IHSP 4 - Living Healthier at Home 2016-2019

Northumberland Hills Hospital
Board of Directors
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Presented by:
David Sudbury, Vice Chair
Deborah Hammons, Chief Executive Officer

Ontario
Local Health Integration Network

Overview

- Environmental Scan
- Integrated Health Service Plan 4
- Stakeholder Engagement & Feedback
- Mission, Vision, Values
- Strategic Directions
- Strategic AIMS
- Direct Care Priorities
- Health System Enablers

Central East LHIN

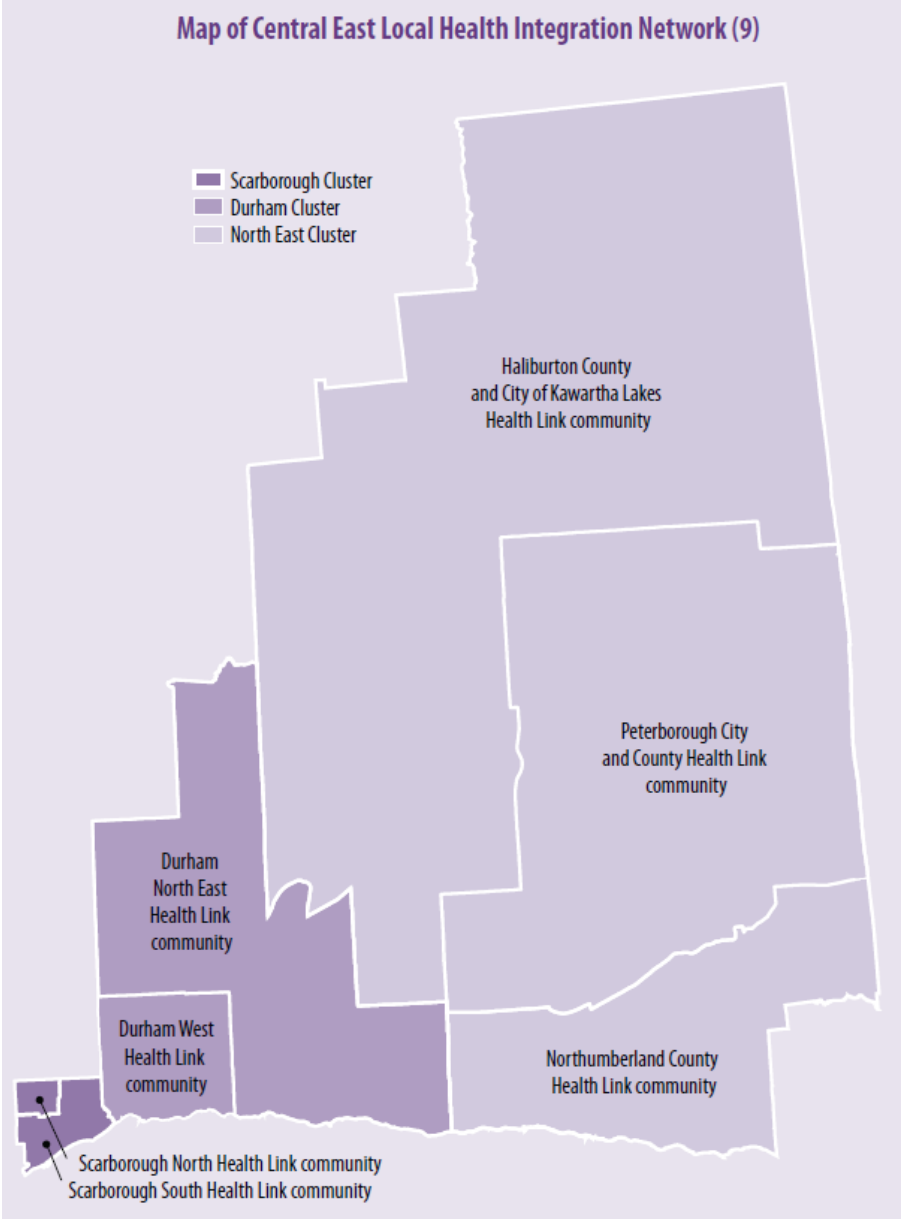
Total Population: 1.6M

Geographical Size: 16,673 km2

6th Largest Geography

2nd Largest Population

7 sub LHIN Health Link communities



HL Profile – Demographics

	Scarborough Cluster		Durham Cluster		North East Cluster		
	Scarborough North HL community	Scarborough South HL community	Durham West HL community	Durham North East community	Haliburtion County and City of Kawartha Lakes HL community	Peterborough HL community	Northumberland County HL community
Land Area (sq km)	42.4	138.3	449.1	2,172.1	7,893.8	4,215.2	1,766.9
Population Density (persons per square kilometre)	4,207	3,144	713	132	11	32	41
Total Population							
Population (Census 2011, based on Dissemination Areas)	**178,395**	**434,815**	**320,400**	**287,800**	**89,310**	**135,085**	**72,475**
Population 65+	30,705	59,615	32,525	40,980	20,370	27,165	15,305
Population 75+	15,490	28,535	14,200	19,055	9,165	13,195	6,940
% population age 65+	17.2%	13.7%	10.2%	14.2%	22.8%	20.1%	21.1%
% population age 75+	8.7%	6.6%	4.4%	6.6%	10.3%	9.8%	9.6%
SES							
Language, Census 2011							
% who include English as their mother tongue	30.8%	56.5%	81.7%	90.1%	94.4%	93.7%	94.3%
% who include French as their mother tongue	0.8%	1.3%	1.9%	2.1%	1.2%	1.3%	1.4%
% with no knowledge of English or French	16.3%	3.6%	0.8%	0.3%	0.1%	0.2%	0.1%
Immigration, Census 2006							
% who are immigrants	69.5%	53.0%	26.6%	13.7%	8.4%	9.5%	11.0%
% who arrived within 5 years	15.9%	10.3%	2.6%	0.9%	0.3%	0.7%	0.4%
Visible minorities and identity, Census 2006							
% who are visible minorities	81.6%	62.4%	26.9%	5.9%	1.5%	2.4%	2.3%
% who self-identify as Aboriginal	0.1%	0.6%	0.9%	1.5%	1.9%	3.2%	2.0%

IHSP 4 – A culmination of 10 years of learning

- IHSP 1: Engaged Communities – Healthy Communities
- IHSP 2: Save 1M Hours in ED– Save 10,000 Days for Vascular patients
- IHSP 3: Community First – Seniors, Vascular Health, Mental Health & Addictions, Palliative
- IHSP 4: Living Healthier at Home – Advancing integrated systems of care to help Central East LHIN residents live healthier at home.

