WINNIPEG INTEGRATED SERVICES INITIATIVE

Manitoba Family Services and Housing
Winnipeg Regional Health Authority
Manitoba Health

A CONCEPTUAL FRAMEWORK

July 23, 2003

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1 INTRODUCTION

1.1 Background

Prior to the establishment of Regional Health Authorities (RHAs), many community health and family services were co-located and administered by a Regional Director responsible to both the Department of Health and to the Department of Family Services. The programs administered by the Regional Director on behalf of the two departments included:

- Health programs/services - Provincial Public Health, Mental Health and Home Care.
- Family Services - Children's Special Services, Community Living, Vocational Rehabilitation (Winnipeg & rural Manitoba) and Child Day Care (rural Manitoba only).

The RHAs assumed responsibility for community health service delivery in 1997 (rural RHAs) and in 1998 (Winnipeg; public health, mental health and home care) as well as the delivery of health services by community health centres, non-government agencies/organizations, long term care facilities and hospitals.

The regional programs/services delivered by Family Services (as listed above) continued reporting directly to the Department of Family Services & Housing through a Regional Manager.

It should be noted that other significant community service delivery systems, such as those of Employment and Income Assistance, Housing and Child Day Care were not part of this regional delivery system structure. As well, in Winnipeg, the City was responsible for the delivery of public health services to the inner city and for the municipal welfare system. These services had not been part of the Health and Family Services regional delivery system.

More recently, both Departments and the Winnipeg Regional Health Authority (WRHA) recognized that fragmented delivery of services is not an effective service system for the public. They also identified that a mechanism to develop a population health approach and to respond to social services reform and primary health care principles was required.

A task team with representatives from both of the departments and the WRHA was requested to identify opportunities to improve service delivery to citizens across a number of service sectors. Through the initial discussions of the task team, it was recognized that both Departments and the WRHA deliver services, which are not well integrated, and in some cases, disconnected from each other. As a result, opportunities exist for each organization to further integrate their own services as well as work on integration across sectors. In October 2000, the task team articulated a vision for the integration of services across sectors:

> ***Vision***
> *The vision of integrated community-based health and social services is the provision of efficient, effective and holistic services that are person/family focused and seamless and that recognize the principles of population health and primary health care.*

2 THE DRIVERS

Although a myriad of influences have shaped the Winnipeg Integrated Services Initiative, the following are viewed as the key drivers:

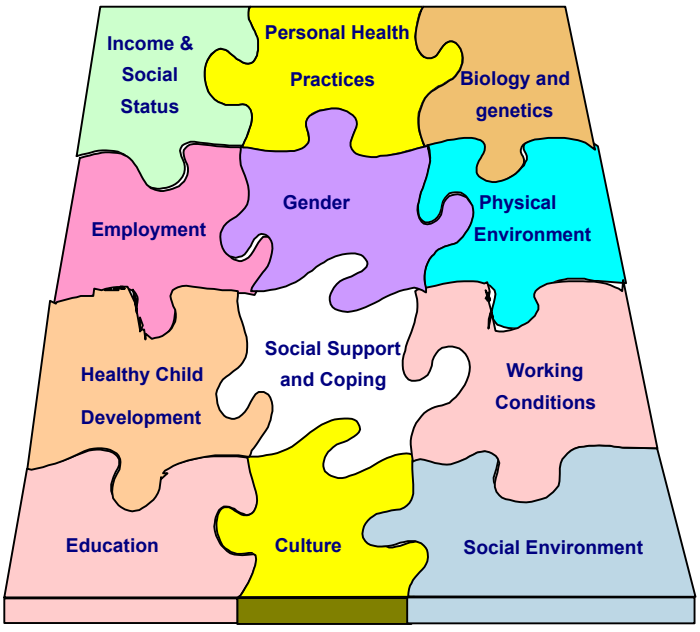
- Population Health Principles
- Social Services Reform
- Primary Health Care Principles

2.1 Population Health: A Broad View of Health and Well Being

Population Health is a way of looking at health and social services and an approach to managing them, that focuses on the needs and assets (capacities) of a given group as a whole and the factors that contribute to and determine, health status. A population health approach facilitates the integration of services such as health, social and education services across the continuum.

A population health approach is a conceptual framework for thinking about health and well being. It helps us to identify the determinants that influence health, to analyze them and to assess their relative importance in determining health. A population health approach has the potential for making a significant contribution to improving the health of communities and to reducing health inequalities. This approach will help integrate services, policies and actions with those of other determinants. "Determinants of Health" is the generic term used when referring to the factors and conditions, which have an influence on health. Health Canada has identified the Determinants of Health (Chart 1, Appendix A).

Chart 1: Health Determinants



For the past decade, government, health and social service organizations have been paying a great deal of attention to population health research findings. They have recognized the multiple determinants affecting the health of a population, and have recognized that there is no single action that will lead to healthy populations. A multiple strategy is required; from healthy public policy to redesigning the way services and supports are provided.

2.2 Social Services Reform

Provincial, territorial and federal Ministers responsible for Social Services have been actively pursuing reforms in social policy that lay the foundation for joint social services and health cooperation. These initiatives include child poverty, early childhood development and inclusion of persons with disabilities. Examples of initiatives include:

Canada's Social Union

In 1999, First Ministers (except the Premier of Québec) signed A Framework to Improve the Social Union for Canadians. First Ministers felt that Canada's social union should reflect and give expression to the fundamental values of Canadians - equality, respect for diversity, fairness, individual dignity and responsibility, and mutual aid and our responsibilities for one another.

The National Children's Agenda

In 1997, federal, provincial and territorial governments agreed to work together to develop the National Children's Agenda, a comprehensive strategy to improve the well being of Canada's children. The Agenda indicated that, as a nation, Canadians aspire to have children who are healthy - physically and emotionally; safe and secure; successful at learning; and socially engaged and responsible.

The National Child Benefit

In 1998, federal, provincial and territorial governments launched the National Child Benefit (NCB). The NCB aims to prevent and reduce the depth of child poverty, promote labour market attachment by ensuring that families will always be better off as a result of working, and reduce overlap and duplication by harmonizing program objectives and benefits across jurisdictions.

Early Childhood Development

In 2000, First Ministers agreed on the importance of supporting families and communities in their efforts to ensure the best possible future for their children from prenatal to age six. First Ministers agreed on four key areas for action, including the following:

- promoting healthy pregnancy, birth and infancy
- improving parenting and family supports
- strengthening early childhood development, learning and care
- strengthening community supports

Early Learning and Child Care

In March 2003, Ministers Responsible for Social Services agreed to make additional investments in the specific area of early learning and childcare.

