LSSO leadership should provide a comprehensive review of the requirements to support those business needs and the appropriate funding to achieve the desired level of output.

Current support systems do not meet minimal standards to support basic operational needs. To address this issue, we recommend:

Recommendation 18

The LHINs should review their needs for basic operational tools such as wireless connectivity, meeting scheduling packages, contact management systems, electronic HR functions, etc. and provide LSSO with the resources to provide these tools.

The LHINs should also change the composition of the LSSO Governing body to include only senior LHIN staff.

Resources

There should be a positive impact on the current workload pressures at the LHINs if the recommendations are implemented to:

- Develop JOSO
- Improve the reporting requirements, access to information, and points of integration between PICE and PCA, to prioritize LHIN planning and community engagement and to improve LHIN basic office tools

Another workload pressure cited was that many LHINs did not have sufficient resources and competencies to execute their mandate. Even though it is acknowledged that some LHINs have been very innovative with their resources and in the management of their pressures through hiring consultants short-term and leveraging their HSPs, LHIN workloads are not always within their control. Pressures can be defined as internal workloads, which the LHIN controls, and external workloads, which originate at the MOHLTC or within the local regions. It is important to segregate the two types of workloads and drivers of these workloads to understand how much control LHINs actually have over their workload pressures. The table following provides a summary of these drivers split between pressures that are in LHIN control and pressures that are beyond LHIN control (the table is not intended to demonstrate all the work LHINs are involved in but areas that have been cited as pressures.) Pressures are shown that are not in the LHINs control to demonstrate that to a large extent, LHINs do not have the control over their workloads and that if the workload continues to increase, the capacity needs of the LHINs should be increased.

Work Pressures	Description
Within LHIN Control	
Working Groups	There are 93 working groups and LHIN representation is a requirement. LHIN staff have to attend meetings, provide input into processes, communicate back to the LHIN/LHINs on findings and sometimes LHIN staff have to provide administrative supports for these groups
Management of planning groups	LHINs have created many different planning areas within their local regions to enable them to plan for their IHSP priorities. Some LHINs have more than 20 planning groups. These

Work Pressures	Description
	areas require management, administrative support, facilitation and financial support.
Performance Management	To be effective system managers, LHINs have to manage the performance of their HSPs. With some LHINs, having more than 200 HSPs, it is a resource-intensive process.
Board Management	In some LHINs, the Board meets twice a month. Staff have to create and review documentation for these meetings. Staff voiced concern about the amount of time they spend working on Board reports. A sample of Board Minutes were scanned and reviewed and this identified that some staff are required to report to the Board on many LHIN operations such as numbers of community engagements, details of service provision in HSPs, details of staff appointments in HSPs and so forth.
Financial Analysis	LHINs have, on average, 157 health service providers (see Appendices). LHINs have to forecast the HSPs financial information every quarter, provide analysis on variances and then reconcile these to the actuals which are reported a few weeks later.
Communications	Communication specialists were not in the original LHIN organizational structure. Many LHINs have recruited one to two communication posts. Some LHIN CEOs changed the structure of their organization to enable them to hire a communications specialist
Process Development	LHINs are new organizations and therefore have spent time developing processes for example an issues management process.
Beyond LHIN Control	
Reporting (including ad-hoc reporting requests)	Staff in both PICE and PCA spend a significant proportion of their time producing reports for the MOHLTC. Both standard reports and ad-hoc reports. There are examples of frequent MOHLTC and Ministers Office requests for various reports and information that are not scheduled
Data Collection and Analysis	LHIN staff require data to analyze and plan for their local needs. At the time of writing of this report, this resource is not fully established at the MOHLTC. In the original LHIN design it was envisioned that decision support would be provided by the MOHLTC. LHINs spend significant time creating tools and scrubbing data to align with their LHIN boundaries. When decisions have to be made quickly by the LHINs, the LHINs require decision support staff to help them make these decisions based on sufficient cost-benefit or evidence-based analysis.
MOHLTC Priorities	When the Aging at Home strategy was rolled out, the LHINs were allocated $3M to assist in the planning of submissions. Some LHINs took on a more Provincial role and planned provincial events.
Program Management	Programs have been devolved to the LHINs, such as Chronic Kidney Diseases (CKD), that LHINs are required to manage. Some LHINs do not have the program managers or the program management skills to effectively manage these programs.

Work Pressures	Description
Capital Issues	LHINs have been involved in HSP capital planning. CEOs or Senior Directors have had to provide opinion on capital planning initiatives related to their longer term system plans.
Health System Providers Management	LHINs have had instances when their HSPs have been in material financial difficulty and have cut resources in their organizations. LHINs have to provide advice, support, and communications during these instances. The original LHIN structure did not clearly define the workload related to providing support to providers.
LHIN Geography	Two LHINs, in particular, have very large geographies. These LHINs also have a significant number of HSPs and community engagement and Service Accountability Agreement negotiations involve a great deal of travel.
Issues Management	Issues Management was not envisaged as part of the LHINs original mandate. There was initial guidance provided to the LHINs on Issues Management in terms of a process to follow but this has not been reviewed. Each LHIN has started its own issues management process. As a result LHINs do not have a consistent process for escalating issues.

The above list is not exhaustive, but does start to provide an explanation of why the LHINs have voiced concerns about their workloads. The issue of resources is related not only to numbers of staff, but also an appropriate skill/competency mix for the required work. As the LHINs have evolved their skill requirements have become clearer. This review has identified the top five skills and resource gaps within many LHINs. Again, this may not be relevant to each LHIN, since a minority of LHINs have created new structures and positions for their organizations. Each skill is discussed below.

Project Management

Description: LHINs work on many multi-function initiatives. The original design of the LHINs did not anticipate a portfolio-management role to perform centralized planning, organizing, staffing, controlling, and management of specific projects as well as providing oversight on multiple LHIN priorities. As a result, some LHINs have created project-management roles (sometimes through hiring of consultants) but resources for this role were not provided to the LHINs.

Clinical Program Management

Description: Many programs have been devolved to the LHINs, such as Chronic Kidney Disease, that necessitate the LHINs to be the program managers. The original LHIN structure does not highlight the need for program-management functions and consequently many LHINs have expressed that program management is not within their mandate.

Communications

Description: There were no communications positions factored into the original LHIN structure. LHINs are involved in communications with the public, MPPs, the MOHLTC, and with their providers. Twelve LHINs have created communication positions using their base budgets. In creating communications posts, many LHINs had to take these salaries away from other positions, such as office managers and

financial controllers. As at April 2008, there were four LHINs without dedicated communications positions. In these LHINs, the role of communications is filled by administrative staff or all staff on a needs basis.

Financial Analysts

Description: In general, most LHINs have one senior financial consultant and one to two financial analysts. Across the LHINs, there is variability in their duties, but responsibilities include allocating and managing funds for all HSPs, uploading funding data and reconciliations of Allocation and Payment Tracking System (APTS) accounts, assisting on negotiations of budgets, review of HSPs reports, preparation of financial and performance reports, and responding to HSP/MOHLTC enquiries.