IHSP 4 - Stakeholder Engagement

Strategic Aim Coalitions:

- Vascular Aim Coalition; Hospice Palliative Care Network; Mental Health and Addictions Coordinating Council; Seniors Care Network

Planning Partnerships & Networks:

- Maternal, Neonatal and Paediatric Advisory Committee
- French Language Services Coalition/Tables
- Primary Health Care Advisory Group
- Local Partnership Table for QBPs and HSFR
- Health Professionals Advisory Committee
- Medical Leadership Group
- First Nations and Metis – Non Status Advisory Circles
- Information Management/IT Leadership
- Hospital VP-Chief Nursing Officers

Governance Advisory Councils

5 Community Health Huddles - 130 participants

356 Provider & Patient Survey responses - 169 patients or caregivers and 187 providers

Primary Care Physician LHIN Lead initiated dialogue

Government Relations: Municipal and Regional Councils, M.P.P.s

IHSP 4 Stakeholder Survey Feedback

We asked patients and providers, why do we need to transform the health care system?

HEALTH SERVICE PROVIDERS IN THE CENTRAL EAST LHIN

Description	Response
1. **Top Challenges** HSPs (80% or more of respondents indicating either "sometimes", "frequently" or "almost always")	
• Complexity of Health Needs	93%
• Social Supports for Patients/Family	92%
• Transitions	91%
• Access to Social Services	80%
• Access to Community Supports	80%

IHSP 4 Stakeholder Survey Feedback (cont'd)

HEALTH SERVICE PROVIDERS IN THE CENTRAL EAST LHIN

Description	Response
2. **Confident** that patients and their family caregivers can access the health care services they need at the right place, at the right time, and receive the right care	less than 10%
3. HSPs rating their current ability as effective/very effective in responding to patient needs as a **Coordinated System**	13%
Conclusion: Confirms how much advancing integrated systems of care (e.g. Health Links) is needed	

Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario

- Connecting Different Parts of the System
- Primary Care
- Home and Community Care
- Population and Public Health Planning

Ontario

Summary of Patients First Feedback

- ***Very similar to the type of feedback collected during the development of IHSP 4.*** *(Note: Report out on IHSP 4 feedback posted on LHIN website – see IHSP 4 – Appendix A*)

- ***How do we support care providers in a more integrated care environment?*** – eHealth, OTN, system standardization, evidence-based decision making, recognizing diversity in communities.