Persons with Disabilities

In 1996, persons with disabilities were identified as a priority area of joint social policy reform at the First Ministers meeting. Actions in this area include the following:

- **Employability Assistance for People with Disabilities**

  In 1997, Ministers approved a Multilateral Framework for Employability Assistance for People with Disabilities (EAPD). EAPD cost shares programs and services to help people with disabilities overcome the barriers they face in the labour force. EAPD was intended to help people with disabilities prepare for, obtain and maintain employment.

- **In Unison: A Canadian Approach to Disability Issues**

  In Unison: A Canadian Approach to Disability Issues sets out a blueprint for promoting the integration of persons with disabilities in Canada. Ministers developed In Unison to make disability issues a collective priority in the pursuit of social policy renewal.

In addition, there have been a number of initiatives that have supported the expansion and development of social services within the province. These include the following:

- Aboriginal Justice Inquiry-Child Welfare Initiative
- Healthy Child Manitoba
- Community Economic Development
- The Affordable Housing Initiative
- Multilateral Framework on Early Learning and Child Care
- Social Union Framework Agreement
- National Children's Agenda

2.3 Primary Health Care

Principles

"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."[1] (Appendix B)

The Declaration of Alma-Ata outlines the strong connection between population health and the actions required by social and economic sectors, in addition to the health sector. It identifies that the promotion and protection of health is essential to sustained economic and social development. Citizens and communities must participate in the planning and implementation of their health care.[1] The re-orientation of service delivery from program silos and centralized locations to service delivery organized around populations and community

[1] Declaration of Alma-Ata, International Conference on Primary Health Care, World Health Organization, Alma-Ata, USSR, 6-12 September 1978

stems from this concept. The evolution of geographic reorganization of services into community areas and ACCESS centres enables the delivery of health and social services to targeted populations, and planning with communities. Primary health care is intended to reflect and evolve from the characteristics of the populations/communities it serves.

Reform

Policy makers at the provincial and national levels have prioritized the reform of primary health care services:

- Federal, provincial and territorial First Ministers' agreement to work together on a primary health care agenda (September 2000)
- *The Future of Health Care in Canada* (Romanow Commission)[2]. The document sets out the directions for change.
- *Primary Health Care Policy Framework*, Manitoba Health, April 2002 (Appendix C). The document sets out the vision, mission, principles and goals for primary health care reform in Manitoba.

[2] Building on Values: The Future of Health Care in Canada, Commission on the Future of Health Care in Canada, November 2002 (www.healthcarecommission.ca)

3 SUPPORTING PARTNER INITIATIVES AND ACTIVITIES

The three partners (Manitoba Health, the Winnipeg Regional Health Authority, and Manitoba Family Services and Housing) have each been pursuing initiatives that grow from population health principles, social services reform and primary health care principles. Two of the key activities include Integrated Service Delivery and the alignment of service delivery to community areas.

3.1 Integrated Service Delivery

Manitoba Family Services and Housing (FSH) has been redesigning service delivery through its Integrated Service Delivery (ISD) initiative. ISD is working toward reducing fragmentation and improving the effectiveness of service delivery through the development of coordinated, holistic approaches to service delivery that are responsive to each person or family's unique situation.

Integrated Service Delivery is oriented toward creating a system that supports and enhances performance improvement. The goal is to create a climate that defines and supports excellence by clearly and continually communicating goals, objectives and the expectations for achieving them.

ISD Initiatives have included the following:

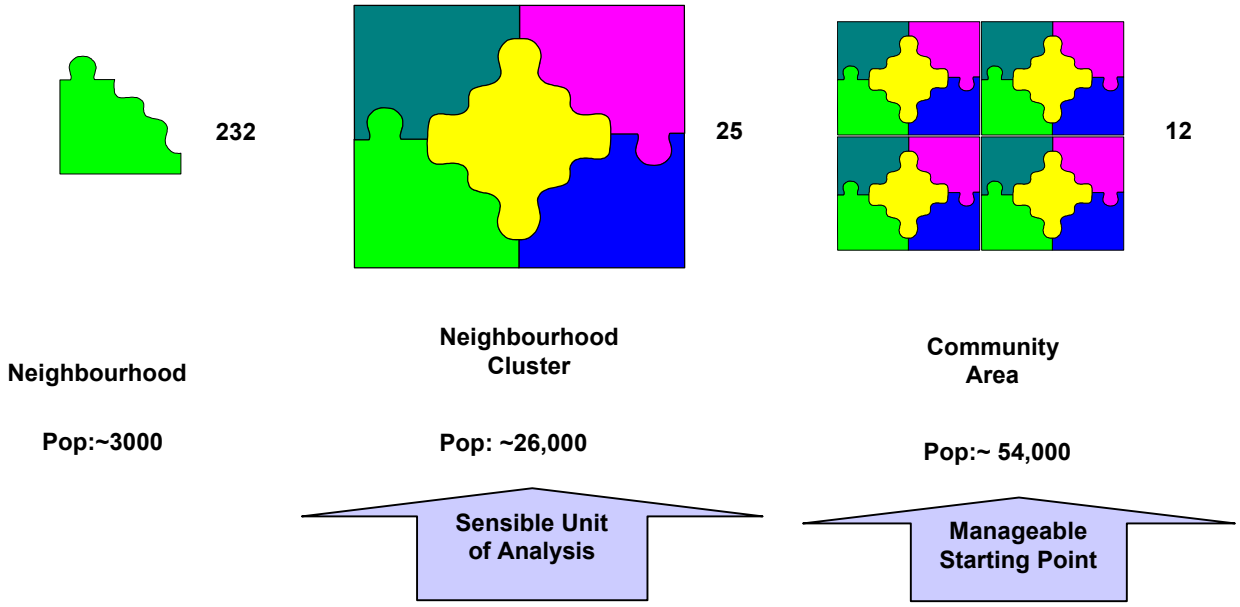
- building quality improvement goals, strategies and priorities into existing work processes
- developing a more efficient, citizen-centred approach to service delivery
- systematizing data collection and analysis to determine what action can be taken to improve program and service delivery
- encouraging staff participation in the ISD process and making it a process that is flexible and responsive rather than prescribed

3.2 The Alignment of Service Delivery to Community Areas

With input from many stakeholders, including government departments, the Winnipeg Region has been divided into three geographic levels (Chart 2):