Performance Management

Description: It is the LHINs mandate to monitor, measure, and understand the performance of their system which they do through review of HSP performance data.

Increasing Capacity

Overall, during 2007/08, the scope of LHIN work has increased without a corresponding review of the LHINs capacity to complete these tasks. The above analysis of LHIN operational structures during 2007/08 leads to the conclusion that many LHINs are under-resourced and under-skilled in several areas. The impact, going forward, is that the LHINs will not be able to achieve their objectives without an increase in their resources. To this end, the LHINs had been provided with an overall increase of 23% to their 2008/09 operational budget. This will enable the LHINs to alleviate, to some extent, these capacity pressures. Whether this is sufficient to manage the LHIN capacity issues depends on the pressures in each LHIN and how they allocate these funds. Some LHINs have indicated that part of this budget increase will be allocated to closing salary gaps to bring positions in line with the market, governance costs, and augmenting office space. It is unknown to what extent that this increase will be sufficient to enable the LHINs to increase their resources to align appropriately with their workloads.

The following recommendation assumes that LHINs and the MOHLTC will implement the earlier effectiveness recommendations.

Recommendation 19

Many LHINs will require more resources in order to effectively manage their responsibilities. The LHINs should be required to go through a systematic process to document their resource requirements as per the following recommendations:

- *LHINs should, if they have not already done so, undertake an organizational review using a consistent work-load methodology. Part of this review should include an assessment of the current LHIN skill requirements and competencies. The needs across the LHINs will differ depending on their characteristics (numbers of HSPs etc.)*
- *LHINs should collate all organizational reviews and identify gaps and the funding increase necessary to address these gaps*
- *The MOHLTC should flow increases to operational funds, for human resources and space requirements, mid-year. If this is not possible, by fiscal year 2009/10 based on the approval of the submitted proposal*

Summary

As described throughout this section, there are many contributing factors to the lack of LHIN capacity. Long before their launch, as the design of the LHINs took shape, it was difficult to map detailed functions to a design that aligned with current realities. The accountability function of the LHINs has become enhanced in this new model, as has the engagement of local communities. This functionality and the requirement of board oversight has created a greater workload than previously existed. The integration function that the LHINs play is also a role that will increasingly draw resources as they translate planning into action. The role the LHINs play in managing the local health system requires increases in the types of skills at the LHINs: clinical program management, project management, financial and performance analysis, and communications and issues management.

MOHLTC Capacity

While capacity was an issue at the LHINs, it was also an issue identified at the MOHLTC. While the LHINs were building their organizations, the MOHLTC was also in the process of reorganizing to support its stewardship role. This included dismantling the regional offices, and creating new and reorganized branches within the MOHLTC. At the time of this writing, the MOHLTC still is completing its transition.

As of May 2008, these are some of the MOHLTC branches not yet fully staffed as intended in the transformation to the role of stewardship:

- Health Data Branch;
- Health Analytics Branch;
- Knowledge Management Branch;
- Strategic Investment Planning Branch; and,
- Health Program Policy and Standards Branch.

These branches also support and interface with the LHINs. Both the LHINs and the MOHLTC are undergoing significant changes and should be cognizant that some capacity pressures and ineffective processes may be short term until processes and activities are fully implemented.

As the MOHLTC transitions to its steward role, there are significant role gaps that impact the ability of the MOHLTC and the LHINs to work effectively together. The model of stewardship that the MOHLTC has adopted requires significant and changing competencies as the MOHLTC moves from managers to stewards of the system. MOHLTC capacity constraints include:

- There is an Access and Release Team within the Health System Information Management and Investment Division (HSIMID) that is the first point of contact for LHIN information requests. There were two FTEs for this team. They were extremely stretched and this impacted the turnaround time of information for the LHINs. Recruitment for the planned vacancies is now underway;
- Significant vacancies within the Strategic Investment Planning Branch also affected the support the LHINs required.

What are the implications of these realities?

The MOHLTC's gaps in planned capacity have had an impact on the effectiveness of the LHINs. Some of the impacts include:

- As the MOHLTC is transforming and staff are being recruited and are moving in from different branches, they do not always begin with an in-depth understanding of the MOHLTC-LHIN model.
- LHINs requests are not always completed on a timely basis. Even if LLB tries to answer the questions, there can be delays in getting answers from across MOHLTC branches since there are some areas that no longer exist and others that are still learning about their new role.

While the MOHLTC is transitioning, there is a need for interim processes to assist the LHINs and the MOHLTC staff to understand each other's needs and to complete the tasks expected of them.

Recommendation 20

The MOHLTC should complete the budgeted staffing up of LHIN support divisions and branches – especially those that provide critical functions for the LHINs – as soon as possible. These should include, but are not limited to, Health Analytics Branch, Strategic Investment Planning Branch, and the Health Program Policy and Standards Branch.

10 LHIN Liaison Branch

The LHIN Liaison Branch (LLB) was created in early 2007 within the System Accountability and Performance Division. The MOHLTC created it to provide coordination and oversight to the LHINs and to be a central point for interaction with the LHINs. The branch's mandate is:

> *To support the ministry's working relationship with LHINs. The branch will see that the obligations of the Local Health System Integration Act and related legislation are met by the LHINs and the Ministry through development, negotiation, and management of relationships and accountability agreements.*

Thus, it is clear that LLB's role is to provide oversight on LHSIA and to hold both the MOHLTC and the LHINs accountable for the obligations within the Act. LLB has been extremely proactive in its first year of operations in developing, negotiating, and managing relationships and the accountability agreement (MLAA), as well as in the development of many new processes and protocols.

Many of LLB's functions involve coordination of processes, provision of guidance, and the review of LHIN implementation of this guidance. These tasks were important to enable success of the LHIN-MOHLTC relationships and accountabilities. The number of new processes created by LLB has been significant. Added to these are roles that LLB has become involved in since its inception, such as working with other MOHLTC branches and divisions to roll out the Aging at Home strategy and working with the LHINs to review the LHIN proposals. This is just one example of a function that was not in the original scope of LLB's mandate but has defaulted to LLB as it coordinates the MOHLTC's relationship with the LHINs.

Further, LLB serves a liaison role and throughout 2007/08 and to date, LLB has been the primary point of contact for the LHINs for any support or guidance they require. LLB has played a significant role in fulfilling this mandate. Many LHIN staff said that LLB staff are strongly supportive of the role of the LHINs and passionate about enabling the LHINs to achieve their mandate. However, MOHLTC and LHIN staff expressed the sense that they do not fully understand the full scope of what LLB does. Interviewees expressed many different perspectives on LLB: as an advocate for the LHINs, as a buffer between the MOHLTC and the LHINs, managing LHINs accountability agreements, being the first point of contact for MOHLTC staff on LHINs, and so forth. LLB is also sometimes perceived as the messenger between the MOHLTC and the LHINs. It may be that LLB has provided all these functions during the first year of LHIN operations but that lack of clarity has contributed to a sense of frustration around the expectations of what LLB should be doing. Some clarity is required on the role of LLB, both within the MOHLTC and the LHINs.

