Hamilton Niagara Haldimand Brant LHIN

HNHB LHIN Clinical Services Plan

Final Report from the
Clinical Services Plan Steering Committee
to the
Hamilton Niagara Haldimand Brant Local Health Integration Network
Board of Directors

November 23, 2009

Ontario
Local Health Integration Network

HNHB LHIN Mission and Vision

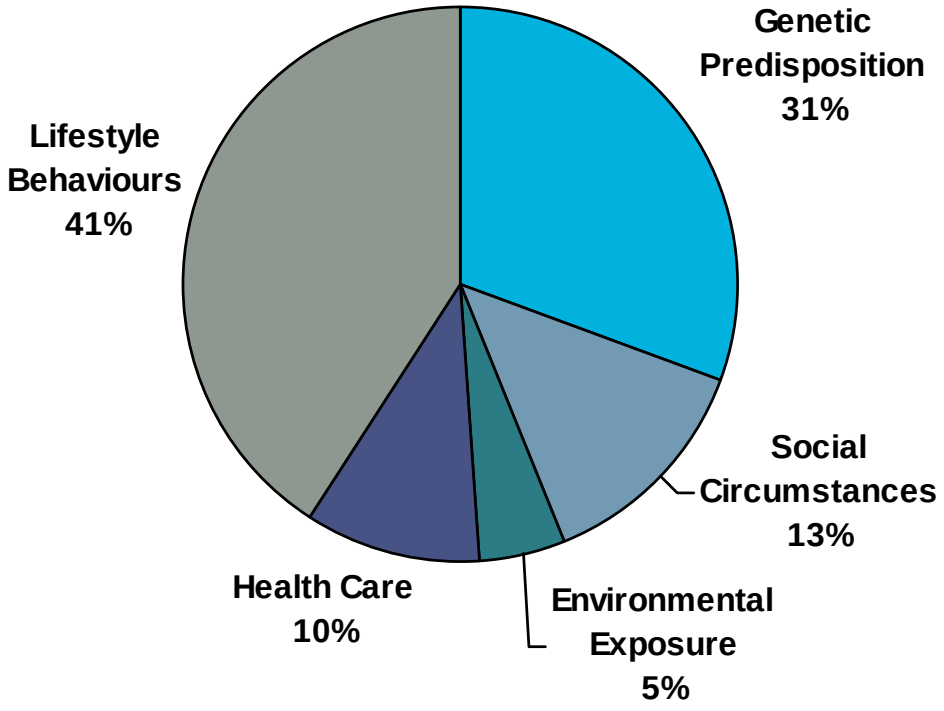
- Mission:
  - We work to ensure availability of, and access to, linked services in order to improve the health of the population and the continuity of health care.
- Vision:
  - A health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.

Keeping People Healthy…

- Higher than provincial rates of preventable conditions
- Need for an increased focus on the areas of health promotion, health screening, and disease prevention
- People want:
  - to be involved in decisions about their care
  - to learn how to live healthy lives
  - providers to respect their values, culture, language and beliefs

Keeping People Healthy…

What contributes to individual health and longevity?



Source: New England Journal of Medicine, Vol. 357, No. 12, S. Schroeder (From McGinnis et al).

