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LHINs, Health Reform and HIV/AIDS Care

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Wellesley Institute

- funds community-based research on the relationships between health and housing, poverty and income distribution, social exclusion and other social and economic inequalities
- provides workshops, training and other capacity building support to non-profit community groups
- works to identify and advance policy alternatives and solutions to pressing issues of urban health
- works in diverse collaborations and partnerships for progressive social change
- all of this is geared to addressing the pervasive impact of the social determinants of health

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Unique Hybrid

- lots of policy institutes and think tanks – but few focus on SDoH and urban health
- many provide training and capacity building – but not all have an explicit goal of rebuilding community capacity lost in funding cuts and constraints
- few focus on funding CBR or have an extensive community training programme in methods
- no other institute brings all three strands together – all focused on SDoH

Local Health Integration Networks

- LHINs were seen to be a key part of the overall provincial ‘transformation agenda’ unveiled in the fall of 2004
- Ontario is the last province to develop regional health authorities
- 14 LHINs will control the envelope of funds for regions and will establish planning for more integrated organization and delivery of health care
- basic idea is that the incredibly complex health care system can best be planned and coordinated regionally rather than centrally
- goals of integrated planning and care have a lot of potential, but only if the LHINs
  - really are driven by community needs and priorities
  - develop effective and responsive governance and community engagement
  - build on existing networks
  - foster innovation and then scale up what works across the system
  - create a system that provides equitable access to a seamless continuum of care for all

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Some Critical Limitations

- the LHINs will operate within an overall provincial strategy – yet to be developed – and broad direction from the Ministry
- some vital elements of the system are not within the LHINs mandate:
  - physicians
  - primary care, except through CHCs
  - public health
  - provincial drugs programmes like ODB and Trillium
- and certain programmes designated as provincial such as HIV

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Outside LHINs' Formal Mandates, But Connected

- HIV $ for community-based groups will still flow from the Ministry's AIDS Bureau
- but this will need to be well linked to regional planning through the LHINs:
  - the AIDS Bureau and other provincial programmes will be moving into a new LHINs Liaison Office
  - at best, this highlights the need for consistent standards and provincial level strategy in key areas – and that these strategies need to be well coordinated into each LHIN
- the AIDS Bureau initiated community planning in regions across the province
  - the goal is that these planners will then work closely with the local LHINs to bring HIV/AIDS issue into LHIN planning

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Beyond Formal Mandates, LHINs Will Be Important To HIV/AIDS

- the LHINs will be responsible for many of the institutional settings within which HIV care is provided:
  - the HIV clinics within hospitals are funded as part of their global budgets and these funds are to flow through the LHINs
  - Community Health Centres will also fall under the LHINs
- secondly, the LHINs are a critical part of the rapidly changing strategic environment for health that will affect every sector:
  - most concretely, they are responsible for the hospitals, CHCs, other community providers, mental health, etc that PHAs (people living with HIV/AIDS) rely on beyond their primary and specialized HIV care
  - so providers – such as HIV docs and ASOs (AIDS service organizations)– will be drawn into referral and coordinating networks with the LHINs to support their clients
  - one theme I will emphasize is that it will be better to be **proactive** in defining what coordination and planning is needed from the point of view of PHAs and HIV providers, and that you are well positioned to take a lead in this

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LHINs: Uncertain Starts

- working groups of providers, community representatives and other stakeholders worked on initial priorities in late 04, reporting in February 2005
- slow to begin
  - as Boards and CEOs chosen though spring and summer of 05
  - no community input and not very diverse/representative
  - some initial consultations through summer and fall
  - fuller management teams by late 05
- significant concerns:
  - uncertainty -- esp over future of smaller community-based service providers – would this be restructuring under another name?
  - boundaries – e.g. 5 in GTA, four are mixed urban and rural
  - would LHINs increase private provision of care as CCACs (Community Care Access Centres) had done?
  - would they really be representative and accountable to local communities?

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Good First Year

- all the LHINs have undertaken extensive community consultations:
  - varied a great deal LHIN to LHIN
  - but far more comprehensive and intensive than ever before
  - 6,000 + people and 200 organizations participated in Toronto Central LHIN
- LHINs undertook research to understand their local environment:
  - population health needs
  - surveying existing local networks and coordinating bodies
- produced their first Integrated Health Service Plans in the fall – 3 year strategic plans
- key next steps=
  - creating coordinating and planning structures to implement the IHSPs
  - funding will be flowing through the LHINs in fiscal 07-08 and extensive discussions are underway on funding frameworks
  - actual flow of $ will be phased
  - a critical part of implementation and funding will be setting up service accountability agreements with providers