LLB's key activities can be split into three sections (not including LLBs role in French Language services)

- First is managing the relationship between the Ministry and the LHINs, the development of negotiation and accountability agreements
- Second is being the liaison to the LHINs
- Third; is being the liaison with the MOHLTC departments and divisions

Relationships and accountability agreements

To a large extent, LLB has been successful in developing and creating processes and protocols for the management of relationships and accountability agreements. In the first year of operations, LLB created processes for the Annual Service Plan, the MLAA refresh, and the Annual Reports and quarterly reports. There had been some issues identified in the first year of these processes, prompting LLB and the LHINs to conduct a review, identify improvements and implement these improvements for the second year of full LHIN operations. Within this realm of LLB activities, challenges are to be expected in the first few years as new processes are developed to support Ontario's new health-care system model. It is essential that LLB continue to review its processes through engagement with the LHINs.

Liaison with LHINs

Within LLB, senior and program consultants have been allocated specific LHINs, and LHIN staff contact LLB consultants with a wide range of queries (MOHLTC staff may also contact LLB staff for queries relating to LHINs). In general, LHIN operational staff said there were effective lines of communication with LLB. There was a range of opinions on the role of LLB. Some interviewees said they do not perceive LLB as adding value and cited examples of program consultants who were not providing the LHINs with the service they expected and not responding in a timely manner to queries. Others said they have a very effective working relationship with LLB and that LLB provides a quality service. As an alternative some LHINs tried to find direct supports within the MOHLTC. The variety of perceptions and some of the examples of process issues that were mentioned and corroborated by LHIN staff are to a certain extent due to LLB being in the first year of operations, and partly due to the internal transformation process within the MOHLTC, which resulted in many staff changes and changes in departments and branches. As a result, LLB has not always met the expectations of those looking for information or assistance.

It is apparent that LLB's role as the LHINs' first point of contact will decline as LHINs build up relationships with other departments in the MOHLTC and gain experience in the different processes they manage. LLB's role as a liaison is necessary to ensure the effectiveness of the system. However, the nature of this liaison role as a support to the LHINs is likely to change over time.

Support to MOHLTC LHIN Focused Activities

MOHLTC branches and divisions are to include LLB in their contacts with the LHINs and can utilize LLB as a resource to find the appropriate contacts within the LHINs. LLB works with the divisions and branches in the MOHLTC in various ways. The Director of LLB meets with the Directors of MOHLTC divisions that interface with the LHINs through the MOHLTC-LHIN Accountability Agreement Committee. This committee is set up specifically for knowledge exchange and ongoing information sharing. In addition, LLB representatives are members of working groups, examples of these include; the MOHLTC-LHIN Capital Working Group, the Service Accountability Working Group, and the Performance Indicator Working Group.

Some MOHLTC staff mentioned that certain requisite skill sets were not available within LLB. For example, there was concern that LLB did not have the program-management skills to roll out new funding strategies and provide support to the LHINs on the programs. As discussed within the section on Authority, there was a lack of clarity over the implementation processes for new initiatives. This lack of clarity extended to the role of LLB in the review of funding submissions by the LHINs. These are not

processes that were envisaged as being within the purview of LLB and thus created some stress on the capacity of LLB. The review of funding submissions after the approval by LHIN Boards led to some confusion. If LLB can work closely with the LHINs prior to Board approval to ensure that there are no legal, regulatory, or policy barriers, the review of funding submissions after Board approval may be negated.

Summary

It is clear that LLB has achieved a great deal given the time it has been operational and the resources with which it has been provided. The MOHLTC, as a whole, has had many changes with the transition and LLB has had to work with the LHINs during this period. To a large extent, LLB has been successful in supporting the MOHLTC's working relationship with LHINs. The Branch has been successful at assisting LHINs while developing its own structures, processes, and culture. As with any start up, not all processes have been effective, but there are continuous efforts through consultations and discussion to refine these processes. LLB has undertaken certain broader responsibilities due to emerging needs in the Ministry in order to expediently implement initiatives. The role of LLB as the first point of contact has been refined and will be refined further as the LHINs develop direct relationships with other parts of the MOHLTC. This will provide an opportunity for the LLB to further develop its core mandate of performance and accountability oversight.

Recommendation 21

The MOHLTC should review and refine the structure of the LHIN Liaison Branch (LLB) to enable it to continue its evolution towards providing a comprehensive link between the MOHLTC and LHINs.

- *LLB should continue to provide the MOHLTC's oversight of the LHINs. In addition, it should enhance its role to assist the MOHLTC to ensure that policy, strategy, and standards development are aligned within the LHIN model.*
- *LLB should coordinate policy support to the LHINs on strategy implementation and special initiatives during the development of submissions by working with the LHINs to review legal and policy constraints prior to Board approval. This may negate the need for LLB staff to review LHIN allocations after they have been approved by the LHIN Boards.*
- *Senior Management of LLB should continue to review the organization structure and roles of LLB staff to align them with their mandate. It is anticipated that there will be a need to shift resources from the liaison function to other mandate areas*

This concludes the operational section of the report. The following section presents the findings of the governance review.

11 Governance

The Local Health Integration Networks (LHINs) were established to facilitate local governance of the health care system in Ontario. Established as Crown Corporations, each LHIN has a nine member Board. Six of the Board members, including the Chair, are appointed by the Minister of Health and Long-Term Care through Orders in Council (OIC). The remaining three are nominated by the initial Board members and put forward to the Minister. The Chair and Board members are paid for the hours they spend on LHIN activities.

Overall, this Review found LHIN Boards motivated to fulfill their roles in local health system governance. They are committed to leading positive change in their communities. There are some issues, however, that limit the governance effectiveness. Some of these challenges require relatively straightforward process changes. Others will require a shift in governance philosophy and a move toward a more consistent province-wide understanding of governance standards and best practices.

Authority

The LHIN legislation grants LHIN Boards substantial authority to both fund and integrate the health system. Many Board Chairs reported that they took on their positions because of the potential it gave them to make a positive contribution to improving the health status and services in their communities. A focus of this review has been to explore whether LHINs have actually received the devolved authority described in the legislation.

The majority of the Board Chairs indicated that they believe that their Boards do have the authority granted to them. Many were able to point to examples where their organizations had driven integration in their communities. They could also demonstrate how their organizations had handled public issues involving significant conflict and had resolved matters satisfactorily.

However, there have been examples where LHINs understood they would have the authority to determine how new funding would be allocated in their communities, but there was a subsequent change in direction by the Ministry. A number of Board Chairs expressed concern that this can result in a reversal of public decisions made by their Boards, and therefore reduced credibility in the community. Interviews with Health Service Providers suggest this concern is valid.