- Neighbourhoods
- Neighbourhood Clusters
- Community Areas

Chart 2: Geographic Levels of the Winnipeg Health Region

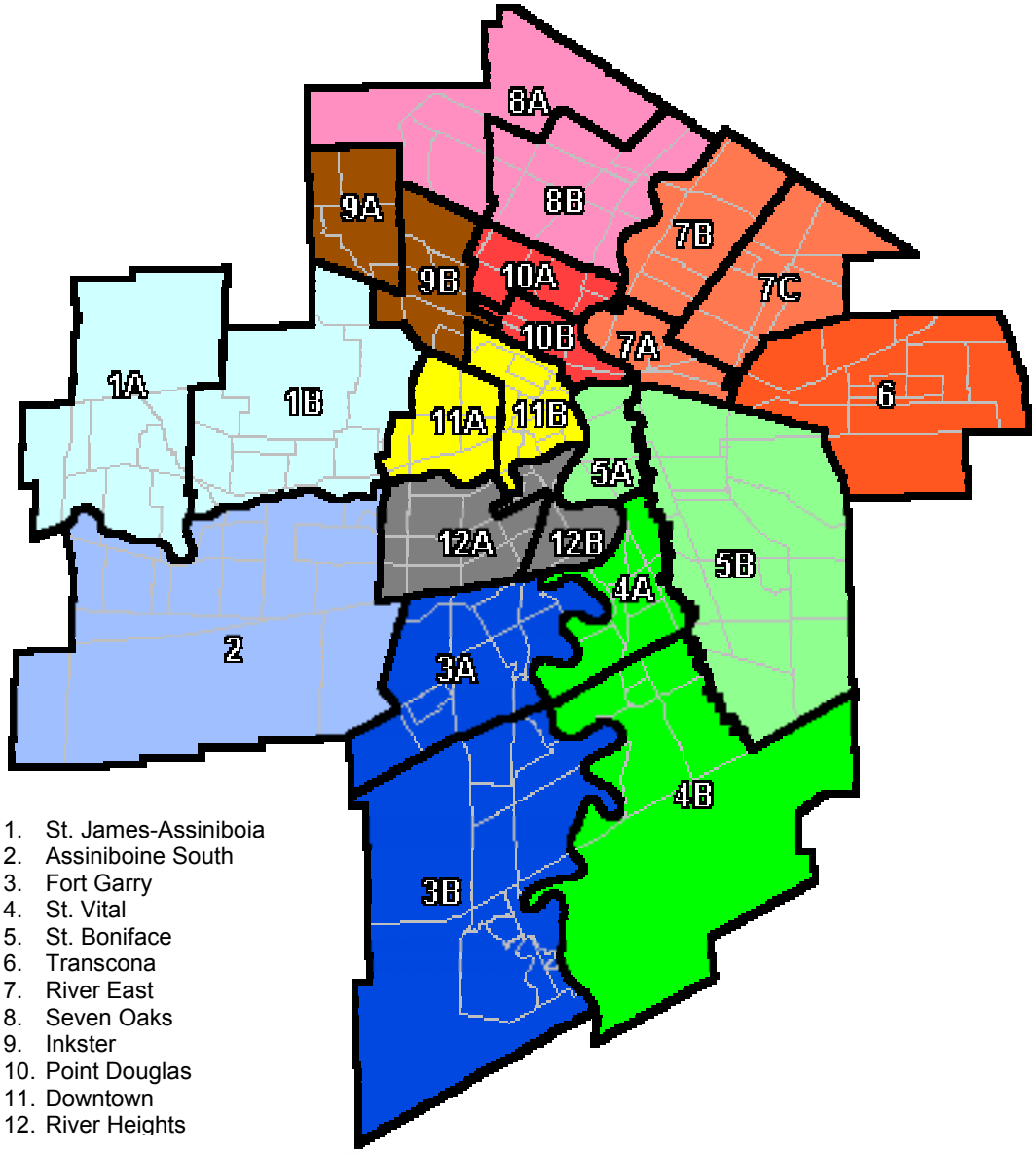


The City of Winnipeg neighbourhood characterization areas have informed the delineation of the geographic areas. The community areas support community development activities and assist community-based service providers to work intersectorally, thus supporting population health principles. WRHA and FSH have adopted the Community Area as the unit for engaging the community and organizing service delivery (Chart 3).

The WRHA has been undertaking several initiatives that are aimed at moving toward more integrated, accessible, and person-centred community services. One of these initiatives was the development of the concept of Health Access Centres. Health access centres were intended to accommodate community-based services that reflect the needs of the neighbourhoods they serve. These centres were proposed to be located in each of the 12 identified community areas. WRHA programs targeted to co-locate in health access centres included community mental health, public health, home care, primary care and select seniors services.

The WRHA continues to target co-location and integration of community-based services in community areas through the Community Area Restructuring process. The WRHA is now working with FSH to mutually advance the ACCESS centre concept.

Chart 3: Winnipeg Community Areas



1. St. James-Assiniboia
2. Assiniboine South
3. Fort Garry
4. St. Vital
5. St. Boniface
6. Transcona
7. River East
8. Seven Oaks
9. Inkster
10. Point Douglas
11. Downtown
12. River Heights

In this document, there are references to “12 paired community areas”. The paired community areas are Assiniboine South/St. James-Assiniboia, Downtown/Point Douglas, River East/Transcona, River Heights/Fort Garry, St. Boniface/St. Vital, and Seven Oaks/Inkster.

4 VEHICLE FOR CHANGE: THE WINNIPEG INTEGRATED SERVICE INITIATIVE (WISI)

Together, the Winnipeg Regional Health Authority (WRHA) and Manitoba Family Services and Housing (FSH) provide many of the supports and services that promote citizen, family and community health and well being in Winnipeg.

The Manitoba Government has recognized the benefits of integrated service and requested that Manitoba Health, WRHA and FSH work together to ensure community-based services be delivered in a coordinated, integrated manner. Government has directed that community-based health and social services be delivered within a *Community Access Model* concept of service further building on principles of population health, social services reform and primary health care principles. This could include the delivery of services from common locations[3] or the development of ACCESS centres. Accordingly, in October 2000, Manitoba Health, WRHA and FSH formed the Winnipeg Integrated Service Initiative to begin the process of implementing a *Community Access Model* and to organize the movement of health and social services into community areas.

On June 29, 2001, Manitoba Health, the WRHA and FSH signed a Letter of Agreement that initiated the planning phase for moving toward a system of integrated health and social services, and forming the basis for the Winnipeg Integrated Services Initiative (WISI):

Commitment to New Service Integration Approaches

As Chief Executive Officers responsible for the delivery of health and social service programs and services in Manitoba, we believe that our respective organizations must work collaboratively to support new service integration approaches for the benefit of the citizens of Manitoba.

Further, we believe that working relationships with other government and non-government and community organizations should be encouraged, in order to better meet the overall needs of the citizens of Manitoba.

United in this belief, we support the following objectives:

1. *Reduction of service fragmentation and the development of more holistic, person/family-centred approaches to the delivery of social services.*
2. *Establishment of coordinated and collaborative processes for the delivery of multiple, cross program services to citizens.*
3. *Development of joint planning mechanisms to further the integrated approach to achieving both the citizens' and our organizations' goals.*
4. *Examination of opportunities to partner with other organizations.*
5. *Structural reorganization to support integrated service delivery.*

_____
Deputy Minister
Health

_____
Deputy Minister
Family Services and Housing

_____
Chief Executive Officer
Winnipeg Regional Health Authority

[3] *Common locations* refers to sites where FSH and WRHA are co-located presently or co-located in future as opportunities arise.