- ***How do we strengthen consistency and standardization of services while being responsive to local differences?*** - provincial standards, meaningful indicators, listening to patients and providers.

- ***How can we support primary care providers in navigating and linking with other parts of the system?*** – EMRs, joint platform for communication, one gateway to all services.

- ***How can public health be better integrated with the rest of the health system?*** – By being part of the planning team in identifying needs within our LHIN and designing solutions. By having a partnership with the LHINs and defined accountability to the LHINs.

Strategy Map

1 Vision & Mission

Central East LHIN Vision
Engaged Communities.
Healthy Communities.

Central East LHIN Mission
To lead the advancement of an integrated sustainable healthcare system that ensures better health, better care and better value.

2 Directions/ Outcomes

Strategic Directions
- Transformational Leadership
- Quality and Safety
- Service and System Integration
- Fiscal Responsibility

Population Health
- Focus on Population Health
- Equitable

Patient Experience
- Integrated
- Accessible
- Person Centred
- Effective
- Safe

Cost Control
- Efficient
- Appropriately Resourced

3 Strategic Aims

Living Healthier at Home


Seniors


Vascular Health


Mental Health and Addictions


Palliative Care

4 Direct Care Priorities

- Health Links
- Primary Health Care
- Patient and Family Caregivers
- Home and Community Care
- Supported Living Environments
- Health Equity – Diversity
- Child and Family

5 Health System Enablers

- Pursuing Quality and Safety through Effective Access and Transitions
- System Design and Integration
- Enabling Technologies and Integration (Electronic Health Information Management)
- Health System Funding Reform

Central East LHIN Mission

To lead the advancement of an integrated sustainable health care system that ensures better health, better care and better value.

Central East LHIN Vision

Engaged Communities. Healthy Communities.

The vision is testimony to the enduring hopes of residents and health care providers to improve health in all communities through an integrated health care delivery system focused on wellness, equitable and timely access to care, and the delivery of high quality outcomes.

Engaged Communities

- People are proactively managing their own health and wellness.
- People are involved in designing their health care system.
- People are participating in planning the coordinated delivery of their care.

Healthy Communities.

- People have timely and equitable access to care.
- Health care providers and their partners work together to improve the health and well-being of their communities.
- The health of the population has improved.

Central East LHIN Values

- Accountability
- Responsiveness
- Respect
- Integrity
- Innovation
- Equity

Transformational Leadership

The Central East LHIN Board will continue to lead the transformation of the health care system into a culture of interdependence.

Health Service Providers will:	The LHIN will:
• Actively participate in all collaborative service delivery, administrative and governance decision making opportunities. • Self-organize to solve problems. • Bring forward integration opportunities aligned with the IHSP.	• Demonstrate accountability and systems-thinking in all decision-making and leadership actions. • Reward innovation which is aligned with the IHSP. • Model fair, transparent, and honest interaction with one another and with HSPs.

Quality and Safety

The Central East LHIN Board defines health care as being person-centred, safe and of high-quality.

Health Service Providers will:	The LHIN will:
• Meet defined standards and targets for safety and quality of services. • Deliver high-quality and safe care informed by patient experience. • Demonstrate ongoing improvement in the quality and safety of services and care..	• Hold providers accountable for safety and quality of services in accordance with their Service Accountability Agreements. • Consider quality, safety and patient experience as criteria for evaluation and decision-making. • Ensure that actions or decisions positively impact the quality and safety of the health system.

Service and System Integration

The Central East LHIN Board will work with all partners to integrate the health care delivery system to better meet the current and future needs of patients, caregivers and communities.

Health Service Providers will:	The LHIN will:
• Align their service and strategic plans to the IHSP goals and objectives. • Participate in LHIN–facilitated integration activities and support implementation. • Pursue integration opportunities that provide the best system of care within available resources.	• Support the creation and implementation of provincial and LHIN strategic plans, such as the IHSP, that guide local decision making. • Engage stakeholders to identify integration opportunities to enhance the health care experience. • Openly review all proposed integrations that improve the system of care.

Fiscal Responsibility

Resource investments made by the Central East LHIN Board will put people and patients first..