Some of these issues can be explained within the context of organizational restructuring and change management, as the natural evolution of new organizations and processes. Both the LHINs and the Ministry are learning how to operate together in this new world. As LHINs and the Ministry learn about each other's decision making processes, they will modify their respective internal processes.

Funding announcements are an example of a need to shift government processes to reflect the reality of the LHIN environment. There are examples, from the past 12-18 months where the Minister's office made funding announcements that were within the purview of the LHIN mandate. Going forward, a

more collaborative approach to announcements – one that considers the LHIN role – could enable all parties to accomplish their goals.

In other sections of this report, we have recommended ways to clarify how the Ministry should act in the new LHIN environment. In addition to those recommendations, it will also be important to ensure that the Minister's staff, as well as the political arm of government, understands the governance role of LHINs and their mandate as stated in legislation. A better understanding of the LHIN mandate should lead to government actions that are more consistent with the desired role of LHINs.

Recommendation 22

The Minister should ensure that there is ongoing training of the political arm of government on the mandate of the LHINs and the authority granted to LHIN Boards.

Orders in Council Process

The OIC process is government-led, and is used to appoint members to Crown Corporations, as well as many other public bodies. The LHIN legislation directs that the OIC process be used to appoint Board members. This process maintains public oversight by elected officials while identifying leaders to reflect the needs of local communities. This process can be an effective way to select the Boards of Crown Corporations. However, there were several concerns identified with the process.

The first is that the selection process is perceived to lack a focus on skills required by Chairs and Board members and subsequent appointments do not reflect competencies. Interviews with the Chairs indicated that very few believed their skills were assessed during the OIC process. The most commonly reported experience was that they had brief discussions that focused on their willingness to serve, but not on their abilities or qualifications.

Chairs also have communicated the importance of an increased focus on competencies and a knowledge of governance and the health care system during the OIC process. This increased focus will support and enhance LHIN Boards in their ability to effectively fulfill their roles in local health system governance.

The timeliness of the OIC process has also presented challenges for LHIN Boards. Requests for status updates do not clarify when Chairs can expect new appointments to be completed. Given that the LHIN Boards only have nine members, this can seriously affect their abilities to function as proper governors. Some Boards have been concerned about having enough members for a quorum at their meetings. The timing of reappointments also has been an issue for the Boards. In some cases, Board member terms expired prior to reappointment decisions. This has led to situations where Board Chairs, who had not yet received their reappointment, received legal advice that they were not legally able to preside over Board meetings.

The terms of the Board members also require some attention. At present, most of the Board members are on their second three-year term. The terms of two-thirds of the original members will expire in the summer of 2011. This may lead to situations where Boards lose the majority of their experienced members and have Chairs who are only in their second year of membership. Succession planning and

staggered appointments are essential to ensure that the LHIN Boards can collectively continue to function and provide leadership.

Each of the LHIN Boards can select three Board members from their communities. The nominees must be put forward through the OIC process for Ministerial consideration. Chairs have stated that they have lost some potential members because of the length and uncertainty of the OIC process. They also have reported that in some communities it has been difficult to recruit new members. One LHIN has tried to address this challenge by establishing a community website to recruit leaders. This process enables potential candidates to submit their OIC applications into the pool in advance of an appointment process. It also creates an opportunity to get community members interested in governance roles.

The Board Chairs expressed their concerns that the vitality and credibility of the Boards could be compromised by the issues of timeliness, skill assessment, competency-based recruitment, and succession planning. The following recommendations are intended to address these concerns.

Recommendation 23

The Minister should review the OIC processes to:

- *Improve timeliness of both new appointments and reappointments. This should include development of a competency model that identifies quality standards for the selection and review of Board appointees' skills and experience.*
- *Modify the appointment process so that the Board terms are staggered to reduce the number of appointments ending at the same time.*

Recommendation 24

The Board Chairs should work together to create shared recruitment strategies to attract community members to sit on the LHIN Boards.

LHIN Board Functions

Role of the Chairs

At the onset of the LHINs, the government initially appointed the 14 Chairs. Some were interviewed by the former Minister, who provided his expectations of their governance role in their communities.

During these formative stages of the LHINs, the Chairs were involved in all aspects of their set up. They led the hiring process to select the new CEOs and were quite involved in the development of policies for the new LHIN structures.

A common message they received was that the Minister expected each LHIN to reflect the needs of its community and to be proactive in facilitating positive change and integration within the local health system. It was reported that some Chairs understood that their roles would be full-time while others understood that they would serve on a part-time basis. In fact, most Chairs found their positions to be full-time during the initial years. Currently, some Chairs continue to work full-time, while others have reduced their time involvement to part-time.

Throughout this stage the Chairs understood from the Minister that they should continue to stay very informed on all LHIN activities so that they could effectively lead Board decision making.

As the LHINs moved into the operating stage under the authority of the Local Health System Integration Act April 2007, the roles became somewhat less clear. The Chairs have identified this as a significant issue. There are several forces that are contributing to this role confusion:

- The Chairs had to be very involved in the initial start-up before staff were hired
- Some Chairs were told to expect a full time-role
- Chairs are paid for their time and therefore expect to "work"
- In some instances, when CEOs had to be replaced, Chairs stepped in for several months until a new CEO could be hired
- Chairs, took an active role in many provincial committees that involve operational matters; and
- Chairs had received messages from the former Minister that they were personally accountable for all aspects and the actions of the LHINs

Board Perspectives on Community Role

All of the LHIN Boards take their system change mandate very seriously. Many members have observed that their LHINs have "not yet tackled the hard integration opportunities". They understand that these actions will require both strong Board and government resolve. In preparation, Boards have been learning more about their communities and building local respect.

The LHIN Boards have taken different approaches to community involvement. These range along a continuum from minimum engagement to more extensive processes. On one end, some Boards believe that individual members should be known in the community. They perceive that being involved in many local activities will build trust and respect. On the other end, there are Boards that feel their deliberations would be compromised if they are seen as too active in the community. These Boards restrict their public activities to their Health Service Provider Board tables. Not surprisingly, most Boards report that they are somewhere in the middle of the continuum. They believe they require a public presence, but feel their community activities should be somewhat limited and strategic.

Many of the LHIN Boards have taken systematic action to engage their community partners in direct Board to Board activities. The intent is to develop relationships and mutual commitment to improving the health system. Health Service Providers, who were interviewed, largely saw this Board engagement as positive. However, it was reported that this type of Board to Board activity was difficult for some organizations, such as private long-term care providers and teaching hospitals that span multiple LHINs.

It is too early to determine which strategies of engagement will be most effective in supporting the LHIN mandate to create positive integration. Effective strategies may also depend on the specific environments and personalities. However, the LHIN Boards appear to be proactively exploring their role in community engagement.

Governance versus Operations

Confusion between governance and operations was also seen in the performance of many LHIN Boards. As described above there are differing understandings across the province regarding governance

philosophies and Board roles. While some have begun to evolve into strategic governance focused boards, there are a significant number that appear to spend a lot of their time on operational issues.