5 DEVELOPING THE FOUNDATION: 2001 – 03

5.1 The WISI Framework

A guiding framework has been developed to shape the conceptual development and implementation of the WISI. This framework includes:

- a vision
- goals
- design principles

5.1.1 Vision

The vision of integrated community-based health and social services is the provision of efficient, effective and holistic services that are person/family focused and seamless and that recognize the principles of population health and primary health care.

5.1.2 Goals

1. To provide citizens with ready access to services and information.
2. To assess community needs and priorities on a regular basis and provide services that are a reflection of those needs.
3. To support and build community activity and development through effective community partnerships.
4. To provide appropriate opportunities for citizens to participate in the design, delivery and assessment of services.
5. To provide high quality services based on the principles of primary health care, population health and integrated service delivery.

5.1.3 Design Principles

A common understanding of and commitment to the vision and an appreciation of how each program area and service fit within that collective perspective is essential. The design principles are a guide for staff to successfully work together toward an integrated and responsive service system. The following principles will assist in guiding and shaping the relationship between Manitoba Health, FSH and the WRHA in providing integrated community-based health and social services.

1. Person/family/community/population-centred service

Citizens, families, communities and populations must be active participants in the design and delivery of services to meet their needs. This approach recognizes that each citizen, family and community has particular strengths, priorities and cultural influences and is built on the belief that these should be both respected and incorporated into service delivery.

2. Accountability

Management and staff are accountable for service delivery to the person accessing the service(s), to the public, and to the government.

3. Outcome-Based Service System

To be appropriate, services must be planned and delivered based on evidence.

4. Accessible, Coherent, Comprehensive, Responsive, Flexible, and Seamless Service Delivery

To fulfil these principles, the system would consist of:

- easier access to services (any FSH or WRHA community-based service door)
- extended operating hours
- services and supports that are tailored to meet both immediate and longer term needs
- maximization of self-service options
- recognition and responsiveness to the uniqueness of each community and region

5. Commitment to a Shared Vision and Culture

Management and staff of each organization need to collaborate and be committed to the vision and design principles for the WISI.

6. Integration is a Process

The integration of previously stand-alone systems requires an evolutionary approach, and will begin with collaboration and coordination (Appendix D).

Features such as common intake and 'seamless' service delivery, where the citizen may receive a range of services from different programs without repeated registration procedures, waiting periods, or other administrative barriers characterize integration. Service integration is expected to achieve several goals. Primarily, it is intended to make it easier for citizens to access services by providing them with a single or integrated point of entry to programs and services, promoting access to the right services, at the right time.

Co-location of services also optimizes integration…promoting access at the right place. Co-location makes it possible for citizens to access a broad range of services normally provided in different locations. With co-location, staff from different programs work closely together and communicate more effectively – therefore becoming more knowledgeable about the range of resources available for citizens. Combining resources, such as staff and facilities, is also expected to increase integration opportunities and minimize duplication.

Progress toward integration will evolve, as each system is ready to move forward.

Integration as a Process:

- **Fragmented Services:** Separate organizations, confusion, duplication

↓

- **Cooperation:** Sharing of program information

↓

- **Coordination:** Sharing of leadership, planning and decision-making

↓

- **Collaboration:** Equal partners, shared goals and commitment, open communication, community involvement, more effective use of resources

↓

- **Integration:** Common values, holistic, person-centred inter-disciplinary approach; flexible, responsive, seamless services, community partnerships

7. Open 2-way Communication and Reciprocal Responsibility

To foster partnerships and collaboration, all parties must understand their respective roles and responsibilities in meeting citizen needs.

8. Staff that are Valued

An integrated system requires valued staff and a culture that focuses on performance improvement, employee empowerment, responsibility and well being. It is understood that in order to perform their job, staff requires the following:

- training
- appropriate tools
- clear performance expectations and evaluation
- motivation and recognition

9. Decentralized and Streamlined Decision Making

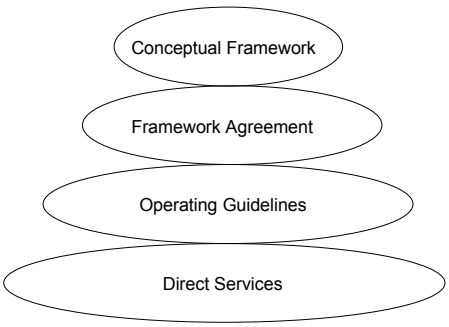
Decisions must be made closer to the service recipient(s).

10. Continuous Quality Improvement and Evaluation

Management and staff must create a positive and dynamic learning environment that values and promotes innovation. Continuous quality improvement initiatives that include performance indicators must be embedded in all service activities. Evaluation frameworks must, therefore, be based on continuous quality improvement strategies and initiatives.

5.2 The Winnipeg Integrated Services Initiative Planning and Implementation Structure

This document, the *Conceptual Framework*, describes the WISI; the drivers, background and context, the related activities of the WRHA and FSH, the vision, goals and design principles, and the *Community Access Model*. The philosophy and concepts of change management are outlined. As planning proceeds, the *Conceptual Framework* will be further defined (ie., service delivery concepts, supporting infrastructure).



In order to lead the conceptual development, planning and operationalization of the WISI, FSH, WRHA and Manitoba Health are undertaking the development of a *Framework Agreement* and Operating Guidelines.

The *Framework Agreement* builds from the conceptual framework for the WISI. It outlines the commitments to the initiative by the respective partners, and illustrates how the partners will work together to implement the WISI. The purpose of the *Framework Agreement* is to set forth the mutual understandings reached regarding the relationship between Manitoba Health, WRHA and FSH (the partners), the desirable outcomes, the performance expectations for the partners, and the oversight arrangements between the partners for the WISI. The agreement will align with the Letter of Agreement signed off by Milton Sussman Deputy Minister of Manitoba Health, Tannis Mindell, Deputy Minister of FSH, and Dr. Brian Postl, CEO of WRHA (June 2001).

The purpose of operating guidelines is to operationalize the *Framework Agreement*. It outlines how elements such as cost sharing, quality improvement and decision making will occur. Operating guidelines bridge the respective corporate and service delivery policies of

the partners. They can include approaches and templates for collaborative planning, decision-making structures, and joint operating policy.

Direct services function within the operating guidelines. The *Framework Agreement* and operating guidelines serve as a bridge between the *Conceptual Framework* to the operationalization of the initiative in community areas, providing a frame of reference to ensure that the services that are delivered align with the vision, goals and design principles of the WISI.