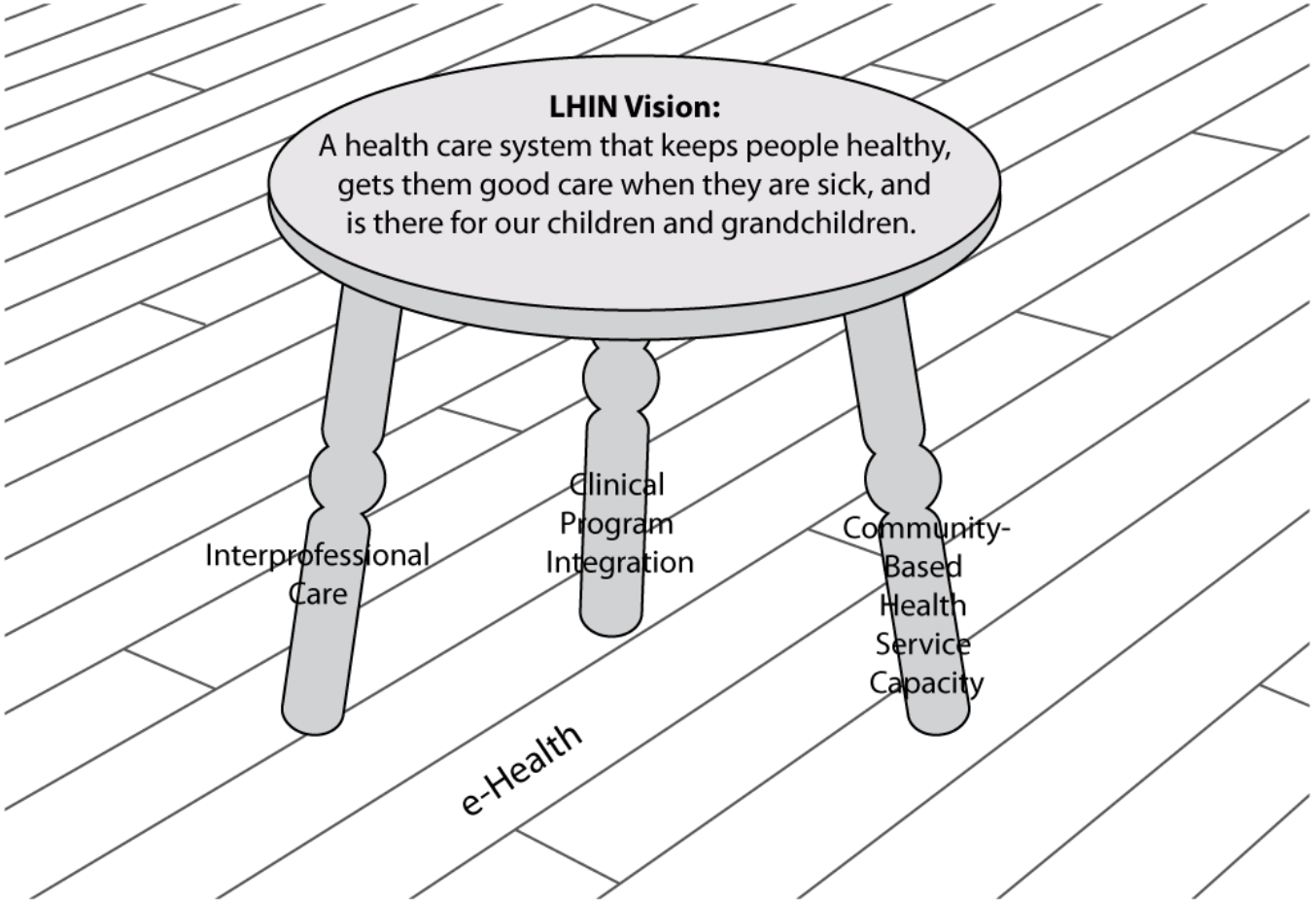
Getting Them Good Care…

- Variation in health outcomes and best practice
- People want:
  - Care close to home
  - A family doctor and timely access to care
  - To have to tell their health story only once
  - Services and supports that are easy to find
  - Access to publicly funded alternative health care, and, above all
  - Good health outcomes

Sustainability into the Future…

- Current challenges:
  - Aging workforce
  - Population growth and aging driving utilization
  - Expensive asset renewal
  - Decreasing availability of funds
- People expect:
  - Timely access to health practitioners and services
  - Accountability for local health system decisions
  - Accountability for public expenditures

Key Themes


LHIN Vision:
A health care system that keeps people healthy, gets them good care when they are sick, and is there for our children and grandchildren.
Interprofessional Care
Clinical Program Integration
Community-Based Health Service Capacity
e-Health

Inter-Professional Care

- Health providers working collaboratively to provide comprehensive, quality health services within and across settings
- Interprofessional care is the concept behind a broader ‘team’ of health professionals and services
  - ‘Team’ may be co-located, or may be virtual, connected electronically
- All members of ‘team’ work to full scope of practice or expertise
  - Better outcomes
  - Improved work satisfaction
  - Support primary care

Clinical Program Integration

- Coordinated, LHIN-wide programs
  - Clear roles, responsibilities and accountabilities
  - Best practice and common standards
  - Elimination of duplication
- Equitable access to a coordinated system of evidence-based services across the continuum
- Multi-year, phased implementation
  - LHIN-wide ‘charter’
  - Implementation plans
  - Formal agreements

Community-Based Service Capacity

- Community-based services:
  - Support independent living
  - Prevent hospitalization
  - Sustain early detection and intervention
- We need:
  - Services linked with primary care
  - Standardized tools, protocols, and a culture of Continuous quality improvement
  - Knowledge of services
  - Linkages across the continuum
  - Demand modeling tools