Both staff and some Board members themselves have identified the challenge that Boards are having in differentiating between strategic governance and operations. A review of the Board packages and minutes show that some Boards are requesting substantial detail on LHIN operations. While it is appropriate for LHIN staff to provide support to the Board, it is important to recognize the relatively small size of the LHIN operations. There is a disproportionate amount of staff time spent focused on Board matters.

Some of these behaviours can be explained by the original direction Boards received from the Minister's office. Nevertheless, the LHIN Boards should be held to a higher standard given their leadership role in the system.

Examples of Board involvement in operational matters include:

- Hiring
- Directing staff
- Meeting with staff from Health Service Providers
- Review of press releases/external communications
- Editing staff documents
- Conducting community engagement focus groups

It is also important to note that the cost of governance has been increasing steadily since the inception of the LHIN Boards. While some of this rise in Board hours is clearly reflective of the large responsibilities and volumes of information members must handle, it may also indicate some activity that falls outside the purview of a Board focused on strategic governance.

Board Evaluations

There are no systematic provincial processes in place to evaluate the performance of Boards and their individual members. The lack of a provincial process to define the performance expectations of the Chairs and their Boards limits the Minister's ability to identify and address the role issue. LHIN Boards require a common set of governance standards to guide their performance along with regular training to help members to understand the characteristics of good governance.

Some individual LHIN Boards have conducted their own internal Board evaluations. However, these processes have differed in their rigor and effectiveness and the information learned from these evaluations has not been shared with the Minister or the Ministry. Board Chairs have expressed concern that there does not seem to be a way for them to replace ineffective Board members. Some Chairs have reported that there are a number of Board members without the requisite skills and experience to carry out their duties.

The ability to assess the performance of the LHIN Boards is essential to understanding their effectiveness. An effective Board evaluation process should include a standardized assessment that is conducted provincially by a single third party. This would ensure objectivity and the application of provincial standards.

Recommendation 25

The Minister with input from Board Chairs should develop a Provincial Evaluation Framework with a shared set of standards that outlines the roles, responsibilities and desired behaviours of the LHIN Board as a whole, as well as individual members. This should include a specific focus on the performance expectations of the Chairs.

Recommendation 26

The Minister should contract one external party to conduct Board and Chair evaluations annually to;

- *Provide each LHIN Board with an assessment of the performance of individual members and the Board as a whole*
- *Prepare a confidential performance evaluation report on each Board and Board Chair for the Minister.*
- *Based on the annual evaluation report, the Minister should take appropriate action to provide remediation, training, or to replace Board members and Chairs not performing to Provincial Standards. This would include providing governance coaches for Chairs who request assistance or who require it based on performance reviews.*

Recommendation 27

The LHIN Chairs should create common tools to guide their Boards in assessing their progress towards strategic governance and ensuring that a consistent provincial governance orientation is delivered to all LHIN Board members at least annually.

12 Implementation Considerations

As the LHINs continue to take on greater responsibility for the Health Service Providers in their catchments there will be increased pressure on them to focus on the transformation of their local systems. They also will continue to respond to the MOHLTC's ongoing request for information and implement provincial strategies and initiatives.

The MLAA Refresh process has incorporated the following into the MLAA Schedule 1 Part D, clause 8: "…and within 90 days of receiving the report, develop an action plan to address any recommendations arising from the evaluation (Effectiveness Review)". This commitment signifies the importance placed on the action to be taken in the next phase of the process.

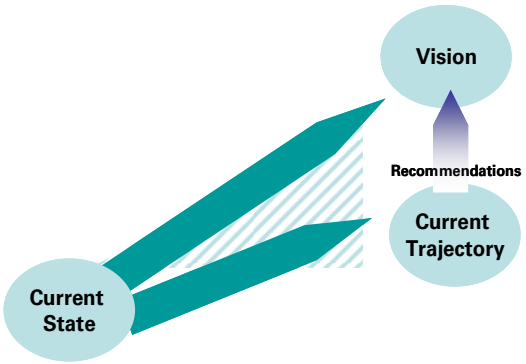
There are high expectations from both the MOHLTC and the LHINs concerning the outcome of this report and the potential changes to enhance effectiveness. It is important that as the committee proceeds, it considers and continues to augment these recommendations from a change-management perspective, using all avenues of available communication. The LHIN CEO/MMC should see these recommendations through to the end and evaluate progress along the way.

Recommendation 28

The MOHLTC/LHIN Effectiveness Review Steering Committee (MLERSC) should continue to function and oversee the implementation of the Effectiveness Review recommendations. The MLERSC should contemplate, within two years, the need for a further third-party review of the effectiveness of the MOHLTC/LHIN model.

Moving Forward

The overall finding of the Effectiveness Review is that the transition of authority to the LHINs has been successful. However, as would be expected in any new system, some areas for improvement have been identified. The recommendations proposed in this report are focused on enabling the system to keep moving towards the vision intended for the model. It is important that timely action is taken to implement these recommendations. The MOHLTC and the LHINs have demonstrated their mutual commitment and abilities to continue shaping Ontario's new Local Health Integration Network model.