To move the WISI forward, a planning and implementation structure has evolved:

Steering Committee: A Steering Committee, with membership from WRHA, FSH and Manitoba Health oversees the planning and implementation of the WISI. The Steering Committee is accountable to the Deputy Ministers of Manitoba Health and FSH, and to the Board of Directors of the WRHA through the Chief Executive Officer.

> ***Steering Committee Vision***
> *The WISI Steering Committee provides unified leadership and championship in articulating the vision, communicating clear direction and priorities and making timely decisions.*
>
> *We are committed to achieving the WISI vision, design principles and goals through open honest and respectful communication; collaborative and strategic planning, coordination, decision making; participatory processes focussing on supporting measurement and continuous quality improvement; valuing innovation; supporting a learning environment; the strategic alignment of the WISI with other initiatives; fostering enthusiasm and commitment; creating an environment where systemic barriers and obstacles are addressed.*
>
> *We will ensure the viability of the WISI: by strengthened organizational capacity; through inclusiveness; through improved access to health and social services; through better service to the public; through quality work life; by obtaining and allocating (systemically), resources.*

Project Management Office: Reporting to the Steering Committee, the Project Management Office (PMO), is charged with providing overall planning and implementation management for the WISI. It manages the various task groups and project teams of the WISI, and collaborates with the WISI Programs Management and Operations Committees to ensure coordination and successful implementation of the project. A Project Co-Chairs Committee originally provided the initial key planning direction for the WISI. The PMO has evolved from this initial planning structure.

WISI Task Groups or Project Teams: Initially, five work teams were struck to focus on specific activities required for the overall WISI:

- Management and Service Delivery
- Change Management, Evaluation and Communication
- Administration Finance and Information Technology
- Human Resources
- Capital Planning and Space

WISI task groups and project teams will evolve over time to continue to advance the planning for the WISI.

Community and Staff Consultation: Consultations are held with community stakeholders and service delivery staff in order to determine program and service delivery needs and preferences in geographic areas.

WISI Programs Management Committee: A Programs Management Committee identifies and addresses joint WRHA and FSH program management related issues. On hand-off from the PMO, they lead the execution of the WISI implementation plans in the 12 paired community areas of Winnipeg and collaborate with the Operations Committee.

WISI Operations Committee: An Operations Committee oversees the joint operations of WRHA and FSH in the 12 paired community areas of Winnipeg. They collaborate with the Programs Management Committee in executing the WISI implementation plans in the 12 paired community areas of Winnipeg.

Community Area Directors: A Community Area Director oversees the joint operations of WRHA and FSH in their paired community areas. Together with their ***Community Area Management Teams***, they will manage the operations and delivery of services to the population within the respective community area. They will develop and maintain an effective relationship with the community area residents. They will also establish and maintain strong working partnerships with their counterparts in other Winnipeg community areas, with WRHA programs and the FSH Community Service Delivery Division, and with other health and social services agencies and institutions within or related to their community area.

6 THE COMMUNITY ACCESS MODEL

The *Community Access Model* draws on the primary drivers of Population Health, Social Services Reform and Primary Health Care with the aim of improving citizen, family and community access to services. Improved access to programs and services will be enabled by the following:

Structural Change

- The restructuring of FSH and WRHA community-based services into interdisciplinary, neighbourhood teams within 12 paired community areas
- Locating services closer to communities; improving access, as a means to engage in local health and social issues, economic development; the co-location of FSH and WRHA community-based services in local communities as opportunities arise

Building Community Connections

- Ongoing identification of the unique needs of populations and communities
- Strengthened relationships with local communities, services agencies and citizen groups

Service Delivery Improvements

- Improved availability of information about the range of programs and services available in each community
- Streamlined access to programs and services
- The development and implementation of service delivery processes that will integrate FSH and WRHA functions such as service coordination and integrated front-end processes (e.g., service needs determination and referral)
- Continued work with local physicians to promote the

What is an ACCESS centre?

A site can qualify to use the term “ACCESS” if it meets the following criteria:

- The community’s perspective and input is encouraged in addressing main health and social issues in the community area, AND,
- Approaches which help prevent problems and promote citizen and community health and well being are supported, AND,
- Citizens are able to obtain information about the full range of services offered by both partners through in-person contact with a service navigator, which may be supplemented by written and electronic information; AND,
- Trained service navigators provide excellent customer service, be able to appropriately assess citizen’s presenting needs, be knowledgeable about the full range of services, and be able to arrange appointments and make referrals to the appropriate program specialist/intake worker/case worker etc, in any location in the community area or with a centralized service, AND,
- Staff must be active participants in the community area’s network of services and interdisciplinary service delivery team(s), AND,
- Hours and locations of service are convenient to the public, AND,
- Services are provided collaboratively with other community organizations such as justice, recreation etc., AND,
- On site services must include one or more services from each of the partners (WRHA and FSH) plus primary care services, plus other services that may be available on an itinerant basis or by appointment at that site.

coordination of a full range of health and social services, and to provide services and supports to their patient populations

- The development of new primary care clinic capacities and the enhancement of the availability of primary care services within ACCESS Centres (ACCESS Centres can function as a hub to enable networking, and supports for primary care physicians)
- Taking advantage of ongoing opportunities to improve access to services (e.g., establishment of Chronic Disease Prevention and Management Services, clinics, support groups)

Technical Enhancements

- Enhancing information technology (e.g., a client registry of both WRHA and FSH clients/participants and a service-tracking tool)

6.1 Organization and Support in Relation to the Community Access Model

The *Community Access Model* will be introduced to the 12 community areas. The community areas will be paired for administrative purposes:

- Assiniboine South/St. James
- Downtown/Point Douglas
- River East/Transcona
- River Heights/Fort Garry
- St. Boniface/St. Vital
- Seven Oaks/Inkster

Each of the 12 community areas will bring together a broad range of health and social services that reflect and serve the needs of community residents. The *Community Access Model* will represent a major shift from a program-based organizational model to an integrated, neighbourhood-based team structure. Key components to support the model are as follows:

- Communication mechanisms to engage the community
- Participation in or fostering community development efforts
- Linkages with service providers, agencies, institutions within the community areas beyond FSH and WRHA community-based services
- Specialized resources to support service delivery
- Integrated and coordinated policies and information

What about capital development in community areas where there is no ACCESS centre?

Opportunities to co-locate office operations of the WRHA and FSH consistent with the WISI will be pursued where possible. However, the WRHA and FSH will also be looking at ways to integrate service delivery through multiple locations. The WRHA and FSH will work toward ensuring that all community-based service delivery locations for each partner are able to provide the following:

- Basic information on the full range of services offered by both partners and how those services can be accessed,
- Direct referral to appropriate program specialists/intake workers/case workers; and
- Access to application forms where applicable

technology systems

- Managers with cross-program responsibilities
- Joint management of FSH and WRHA programs and services

6.2 What will Community Access Mean for Citizens & Staff?

It is expected that the *Community Access Model* will provide a different and improved experience for citizens requesting and receiving services, and for staff members. The following are a few of the key benefits linked to this model.