E-Health

- Key developments:
  - ClinicalConnect provider portal
  - Diagnostic Imaging Repository
  - Integrated Decision Support
- Benefits:
  - Reduction in repeat diagnostic tests
  - Reduction in medical errors
  - Improved patient safety and outcomes
  - Patient, physician and staff time savings
  - Improved workflows with less manual processing
  - Reduced phone calls to get patient results

Priorities for Action and Early Starts

Year 1: 2010-11

Implementation of interprofessional model of care:

- Implement and evaluate a 'virtual' interprofessional care model
- Develop interprofessional care toolkit to support interprofessional care model dissemination in the LHIN
- Maximize health professionals' scope of practice.

Implementation of clinical program integration:

- LHIN-wide charter for clinical program integration endorsed by hospital leadership
- Realignment of the following program areas across the continuum of care:
  - complex continuing care and rehabilitation
  - cancer care
  - hepatobiliary
  - vascular and thoracic
  - maternal/newborn.
- development of a functional plan for a LHIN-wide integrated laboratory medicine program, to support clinical program integration - for capital approval
- establish LHIN-wide hospital common credentialing to support clinical program integration for physicians, dentists, midwives, and nurses.

Priorities for Action and Early Starts

Year 1: 2010-11

Realignment of community-based health service capacity:

- Establish peritoneal dialysis units in three long-term care homes
- Enhance organizational capacity in the community sector through process improvements (e.g. pilot common tools and processes to link clients/patients to appropriate community-based services)
- Implement 'demand modeling tool' to identify service gaps in community sector
- Implement strategies and fund initiatives (e.g. through Aging at Home) to address service gaps in community sector
- Expansion of diabetes education centres
- Expansion of foot care services for high risk diabetics – starting in Niagara and
- Implement falls prevention strategies across the LHIN
- Implement common client eligibility criteria for LHIN-funded transportation programs.

Implementation of e-Health activities:

- Implementation of regional Diagnostic Imaging Repository (DI-r) at St. Joseph's Healthcare Hamilton, Hamilton Health Sciences Corporation, West Lincoln Memorial Hospital, Niagara Health System
- Expand access to ClinicalConnect to all hospitals and CCAC to enable health care providers to obtain patient/client health information, diagnostic imaging and medical/lab test results in 'real' time
- Implement CCAC 'resource matching' tool to connect clients to services.

Priorities for Action and Early Starts

Year 2: 2011-12

Implementation of interprofessional model of care:

- Expand interprofessional care models into a minimum of two additional communities
- Formalize linkages with academic sector to support ongoing performance measurement, evaluation and quality improvement processes
- Establish a process and implement two best practice or quality projects LHIN-wide every year

Implementation of clinical program integration:

- Realignment of the following program areas across the continuum of care:
  - Diabetes
  - Chronic Kidney Disease
  - Mental Health and Addictions
  - Cardiac
  - Emergency/Trauma
  - Pediatrics

Priorities for Action and Early Starts

Year 2: 2011-12

Implementation of community-based health service capacity:

- Ongoing 'demand modeling' for continuous improvement
- Ongoing implementation of strategies and funding of initiatives (e.g. through Aging at Home) to address service gaps in community sector
- LHIN-wide application of common tools and processes to link clients/patients to appropriate community based services.

Implementation of e-Health activities:

- Connect remaining LHIN hospitals to DI-r

Priorities for Action and Early Starts

Years 3+: 2012 and beyond

Implementation of interprofessional model of care:

- Expand interprofessional care models LHIN-wide
- Establish screening/health promotion targets LHIN-wide.

Implementation of clinical program integration:

- Realignment of the following program areas across the continuum of care:
  - Respiratory
  - Ear, Nose, and Throat
  - Gastroenterology
  - Chronic Pain
  - Ophthalmology
  - Orthopedics
  - Urology
  - Specialized Geriatrics
  - Neurosciences

Priorities for Action and Early Starts

Years 3+: 2012 and beyond

Implementation of community-based health service capacity:

- Continue to address gaps in community capacity based on estimates of unmet need for services.

Implementation of e-Health activities :

- HNHB LHIN health service providers fully connected electronically
- Establish patient portals to provide access to health care information and support self-management of chronic health conditions.

Thank You!