Example: Toronto Central LHIN

- IHSP identified major integrated care priorities – mental health, seniors, rehabilitation – and building solid foundations – human resources, e health, back office integration
- its first planning assumption was to recognize the importance of broader social determinants of health
- it highlighted other unique features of Toronto's population:
  - incredible diversity
  - pervasive social and economic inequality
  - concentrations of specific needs – such as HIV
  - but also concentrations of research, specialized expertise, major hospitals and other institutions, community-based providers, and dense networks and collaborations to build on

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Challenges

- building on a good start in community engagement
  - how to create structures and processes that will embed significant community participation in planning and priority setting from now on?
  - how to make boards and other planning bodies more representative?
  - so there is real consumer and local input to the inevitable trade-offs and complex priority setting to come
  - more specifically = how to make sure that HIV community is also part of this where necessary
- ensuring community and consumer-driven standards get built into performance agreements with providers:
  - what are good standards of culturally competent care?
  - what would a continuum of care look like from consumer's point of view?
  - what does good HIV care in hospitals look like?

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Challenges II

- how to build social determinants into action:
  - planning tables and facilitating wide collaborations beyond health
  - encouraging innovations in programming that build in SDoH – like CHCs
  - acting on SDoH is increasingly impt for HIV as the shape of epidemic changes and more marginalized communities face the harshest impact
- how to coordinate across LHINs
  - particular challenge in Toronto with 5 LHINs → need cross GTA planning table
  - and in areas like HIV/AIDS -- where people come from many other LHINs to get specialized care in Toronto

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Positioning HIV/AIDS Within Reform Priorities

- the Province is driving a massive transformation of the overall system and is looking for innovation
  - where are the opportunities in this for the HIV movement generally and HIV docs specifically?
  - where and how might you get hooked into provincial or LHIN planning?
- HIV service providers in general and docs and other health care providers more specifically are well positioned:
  - you have had a long history of providing care in the most difficult circumstances and for people with incredibly complex needs
  - similarly, a long history of pioneering collaborations within health care and beyond with community organizations
  - you've long led the way in on-the-ground innovation
- will illustrate how you could position yourselves within a few key health reform issues and trends

Positioning II: Key Provincial Strategies

- mental health is top priority for the Province and for every LHIN:
  - HIV care providers have long emphasized the integral connection between treating the virus and its impact, and supporting the whole person, including mental health
  - have been many innovative care models in HIV and mental health
  - HIV/AIDS providers will want to get linked to mental health planning in your local LHINs
- e health is also a major driver within Ministry strategy and within each LHIN:
  - given a defined population with complex needs → could this be an area for pilot projects or your hooking in as demonstration sites for wider e records or info management projects?
  - you could think bigger and push HIV docs as a pilot in innovative knowledge management:
    - HIV community has long history and solid infrastructure for translating research into practical knowledge – CATIE and others
    - pose your group as a distributed electronic network to exchange info and build up 'best practices'

Positioning III: Wider Planning

- have been arguing that LHINs will need to develop collaborative and planning process beyond their health care sectors if they are to really address broader social determinants of health:
  - some of this will be quite practical planning – all LHINs are going to need to include public health and other providers beyond their mandate in their planning
  - ASOs and other service providers will likely want to be included at such broader planning tables as well
  - AIDS providers can argue that they have a long history of innovative and effective cross-sectoral collaboration
  - more specifically, you will likely want to ensure that HIV docs are involved in any linking of LHINs to primary care initiatives in their regions
- there also needs to be cross-LHIN coordination:
  - the 5 GTA LHINs was mentioned earlier, and a critical area for such coordination is HIV/AIDS

Positioning IV: Hot Reform Issues

- wait times has been a huge issue in reform debates:
  - focus on particular conditions or operations -- danger of this focus at expense of other areas
  - are their areas where wait times for specialist care or tests are too long for HIV? → idea of pushing for pilots to apply lessons learned in other areas to HIV
  - the advantage to be promoted is that HIV physicians and other providers are already well organized and connected
- chronic care management is also seen as a critical component of overall reform and of LHIN strategies:
  - HIV providers have been leaders in integrating medical and community-based care
  - again → could position yourselves as pilot project of integrated chronic management of complex care needs
  - probably easiest – and most strategic for you – to make this case in big city LHINs with major concentrations of PHAs and HIV care
- alternative practice models:
  - you have been discussing this here today
  - can pose HIV docs and their practices as leaders of innovation that have long involved multi-disciplinary teams and connections to non-medical care
  - could consider emerging models such as Community Family Health Teams

Positioning V: New Provincial Strategy

- finally, the Province is undertaking an ambitious plan to develop a new ten year health strategy:
  - all in HIV movement will want to ensure that HIV/AIDS is recognized as a priority within the new strategy
  - you can position yourselves as leaders in innovative community-grounded primary health care within these strategic discussions
  - you – more than any other physicians – can provide experience and insight in primary care, managing rapid change in both medical practice and client base, working in innovative collaborations, working with community groups, consumer-driven and empowered care, and many other crucial issues