6.2.1 Service Excellence

Citizens can expect to see a variety of positive changes, including:

- Enhanced access to information about the full range of health and social services available
- More convenient and timely access to services at a location(s) closer to home
- Simplified information collection and referral processes
- More continuous service provision
- Coordinated service provision for citizens and families requiring a number of health and social services
- More responsive population specific services enhanced through the WRHA and FSH's improved partnerships with the community, other agencies and sectors

6.2.2 Quality Work Life

Within the *Community Access Model* staff will have greater opportunities to work more closely together. Opportunities to improve access and quality of the services for the public will be enabled. FSH and WRHA are committed to supporting staff in the provision of policy, tools and training to support the WISI with the following results:

- Staff will share a common understanding of the vision, design principles and goals of the WISI.
- Staff will have a clear understanding of where their program fits within the overall *Community Access Model.*
- Staff will understand the needs of citizens residing in their community area and respective neighbourhood clusters.
- Staff ability to work successfully in an integrated environment, characterized by quality and continuous improvement, will be actively facilitated by management support.
- Policies and procedures will be streamlined.
- Common work processes will exist.
- Staff will collaborate and share information between programs.
- There will be ongoing skill development and training.
- Staff will have easier access to necessary health and social services for their clients.

- Improved tools to identify trends and service issues in client care will exist.
- There will be a more interesting work environment and exposure to a broad range of professionals, skill-sets, programs and services.

7 PLANNING FOR THE WINNIPEG INTEGRATED SERVICES INITIATIVE

FSH and the WRHA are each undertaking a restructuring initiative within their respective organizations. For FSH this includes the Integrated Services Delivery initiative, and for WRHA this includes the Community Area Restructuring process. The WISI, and correspondingly the *Community Access Model*, will build on these initiatives during the planning and implementation phases.

With the completion of the *Conceptual Framework*, Manitoba Health, WRHA and FSH are coming together to develop a *Framework Agreement*. WRHA and FSH will also be developing Operating Guidelines (outlined in section 5.2).

The following list sets out additional first steps in planning for the WISI:

- identification of key working assumptions for the WISI
- defining services that are centralized and decentralized
- work process redesign, that is, phasing in a joint WRHA and FSH service delivery model
- review/establishment of joint infrastructure support
- development of a Change Management and Accountability Framework

7.1 Key Working Assumptions for the WISI

Manitoba Health, FSH and WRHA originally developed a set of working assumptions in January 2002. The working assumptions were revised on April 25, 2003 and are organized as follows:

- Planning
- Policy
- Structure and Organization
- Service Delivery
- Technical Requirements and Infrastructure Supports
- Change Management

The working assumptions are subject to change over time, and as a result, have not been included in this document.

7.2 Defining Services that are Centralized and Decentralized

FSH and WRHA have determined that there will be a framework that will guide decision making and organization for the decentralization or centralization of services. WRHA and FSH core community-based services will be decentralized to align with population service needs whenever possible and appropriate.

7.2.1 Guiding Principles

1. Program/service teams that are interconnected in order to enhance coordination of services for the citizen, need to be decentralized in order for optimal integration of services to occur in geographic areas to ensure accessible, responsive, flexible and seamless service delivery.
2. Not all components within each of the core services will be decentralized and these decisions need to allow for unique program configurations.
3. A service may be centralized when financial and equipment resources are not available to decentralize. It is possible to make decentralizing the service a long-term goal and to move incrementally towards it.
4. A service may be centralized when the number of staff to deliver services is minimal and/or the population base is not geographically specific.
5. A service may be centralized when there are physical design requirements which may be necessary to protect the health and safety of staff and the public, and when they are required for the majority of other services at the site.
6. In order to decentralize clinical or program specialists, there must be a sufficient volume of clients in a community area so that the service providers with a high degree of specialized training are able to maintain their skill proficiency.
7. In some instances, a service will require centralization to efficiently coordinate services in this team, as it precludes or outweighs the need to integrate with other service delivery teams in decentralized sites.

FSH and WRHA have agreed on a service listing that identifies those services that will be decentralized and those that will be centralized. Modifications to the listing may occur over time, and as a result, they have not been included in this document.

7.2.2 Core Services

Each of the community areas has unique characteristics that will be considered when determining the range of services and programs for each area. However, typical services will include the following:

- Child and Family Services
- Child Day Care
- Children's Special Services
- Community Engagement and Development
- Community Mental Health
- Employment and Income Assistance
- Employment Supports for Persons with Disabilities
- Home Care
- Housing
- Primary Care
- Public Health
- Services to Seniors
- Supported Living

Program leaders or specialists that support decentralized service delivery may be centralized (clinical consultation, recruitment, and training consultation). FSH and WRHA have determined that centralized services will support the geographic organization of services.

7.3 Work Process Redesign

In keeping with the aim of improving access to programs and services, the FSH and WRHA are undertaking the redesign of work processes. Redesign of work processes will occur over time. As a first phase, redesign includes:

- **establishment of processes at the "front-end" of the publics'/citizens' contact with the system that make information readily available and simplify access to services**

  FSH and WRHA have identified that there will be a common philosophy agreed to by both organizations for an integrated front-end. Public and citizen access to programs and services will be simplified. A streamlined process will ease entry into the system, and guide citizens to the appropriate information and services. A defined set of business functions and services will be conducted at the front-end of service delivery. Over time, they will be present at every WRHA and FSH service site. Establishment is dependent on feasibility, and a phased implementation approach will be used.

- **service coordination across FSH and WRHA programs and services**

  FSH and WRHA have agreed that there will be consistent processes to access and coordinate services and supports across community areas and programs for citizens with multiple system needs. Service coordination will result in the delivery of services that are efficient, effective, holistic, person/family focused and seamless. The implementation of service coordination will be phased.

Subsequent phases will include work processes such as intake and after hours call.

For each phase, a Service Delivery Model will be developed that describes the work process redesign and implementation requirements.

7.4 Infrastructure Support

7.4.1 Human Resource Management

FSH and the WRHA are working together to review, assess, develop and implement a comprehensive range of human resource services that will support the integration of human resource services as well as enable the orderly movement of staff from both organizations to the community areas throughout the region. This includes review of existing practices, policies, agreements and services including recruitment and selection, payroll, job classification and evaluation, organizational design, employee relations, staff development and training, and human resource policy development and administration.

7.4.2 Finance and Administration

The WRHA and FSH have begun discussions and planning exercises regarding the integration of financial processes and systems between the organizations. Consistent with the services delivery objectives, financial functions will be integrated to provide a consistent approach for the benefit of both staff and citizens of community areas wherever possible.