Health Service Providers will:	The LHIN will:
• Use the best available evidence and proven best clinical practices to resource care. • Use funding to deliver sustainable services based on defined system standards and targets for safety and quality. • Develop short- and long-term resource investment plans that address risks to quality service and fiscal sustainability at the organizational and local health system levels.	• Prioritize high quality and high performance when allocating funding. • Invest in initiatives that lead to patient-centred care across the care continuum, greater • coordination of care, and quality outcomes. • Promote a population needs-based approach to system resource planning and management.

Setting our Central East LHIN

STRATEGIC AIMS

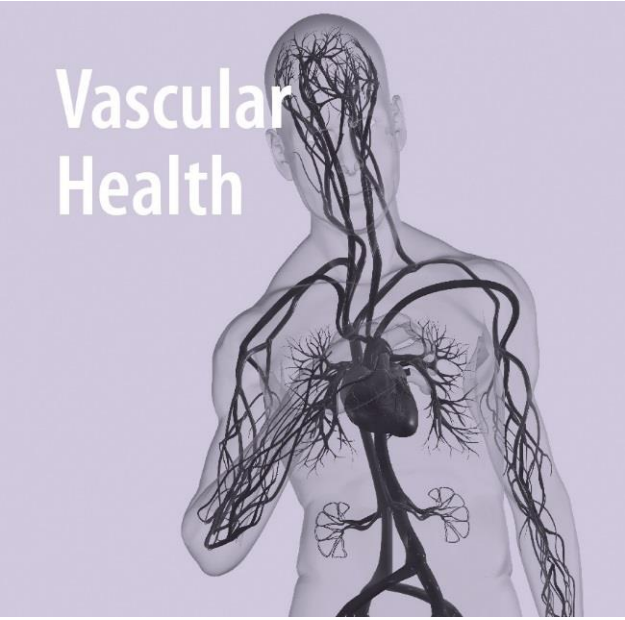
IHSP 4 Strategic Aims

Strategic Aims serve two purposes:

- Focus on reducing the need for hospital care (defined by emergency department visits and inpatient days including ALC days) for:
  - frail older adults, people with mental health or addiction needs, palliative patients and those with vascular health conditions
- Provide direction for Health Link community health service providers to achieve a related MLAA or key supporting indicator that coincide with each Aim

Continue to support frail older adults to live healthier at home by spending 20,000 fewer days in hospital and reducing Alternate Level of Care days for people age 75+ by 20% by 2019.

- The Central East LHIN population for **residents over the age of 65 increased by 17%** from 2010 to 2015.
- The Central East LHIN population for **residents over the age of 75 increased by 12%** from 2010 to 2015
- Central East LHIN has the **3rd highest demand for long term care.**
- Central East LHIN demand (118/1000 pop. 75+) is **higher than the provincial average** (102.4/1000 pop. 75+)



Continue to improve the vascular health of people to live healthier at home by spending 6,000 fewer days in hospital and reducing hospital readmissions for vascular conditions by 11% by 2019.

- 51.4% of Central East LHIN residents are **overweight or obese**
- In 2014, **48% of Central East LHIN residents reported being physically inactive**
- 65% of LHIN residents **do not consume enough fruits and vegetables**
- The prevalence rate for Central East LHIN residents who have **at least one chronic condition is 40.1%**
- This value is above the provincial average of 37.3% and **has been increasing since 2009-2010**

Continue to support people to achieve an optimal level of mental health and live healthier at home by spending 15,000 fewer days in hospital and reducing repeat unscheduled emergency department visits for reasons of mental health or addictions by 13% by 2019.

- Central East LHIN has the **2nd highest number of active mental health cases**
- Support within housing for community mental health services had the **longest median wait times** compared to other wait times for services in the Central East LHIN
- **Active mental health cases increased 6.8%** since fiscal year 2010, slightly higher than the provincial increase of 4.9%

Continue to support palliative patients to die at home by choice and spend 15,000 fewer days in hospital by increasing the number of people discharged home with support by 17% by 2019.

- The Central East LHIN ranks 12th amongst the 14 LHINs **for patients discharged home with support for palliative care** – (3rd from the bottom)

Identifying our Central East LHIN

DIRECT CARE PRIORITIES

Direct Care Priorities

Direct Care Priorities have been introduced in IHSP 4 as elements critical to achieving the Strategic Aims and advancing integrated systems of care:

- Health Links & Primary Health Care;
- Patient and Family Caregivers;
- Home and Community Care;
- Supported Living Environments;
- Health Equity – Diversity and Building Cultural Competency; and
- Child and Family.