13 Appendices

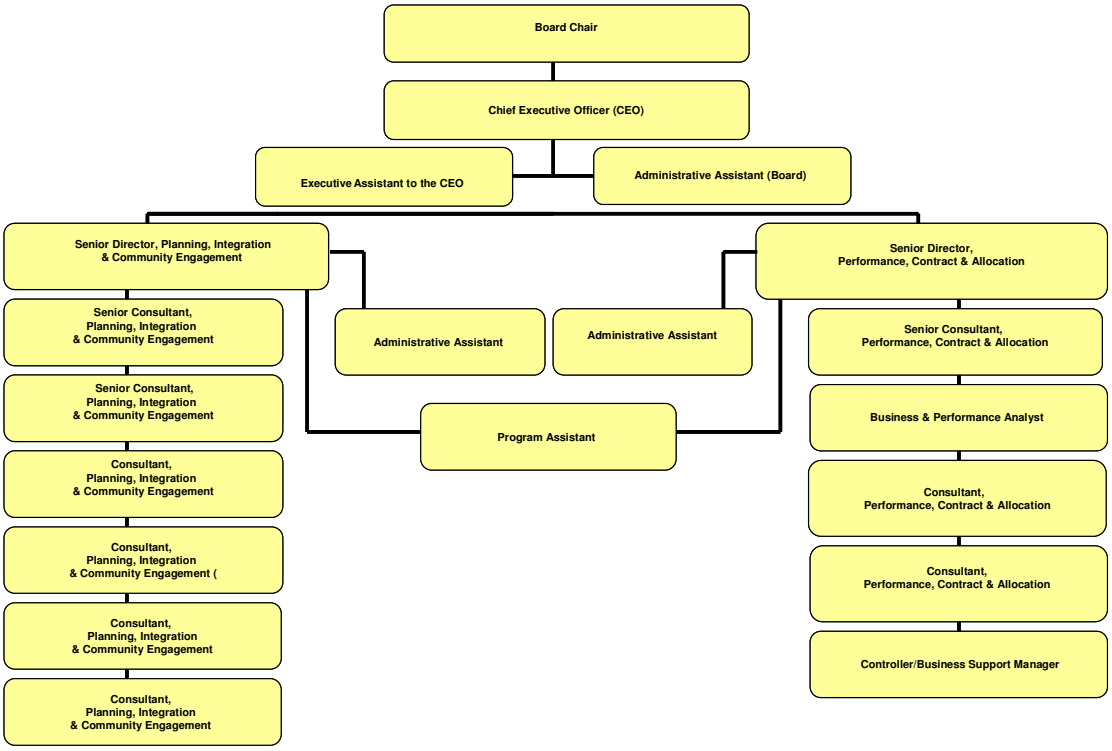
Appendix A: LHIN Facts

LHIN Characteristics

This report has referenced, the geography, numbers of HSPs and other key characteristics of the LHINs. The diagrams below illustrate these characteristics per LHIN.

Structure:

LHINs were provided with an organizational structure – an example of a structure is shown below;



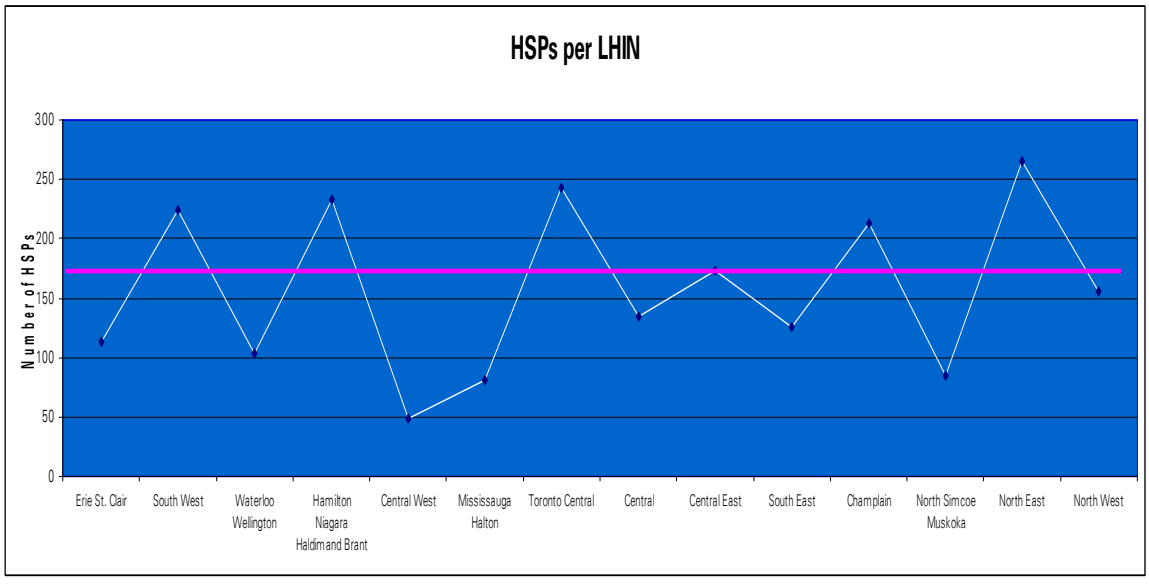
- These organizational structures were similar across the LHINs and the average FTE for a LHIN was 23 as at March 31, 2008.
- The table below shows the population per LHIN, FTE per LHIN, and HSPs per LHIN. Data has been extracted from the LHIN websites and all FTE information is as at March 31, 2008.

Table A.1: LHIN Figures as at March 31st 2008

LHIN	Population	FTEs	HSPs/LHIN
Erie St. Clair	650,000	23	113
South West	1,000,000	23	224
Waterloo Wellington	685,400	23	103
Hamilton Niagara Haldimand Brant	1,400.00	22.5	233
Central West	772,973	18	49
Mississauga Halton	1,040,800	20	81
Toronto Central	1,146,800	28	243
Central	1,600,000	29.5	135
Central East	1,400,000	18	173
South East	485,500	22	126
Champlain	1,100,000	26	213
North Simcoe Muskoka	425,000	22.5	85
North East	567,900	21	265
North West	242,500	22	155
Average	**794,162.36**	**22.75**	**157**

Using this data, we have created the following diagrams to illustrate the information:

Diagram #1: Number of HSPs per LHIN. (Pink line is the average of 157)



What this diagram highlights:

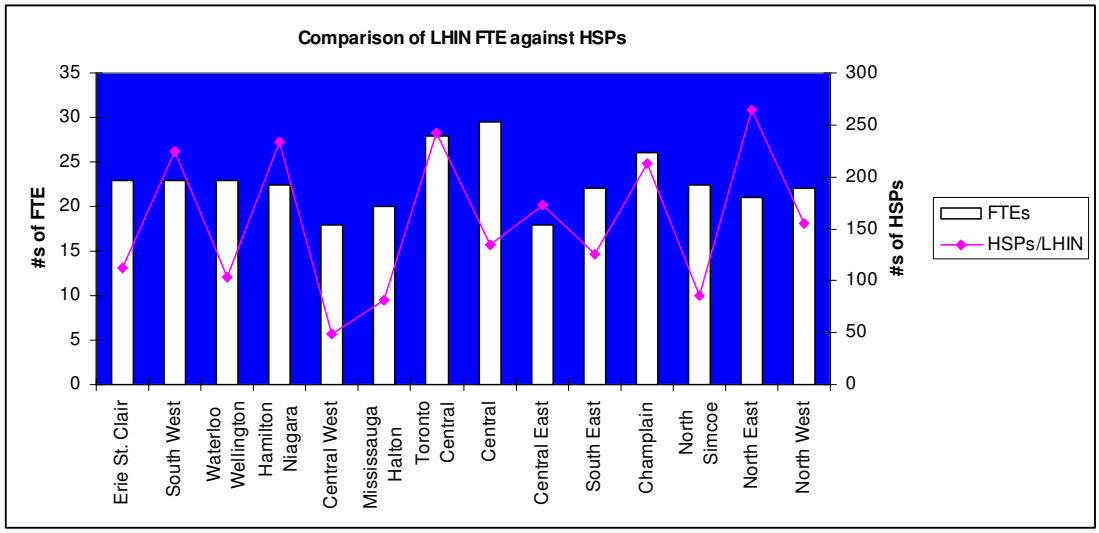
- There is no standard number of HSPs per LHIN. There is a large variation in the number of HSPs, and five LHINs have more than the average number of HSPs.

Diagram #2: Number of HSPs and geography per LHIN

What this diagram highlights:

- LHINs with the largest geography have the highest numbers of HSPs
- A large geography impacts your capacity since traveling to your HSPs for community engagements or negotiations takes a significant amount of time.