Changes to integrate functions and approaches will be consistent with the existing internal Governance structures of both organizations.

7.4.3 Information Technology

Within the WISI, Information Technology (IT) is viewed as a critical enabler for effective integrated service delivery. The initiative's strategic IT goal is "Seamless access to information, where and when it is required, by all those that need it." Currently, neither organization enjoys a fully integrated environment and this situation has the potential to be exacerbated when new information system collaboration requirements arrive with the opening of new ACCESS centres. In anticipation of this, both the WRHA and FSH are already undertaking projects to increase the degree to which their respective environments are integrated internally and are jointly designing a technical integration solution which would enable the organizations to securely integrate information across their current technical boundaries. This integration solution will be required to support even the most basic sharing of IT information and, once it is in place, will support the information system collaboration needs of all of the planned ACCESS centres, and possibly other WRHA and FSH shared and separate sites in Winnipeg.

7.4.4 Capital and Space Planning

ACCESS centre development will be coordinated through a capital planning process that is consistent with the Manitoba Health Capital Project Planning Process. This entails the development of a Role Statement and Functional Program, and a coordinated design and development process. A joint WRHA and FSH team leads this process.

The team also reviews and rationalizes other joint space needs within sites in Winnipeg community areas in order to support the implementation of the WISI. The project team with the involvement of the related community area and program staff manages projects arising from this review.

7.5 Change Management Process

Implementation of the WISI will require significant change from the current delivery of services. A change management framework has been developed to facilitate the process of implementation. The framework will enable the successful coordination and integration of health and social services in each community area. In addition, the change management framework will inform and support each of the planning and implementation teams' direction and further, will engage the teams in applying the change management framework to their tasks.

The WISI will define *what* will change, and *how* the changes will be introduced and successfully implemented. In this context, the change management framework will be an organized, systematic application of the knowledge, tools and resources of change that will provide the WISI with key processes to achieve the strategic changes and to develop a new strategic plan for implementation.

Change management/Strategic planning processes ask and answer the following questions:

- Where are we now?
- Where do we want to be?
- How do we get there?
- How do we measure our progress?

- How do we track our progress?

Key elements of the change management process include the following:

- Defining principles
- The roles in change
- The critical change variables
- The state of change
- The change system

Communications, orientation and training, continuous quality improvement and reward are key components of change as follows:

7.5.1 Communications

Manitoba Health, WRHA and FSH are working together to address the broad communication requirements for the WISI.

WRHA and FSH are also working together to develop a framework and implementation plan for communicating and consulting with identified communities and stakeholders and with staff of the WRHA and FSH regarding the introduction of the WISI. Initially, this work has focussed on the development of ACCESS Centres. In the next phases, a framework and implementation plan will be developed for the community areas across Winnipeg.

The framework and implementation plan will include:

- An action/implementation plan that will include time frames, identification of responsible parties and a detailed analysis of resource requirements required for implementation
- Communication with community residents and organizations and relevant stakeholders regarding the introduction and benefits of the WISI and community area implementation
- Strategies to heighten public awareness of health and social services, and ensure that residents have the information they require to effectively participate in a community consultation process
- Consultation with residents and community organizations regarding their attitudes, opinions and beliefs about the provision of health and social services and the concepts of the WISI and ACCESS centres
- Communication and consultation with the staff of the WRHA and FSH in a manner that fosters a common understanding of the vision, design principles and goals of the WISI and encourages staff to work together towards a common purpose
- Creation of a template for communication and consultation that builds on previous and existing communication and consultation initiatives, and that can be applied, with minor modification, in each of the 12 identified community areas as the WISI and ACCESS centres are introduced.
- Strategies to establish the basis for an ongoing, effective dialogue/exchange of views and information between the community/stakeholders and WRHA/FSH, and between staff and management of WRHA/FSH, regarding the WISI.
- Communication, collaboration and consultation with each of the structures of the WISI (e.g., project teams, task groups, community area implementation teams), and relevant stakeholder groups.
- Provision of data from community consultations to help to inform key decisions regarding the WISI.

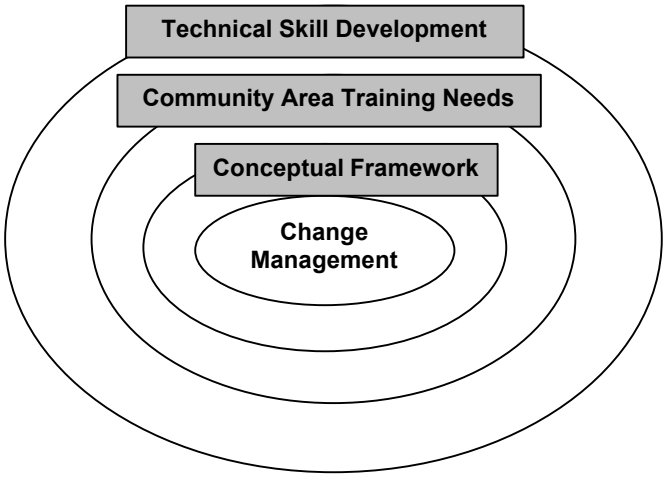
7.5.2 Orientation and Training

The WISI is an extremely complex initiative, which has numerous components of implementation. A comprehensive orientation framework is in development, and will support the information and skill development needs of WRHA and FSH staff as the WISI implementation unfolds.

The training dimensions and related needs are as follows (Chart 5):

- Overall WISI Change Management – all stakeholders involved in the WISI require orientation and training related to change management principles and the overall conceptual framework of the initiative. Without this knowledge and skill development, change cannot be led successfully and within a consistent context.
- Community Area Training needs – all WRHA and FSH staff in each of the community areas require orientation and training related to the following:
    - change management
    - the components of the overall conceptual plan
    - specific work process changes
- Technical Skill Development – as work processes changes, some staff in some areas will require technical skill training/retraining. (e.g., service coordination skills, service navigation skills)

Chart 5: Training Dimensions



7.5.3 Continuous Quality Improvement

A quality framework and implementation plan is in development that will serve as a mechanism for determining the extent to which the WISI is meeting its goals and identifying where changes need to be made.

The implementation plan will identify structural elements required within the quality change management frameworks. The plan will reflect the design principles, goals and objectives of the WISI, and will identify how communities will be engaged in the process.

Quality monitoring will be built into activities at the following levels:

- policy
- program
- service delivery

Developing a framework for quality monitoring will enable the measurement of progress, guide quality improvements and contribute to impact assessments for each community area. It will support continuous improvement through gathering information (e.g., community, staff and stakeholder surveys, service experience data), and applying the results to policy and program development and service delivery. As part of continuous quality improvement, the quality framework will also ensure success and rewards. The quality framework will build on existing systems and will be implemented over time.