Health Links and Primary Health Care

- Collaboration between primary care providers and broader system partners will support transformation toward a more seamless system for patients and families.

- Supporting primary care providers to be engaged in system design within a Health Link is a critical step to advancing integrated systems of care, and putting patients first to increase their ability to *live healthier at home.*

- Strengthening access, performance and accountability of primary care is a provincial commitment; the Central East LHIN will work together with primary care providers and their system partners to achieve this commitment.

Patient and Family Caregivers

Only 40% of service providers in the *IHSP* 4 - *Survey* agreed that patients and caregivers were working 'hand in hand' with their care team.

- Caregivers are usually family members, significant others or friends, who provide ongoing care and assistance (without pay), to those in need of support due to physical, cognitive, mental health or addiction conditions across the continuum of care.
- Caregivers provide the majority of the care needed by individuals and are part of the health provider "team". They need to be acknowledged and consulted at each stage of the care process.

Patient and Family Caregivers (cont'd)

- Patients and family caregiver input, when combined with the perspectives of health service providers, portrays a more accurate picture of the quality of healthcare services.

- Broader engagement of patients and caregivers including the most vulnerable will be emphasized in next three years.

- Recognizing the value of listening to the voice of patients and their family caregivers and taking action on the lived experience of patients and their caregivers has resulted in the establishment of new programs, improvements to existing services and when warranted, the re-design or closure of services – this will continue and broaden.

Home and Community Care

- In response to the *Bringing Care Home report (Donner, 2015) the* MoHLTC released *Patients First: A Roadmap to Strengthen Home and Community Care. The Roadmap* identifies 10 steps for provincial action toward higher quality, more consistent and better integrated home and community care, namely:

1. Develop a statement of values with a focus on patient- and caregiver-centred care
2. Create a Levels of Care Framework
3. Increase funding for home and community care
4. Move forward with Integrated Funding Models (Bundled Care)
5. Offer self-directed care to give patients more control
6. Expand caregiver supports
7. Enhance support for Personal Support Workers
8. Increase nursing services for patients with complex needs
9. Provide greater choice for palliative care
10. Develop a capacity plan

Home and Community Care (cont'd)

IHSP 4 implementation will directly advance many elements of the Roadmap:

- **Patient and Caregiver** engagement will be core to implementation of all Strategic Aims and Health Links - a Framework to guide engagement has been developed.
  - Patients and Caregiver direct involvement in care planning will increase supported by the identification of patient goals and care plans that advance these goals. Understanding the capacity of patients and families to self-direct their care will be part of the Coordinated Care Planning process.
- **Create a Levels of Care Framework** – Central East LHIN is a provincial early adopter for the enhanced Personal Support Service (PSS) model for Community Support Service agencies. This project continues to advance the objectives of the Community Health Services Integration process (CHS) which include standardized, equitable access to home and community services across the LHIN
- **Integrated Funding Models** (Bundled Care) – while no projects in our LHIN were selected as provincial pilots the LHIN will continue through the development of integrated systems at HL and cluster level to explore further opportunities for integration.

Home and Community Care (cont'd)

- **Investments in home and community care** will continue to be proposed that are aligned with the Strategic Aims and focused on the need for services and supports for a patients with complex needs
- **Provide greater choice for palliative care** – Palliative Care remains a Strategic Aim and priority within Central East LHIN
- **Develop a capacity plan** – The capacity to meet the population needs at the HL community level will be a focus for the next three years. This will include service and health human resource availability including access to primary care.

Supported Living Environments

Housing is a key contributor to achieving the Central East LHIN vision, mission and performance goals.

- Limited access to stable housing and health or social service supports within housing impacts the ability of patients to be discharged from hospital, can lead to unnecessary dependence on hospital emergency departments and premature or unnecessary placement in LTC homes.

Recognizing the need and opportunity of improved collaboration between Ontario's housing and health systems, the Central East LHIN and the five Municipal Service Managers have established a Housing and Homelessness Framework.

- The Framework provides a predictable, stable approach for LHIN-Municipal strategic and service level planning, with a shared strategic aim to advance the common objective of improved access to high-quality, timely, stable, affordable, appropriate, long-term housing options.