The chart below shows the numbers of FTE per LHIN at March 31, 2008 and the numbers of HSPs per LHIN.



The chart highlights that the numbers of HSPs per LHINs are not always directly proportional to the numbers of FTEs (as per North East and Central LHINs)

Appendix B: Interview List

HSP and Provincial Association Interviews

As part of this review, a sample of Health Service Providers and Health Service Provider Associations were interviewed to explore their perspectives on the transition of authority to the LHINs. This sample was selected by asking Provincial Associations and LHIN CEOs for recommended HSPs. A sample of HSPs was selected from across the five sectors and the 14 LHIN boundaries. The organizations interviewed:

HSPs

- Pinecrest Queensway Community Health Centre
- North Hamilton Community Health Centre
- Country Roads Community Health Centre
- North Kingston Community Health Centre
- London Inter-Community Health Centre
- South Riverdale Community Health Centre
- Woolwich Community Health Centre
- Dryden Regional Health Centre
- Leisure World Care giving Centre
- Peel Senior Link
- Chartwell Seniors Housing REIT
- Simcoe Country for the Physically Disabled
- Christie Gardens Apartments & Care Inc.
- COTA Health
- Canadian Mental Health Association, Cochrane-. Timiskaming Branch.
- Sister Margaret Smith Centre
- Central CCAC
- Central East CCAC
- Central West CCAC
- Hamilton Niagara Haldimand CCAC
- North East CCAC
- North West CCAC
- Waterloo Wellington CCAC
- Peterborough General Hospital
- Trillium Health
- London Health Sciences Hospital
- St Michaels Hospital
- Toronto Rehabilitation Institute
- Guelph General Hospital
- William Osler Hospital

Provincial Associations

- Ontario Hospital Association
- Ontario Association of Community Care Access Centres
- Ontario Long Term Care Association
- Association of Ontario Health Centres
- Ontario Council Of Teaching Hospitals
- Canadian Mental Health Association, Ontario
- Ontario Federation of Community Mental Health and Addiction Programs

LHIN Interviews

For this review, interviews were completed at each of the 14 LHINs. The following roles were interviewed (note in some LHINs, roles have been re-named or changed);

- Board Chair
- Chief Executive Officer
- Senior Director, Planning, Integration and Community Engagement
- Senior Director, Performance, Contracts and Allocations
- Communications Specialist
- Controller

Senior consultants and consultants in both divisions were interviewed in focus group sessions.

MOHLTC Interviews

For this review, interviews were completed with MOHLTC staff in roles that interfaced with the LHINs. Staff were interviewed from the following divisions and branches;

- Members of MOHLTC Management Commitee
- e-health Project Division
- Transition Division
- Health System Accountability and Performance Division
    - Primary Health Care Branch
    - Access to Services and Wait Time Strategy Branch
    - Performance Improvement and Compliance Branch
    - LHIN Liaison Branch
    - Negotiations and Accountability Management Branch
    - Provincial Programs Branch
- Health System Information and Management and Investment Division
    - Information Management Strategy and Policy Branch
    - Health Analytics Branch
    - Knowledge Management Branch
    - Investment and Portfolio Management Branch
    - Strategic Investment Planning Branch
    - Health Capital Investment
    - Hospital Alternative Financing and Procurement Branch
    - Health Reform Implementation Team
    - Capital Planning and Strategies Branch
- Health System Strategy Division

        - Health Program Policy and Standards Branch
        - Health System Strategy
- Health Human Resources Strategy Division
- Corporate and Direct Services Division
        - Financial Management Branch
        - Health Audit Services Team

Appendix C: Glossary

Definitions

ADM	Assistant Deputy Minister
ALC	Alternate Level of Care. The designation given to a patient in an acute care bed once they are ready for discharge from acute care but require on-going support such as long term care or home care.
Allocation and Payment Tracking System (APTS):	LHIN system for uploading funding transfer.
Annual Service Plan (ASP)	The plan for spending the funding received by the LHIN from the MOHLTC
Authority:	Herein, authority is defined as having the legitimacy to control.
CKD	Chronic Kidney Disease. A Provincial program that was devolved to the LHINs as of the 1st April 2007.
FMB	Financial Management Branch. The MOHLTC Branch that processes LHIN funding allocations.
FTE	Full Time Equivalent
HBAM	The Health Based Allocation Model (HBAM) is a tool being developed by the MOHLTC. This model will include both population-based indicators and direct measures of health status, to provide a more accurate measure of local health needs.
Health System Information Management Investment Division (HSIMID)	Health System Information Management Investment Division within the MOHLTC
Hospital Annual Planning Submission (HAPS)	The Board-approved hospital annual planning submission provided by the hospital to the LHIN
Health Service Providers (HSPs)	Health Service Providers including hospitals, community care access centres, long-term care homes, community support service agencies, and mental health and addiction agencies
Hospital Service Accountability Agreement (H-SAA)	A service accountability agreement between a hospital and a LHIN
Integrated Health Service Plan (IHSP)	A guide to each LHINs environment and outlines strategic priorities for the LHIN for a three year period
Integration	Plans that aim to coordinate, partner, transfer, merge or amalgamate

	services/operations for the improvement of health service delivery and patient flow through the local health care system. Integration can be voluntary (facilitated by the LHIN) or through an Integration order (mandatory).
LHIN Liaison Branch (LLB)	The MOHLTC branch which ensures that the obligations of the Local Health System Integration Act and related legislation are met by the Local Health Integration Networks and the Ministry of Health and Long Term Care through the development, negotiation, and management of relationships and accountabilities
LHIN Shared Services Office (LSSO)	The office that manages the following shared functions: IT, Finance and Accounting (F&A), Human Resources (HR), Payroll, Legal, Procurement and other services.
Local Health Integration Network (LHIN)	LHINs are not-for-profit corporations that work with local health providers and community members to determine the health service priorities of their regions. They were created in April 2006, and took on their full role of planning and funding health services April 1, 2007. LHINs do not provide services directly, but are instead be responsible for integrating services in each of their specific geographic areas.
Memorandum of Understanding (MOU):	The agreement between the LHIN Board and the MOHLTC
Ministry LHIN Accountability Agreement (MLAA):	The agreement between the LHINs and the MOHLTC that defines the roles and responsibilities of each member. The agreement contains performance indicators for each LHIN and specific funding allocations for the providers in their LHIN.
MLERSC	MOHLTC LHIN Effectiveness Review Steering Committee
Ministry of Health and Long -Term Care (MOHLTC):	Heath Ministry for the Province of Ontario
Order in Council (OIC)	The OIC process is government-led, and is used to appoint members to Crown Corporations, as well as many other public bodies.
PCA	LHIN Performance Contracts and Allocations Division
PICE	LHIN Planning, Integration and Community Engagement Division
Service Accountability Agreement (SAA):	Service Level Agreement between service provider and LHIN
Stewardship:	The MOHLTC will be responsible for strategic direction and provincial strategy, guiding legislation, policies and standards, monitoring and evaluating system performance and development of health system funding model