The Steering Committee has made a commitment to a strategic approach and to focussing on performance measurement. They have determined that principles of performance measurement will be incorporated into the *Framework Agreement*, enhancing the *Framework Agreement's* utility as a living document. Further to the development of the *Framework Agreement,* a set of indicators and a performance monitoring process will be developed. Through the performance monitoring process, key issues for improvement will be identified. The Steering Committee will have the ability to address performance, revise the implementation plan for the WISI, or amend the *Framework Agreement* in a timely and proactive fashion. Manitoba Health, FSH and WRHA can be assured that the mutually agreed upon goals are met as the implementation unfolds.

The WRHA has a commitment to the national accreditation process.

The WRHA and Manitoba Health also have an additional accountability relationship as set out within the *Regional Health Authorities Act*.[4]

[4] Manitoba's health care system is a broad network of services and programs. Overseeing this system is Manitoba Health, a department of the provincial government. For the most part, the actual services are delivered through local regional health authorities. Eleven regional agencies are set up by the province to meet the local needs of Manitobans.

The decision to regionalize the operation and administration of health in Manitoba was a major change in the way that health care is planned and delivered. In this model, the regional health authorities are responsible within the context of broad provincial policy direction, for assessing and prioritizing needs and health goals, and developing and managing an integrated approach to their own health care system.

The *Regional Health Authorities Act* legislation came into force in 1997. It sets out the conditions under which the RHAs are incorporated, as well as defining duties and responsibilities of the RHAs and the Minister of Health. Both parties are responsible for policy, assessment of health status and ensuring effective health planning and delivery.

8 APPENDICES

A: Health Status and Health Determinants

Health Determinants

- ***Personal Health Practice:*** Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status.
- ***Personal Resources (ie., Social Support and Coping):*** Measures such as the prevalence of factors such as social support and life stress, that epidemiological studies have shown to be related to health. Examples would include self-reported loneliness, life stress and coping.
- ***Living and Working Conditions (ie., Working Conditions, Education, Income & Social Status, Employment):*** Indicators related to the socio-economic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health. Examples would include education, income and literacy.
- ***Environmental Factors (ie., Physical Environment and Social Environment):*** Environmental factors, both physical and social, have the potential to influence health.
- ***Healthy Child Development:*** Early experiences affect brain development, school readiness and health in later life. Also, all of the other determinants of health affect the physical, social, mental, emotional and spiritual development of children and youth.
- ***Biology and Genetics:*** The basic biology and organic make-up of the human body are a fundamental determinant of health. In some circumstances, genetic endowment appears to predispose certain individuals to particular diseases or health problems.
- ***Culture:*** Some persons or groups may face additional health risks due to a socio-economic environment that is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.
- ***Gender:*** Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis.

Health Status

A range of indicators determine health status, including:

- ***Deaths:*** A range of age-specific (e.g. infant mortality) and condition-specific mortality rates (e.g., AIDS deaths), as well as derived indicators (e.g. life expectancy and potential years of life lost.
- ***Health Conditions:*** Alterations or attributes of health status of an individual which may lead to distress, interfere with daily activities; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health-related states such as pregnancy, aging, stress, congenital anomaly or genetic predisposition.
- ***Human Function:*** Levels of human function are associated with the consequences of disease, disorder, injury and other health conditions. They include body function/structure (impairments), activities (activity limitations), and participation (restrictions in participation).

- ***Well-being:*** Broad measures of the physical, mental and social well-being of individuals.

B: Declaration of Alma-Ata[5]

International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I
The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II
The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III
Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV
The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V
Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI
Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

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[5] http://www.who.int/hpr/archive/docs/almaata.html

VII
Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII
All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX
All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X
An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international

organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

C: Primary Health Care Reform in Manitoba[6]

Vision for PHC Reform

Manitobans will have access to community-based, integrated and appropriate PHC services.

Mission for PHC Reform

Manitoba Health will work with Regional Health Authorities, in partnership with key stakeholders, to develop and support PHC services.

Principles for Primary Health Care Reform

- *Community Participation*: Community members must be involved in the assessment, planning, implementation, monitoring and evaluation of PHC
- *Population Health*: The focus must be on the health of the entire population with particular attention to health promotion, disease prevention and self-care.
- *Intersectoral/Interdisciplinary*: To adequately address the determinants of health, the skills and services of numerous sectors and disciplines will be required. Formally integrated and coordinated teams of service providers must be developed.
- *Accessibility*: Citizens are able to obtain appropriate services by appropriate providers at the right place and time (24x7x365) through personal service and/or telephone triage.
- *Appropriateness:* Care and services are provided by the appropriate provider using the appropriate technology based on established standards of practice.
- *Continuity of Care:* Integrated and uninterrupted service across the continuum of programs, practitioners, organizations and levels of care must be facilitated.
- *Efficiency:* Expected outcomes must be achieved with the most cost-effective use of resources.
- *Affordability and Sustainability:* PHC reforms must reflect and operate within the economic realities of governments and communities.

Goals

1. Promote the development of PHC organizations delivering service to Manitobans based upon the principles of PHC.
2. Enable PHC service providers to deliver services in ways that reflect PHC principles.
3. Improve the ability of PHC organizations to deliver services in accordance with the principles of PHC.

[6] Excerpt from "Primary Health Care Policy Framework", Manitoba Health, April 2002

D: Integration is a Process

Fragmented Services	Co-operation	Coordination	Collaboration	Integrated Services
• No common philosophy, language or perspective among organizations • Different service area boundaries • The public experiences confusion • Competition for resources • Ineffective use of resources and duplication of effort • Centrally controlled • Separate organizations (silos), mandates, policies, procedures, protocols, and legislation • Organizations act in isolation from one another to provide separate and distinct services to the same people	• Autonomous organizations still functioning independently • Program information shared among organizations informally when requested • Committees may be formed as a means of sharing information • Still competition for resources • Still duplication of effort and ineffective use of resources	• Sharing of leadership, planning and decision-making • More collegial relationships among organizations • Moving toward open communication • More of a desire to work together • Movement toward becoming proactive • Recognition of some common goals between organizations • Move toward making better use of total resources and avoid duplication	• Partners involved as equals in planning, decision-making and evaluation • Shared goals and commitment • Collaborative culture and open communication • Diversity of a person's needs recognized • Both central directorates and front-line workers empowered to work collaboratively • Community involvement • More effective use of resources • Revisions to rules, policies, legislation being considered	• Common values and philosophies • Interdisciplinary team approach • Holistic person-centred planning and delivery • Flexible, responsive and seamless services • Any door service • Flexible funding by logical services groupings • Single delivery structure • Common data base • Co-operation, coordination, collaboration is routine • Simplified/reduced rules • Community partnerships