Health Equity – Diversity & Building Cultural Competency

In achieving each Strategic Aim, the Central East LHIN, is committed to health equity and a social determinants of health focus in LHIN planning and decision making. Health equity is achieved through:

- Recognition of diversity and development of cultural competency for all populations;
- Providing an “equal opportunity” for good health for all by:
- Increasing access to health care for vulnerable and marginalized populations; and,
- Mitigating impacts due to inequitable access to healthcare services, social and economic environment, unhealthy living conditions and language barriers; and,
- Developing and monitoring Health Equity data.

Child and Family

- Addressing the health needs of mothers, newborns, children, youth and their families is a key focus of the current delivery of services across the Central East LHIN as their well-being determines the health of the next generation and can help predict future health challenges for families, communities and the healthcare system.
- *Living healthier at home* and advancing integrated systems of care for child and family will enable consistent, standardized care for complex neonatal, and paediatric patients and their families with appropriate, timely access to quality clinical services.
- This requires the Central East LHIN, its HSPs and broader system partners to take action on the needs of the child and their family through involvement in the implementation of initiatives such as the provincial Special Needs Strategy.

Identifying our Central East LHIN

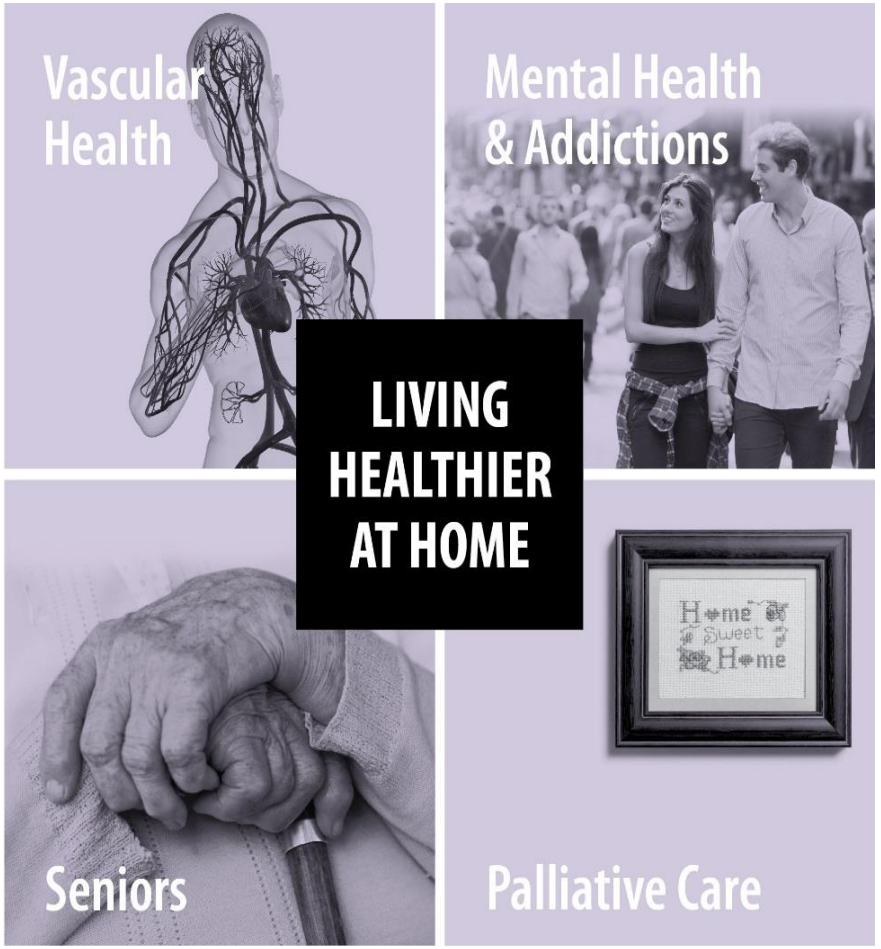
HEALTH SYSTEM ENABLERS

Health System Enablers

The enablers promote the advancement of integrated systems of care and apply consistently across all four Strategic Aims

- **Pursuing Quality and Safety through Access and Transition** – ensuring seamless and integrated care across the system through planning, implementing and evaluating.
- **System Design and Integration** – founded on system-based quality improvement principles and the patient's experience.
- **Enabling Technologies and Integration (Electronic Health Information Management) –** enabling new technologies to support opportunities for provider collaboration, communication, coordination and the resourcing of front-line service.
- **Health System Funding Reform** – working with HSPs to ensure care pathways are standardized, based on best practices and funding is appropriately allocated, to maximize patient benefit and efficacy of the Central East LHIN healthcare system.

Putting Patients First



Thank you.