Appendix D: Document List

Document List

The nature of this review relied on the experiences of many individuals involved in the creation, ongoing development, and management of the LHINs. To support the highly qualitative nature of this review, many documents and much qualitative evidence were collected and reviewed where possible. These are listed below;

- Local Health System Integration Act, 2006
- MOHLTC – LHIN Accountability Agreement April 1, 2007 - March 31, 2010
- Memorandum of Understanding
- Ontario health system strategic planning documents
- Cabinet meeting minutes
- MOHLTC, Health Results Team – Original LHIN planning documents and meeting minutes
- LHIN Project Team, Programs and Services for Transfer to LHINs, Ministry and LHIN Decision Making, November 5, 2006.
- LHIN Project Team, Proposed Provincial and LHIN Functions, Sub-Functions, and Activities.
- LHIN Project Team, Framework for Managing the Local Health System, Programs and Services Roll-up, Final Draft for LHIN and Minister Review.
- LHIN Performance Logic Model, February 5, 2007
- MOHLTC Strategic Directions, Letter to the LHINs from the Minister, 2006.
- Letter from Deputy Minister Ron Sapsford to MOHLTC Stakeholder, Introducing the LHINs, January 18, 2006.
- LHIN Think Tank Documents (Planning, Health System Integration, Funding, Governance and Ethics)
- LHIN Management Directives, Summer 2005
- LHIN Governance Manual and July 2005 Governance session materials
- LHIN Communications protocols
- LHIN Community Engagement methodology documents
- MOHLTC-LHIN Performance Agreements
- LHIN Business Operating Manuals
- LHIN Bulletins
- MOHLTC New Directions Newsletter
- Health System Strategy Division, Update on the Health System Strategic Plan, Presentation to MOHLTC MMC, June 3, 2008
- Health System Strategy Division, Health System Transformation – Planning for the Future, Presentation to DMC, May 30, 2008.
- Formal requests for information from the MOHLTC and letters of correspondence
- Overview & Status of LHIN/MOHLTC Cabinet Decisions, 2004-06
- Resource Guide used in Community Workshops - 'Taking Stock - Setting Integration Priorities'
- By Law No. 1
- LHIN Orientation Session August 22-26, 2005
- LHIN Orientation Session June 22-24, 2005

- LHIN Information Resources and Reports Part 1
- LHIN Governance Session, July 7-8 2005
- MOHLTC Planning Document: LHIN Corporate Governance, Summary of Forum on December 13, 2005.
- Instructions for recruiting Community-based Board Members
- Management Directives, Policies and Guidelines Applicable to LHINs Summer 2005
- LHIN Leadership Update, Issue 1.0
- Development of Compensation Program
- LHINs technical briefing
- 2005-06 Performance Agreement Central East
- Roadmap to the Integrated Health Service Plan, Final Draft
- LHIN Business Operations Manual
- Conflict of Interest Policy for LHINs
- Guide to Conflict of Interest Policy for LHIN Boards of Directors
- LHIN Funding Model Think Tank
- LHIN Think Tank on Planning, Summary of Meeting
- Health System Integration Think Tank, Summary of Forum
- LHIN Corporate Governance, Summary of Forum
- Discussion Forum on Physicians and Local Health Integration Networks, Summary Report
- Think Tank on Ethics for LHINs, Summary of Discussion Forum
- LHIN Cross Boundary Issues - Summary of Discussion Forum
- A Framework for the Relationship between Academic Health Sciences Centres and Local Health Integration Networks in Ontario
- Hospital Funding "An opportunity to change behaviour"
- McGuinty Government's Health System Vision - George Smitherman Speech
- LHIN Legislation Project Team Resources Proposal
- Province of Ontario - List of Classified Provincial Agencies
- Memo: MOF/MGS Comments of Draft LHIN Legislation
- Areas requiring development of operational policy and procedures - Preliminary Assessments
- LHIN Legislation Project: Portfolio Assignments (Leads and Supports)
- MOH-LHIN legislation project - MOHLTC File Management Guidelines
- LHIN Budget Explanation
- Ontario Health System Strategic Plan - letter from Minister's Office and Slide Deck for LHINs
- MOHLTC Organizational Chart, April 1, 2008.
- MOHLTC LHIN Backgrounder.
- LHIN Fact Sheet
- Health Analytics Response to MLAA Performance Indicators Q1 Data 2007/08
- List of Accountability Instruments
- Summary of Accountability Provisions in Selected Legislation affecting MOHLTC Programs and Services
- Towards Integrated Specialized Disease Management in Ontario: A proposal for an Ontario Specialized Health Services Agency in the context of LHINs
- Ontario Specialized Health Services Integration Network (OSHSIN) in context of LHINs
- TPA Financial Transaction Processing
- LHIN Board Meeting Minutes and supporting documentation

- The annual reports from the 14 LHINs 2005/06, 2006/07 and 2007/08.
- Integrated Health Service Plans from the 14 LHINs
- Sample of quarterly reports sent to MOHLTC from LHINs
- MOHLTC Aging at Home: August 28th 2007 Strategy Description
- MOHLTC Aging at Home: Detailed Service Plan Instructions
- MOHLTC Aging at Home: News releases
- MOHLTC –LHIN Leadership Action Workshop Materials; Aging at Home April 3, 2008.
- MOHLTC Aging at Home Directional Plan Templates
- MOHLTC Aging at Home Project Schedule
- LHIN Aging at Home Directional Plans and Information Session Presentations (various)
- Overview Slides for Aging at Home, April 23rd 2008, Innovations Showcase
- Annual Service Plan Guidelines 2007 and 2008-08-11
- LHIN Liaison Branch Orientation: An Overview
- MOHLTC Strategic Directions 2006 (letter)
- "Accountability Agreement Update" H-SAA newsletter
- HAPS Guidelines 2008 – 2010
- Organizational Charts and staffing lists from each LHIN
- Health Service Provider Transfer Payment Process Review, Report to LSSO, March 17, 2008
- MOHLTC News Releases: Funding Boost For Ontario Hospitals, April 13, 2008; Ontario Tackles ER Waits with $109 Million Investment, May 30, 2008.

LHINs specific documentation also reviewed. Such documentation received directly from LHIN or from LHIN websites. List of websites used for this report are listed below;

- www.health.gov.on.ca
- www.centrallhin.on.ca
- www.centraleastlhin.on.ca
- www.centralwestlhin.on.ca
- www.champlainlhin.on.ca
- www.eriestclairlhin.on.ca
- www.hnhblhin.on.ca
- www.mississaugahaltonlhin.on.ca
- www.nsmlhin.on.ca
- www.northeastlhin.on.ca
- www.northwestlhin.on.ca
- www.southeastlhin.on.ca
- www.southwestlhin.on.ca
- www.torontocentrallhin.on.ca
- www.waterloowellingtonlhin.on.ca