Clinical Services Plan - Speaking Notes
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1. Introduction

- Pleased to present final report - culmination of 9 months of work by Steering Committee and staff, with assistance from Deloitte – and a great deal of input from Planning Advisory Groups, Reference Groups, and open houses, etc
- Board ....you will recall a two-day session in summer of 2008, where together - you and the hospitals - talked about strategic plans, capital requirements and money pressures. And I recall that you took a very deep breath when you saw the magnitude of the total picture…
- In addition, we have an aging population, high illness burden, requirements for new technology, and finite resources..... You commissioned a plan that would guide decision making for safe, effective and quality health services
- The Clinical Services Plan is a roadmap for change and a call for action – it signals that change is coming and that tough decisions will be made. It outlines what needs to be different in 3 key theme areas – interprofessional care, clinical program integration, and community based service capacity – and highlights the importance of e-health as a common enabler
- As a vision oriented document, it is not prescriptive – it does not dictate how things are to be accomplished, or what the future configuration of services should be
- Rather, it allows the LHIN to play its role in directing, or commissioning providers to move forward with implementation, facilitating where necessary, and ensuring accountability for results. Much of the work of implementation will be in the hands of providers, but shaped by the LHIN to meet the specifications outlined in this plan.
- As such, you will not see a lot of data presented in this report – data was one of many inputs used to guide Steering Committee discussions and inform opinion – but rest assured that the data is all available in the supporting documents to the report (see the 4” binder!)

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- This data, and indeed all of the background material including the PAG submissions and recommendations, will be made available as support material for implementation – that's when the data gets 'put on the table' so to speak
- Two final comments of context from the Steering Committee, before we get into the specifics
  - The three themes are interdependent. Along with the key enabler of e-health, progress must be made on each front in order to gain the synergistic effect of transformational change
  - The St Committee strongly believes that the real value in this plan will be found in building capacity in the community and in supporting primary care through interprofessional care. That is not to say that clinical program integration is not important – it is. But, the Steering Committee believes that, in this LHIN, we have a lot to build on, and can make clinical program integration happen quickly through joint accountability mechanisms, such as MoUs, and by leveraging our local successes in e-health
- The report summarizes the process and inputs – including the PAG process involving over 200 clinical and administrative leaders – but I won't spend time on that
- I will highlight, however, some of the key findings from what we learned and what we heard, organized into 3 categories consistent with the LHIN 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"

2. Findings

Keeping people healthy:

- An analysis of health service utilization and key determinants of health for LHIN residents reveals that LHIN residents have higher than provincial rates of preventable conditions related to lifestyle behaviours (e.g. diabetes, heart disease, respiratory disease, and stroke). These conditions are putting pressure on the health care system (e.g. visiting the emergency room with conditions that are preventable, could be self-managed, or supported by a primary care provider).
- Planning Advisory Groups and residents consistently brought forward the need for an increased focus on the areas of health promotion, health screening, and disease prevention (e.g. better coordination and increased uptake of best practices/screening protocols).
- People want to be involved in decisions about their care; they want to learn how to live healthy lives; and they want providers to respect their values, culture, language and beliefs
- The health system is not solely responsible for keeping people healthy. We need a greater focus on health promotion, disease prevention, and screening. People need to be welcomed as part of the care team and be an active partner in decision-making about their care. We need better coordination and collaboration among primary care providers, public health, community-based health services and the broader municipal human services sector.

Getting them good care when they need it:

- There is variation in health outcomes across the LHIN as reflected in higher than provincial rates of hospitalization and death. Access to quality health services and use of best practice guidelines also vary across the LHIN.
- 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
- Right now, there is variation in health outcomes across our LHIN. Inequitable access to health services and variation in the application of best practice guidelines contribute to these outcomes. Hospitals have, in many cases, become the default health system treating people with preventable health conditions, and for whom other supports and self-care could have prevented serious illness.
- A more coordinated and standardized approach to care is needed, with providers accountable for outcomes. A uniform mechanism for clarifying roles, responsibilities and accountabilities, such as a MOU, is needed…and…
- It is critical that an electronic connectivity system be implemented as soon as possible.

Being sustainable into the future:

- The health care system, including our local health system, is challenged on a number of fronts:
    - The health care workforce in our LHIN is aging, with high percentages of doctors and nurses reaching retirement age
    - The acute care hospitalization rate for residents of our LHIN is significantly higher than the provincial rate. As the population grows and ages, the demand for hospital services will grow by approximately 30% over the next 10-15 years, if current patterns of health care use remain the same
    - Hospitals are expensive care settings. Buildings, equipment and diagnostics are expensive to sustain and renew, and multi-site equipment purchases are very costly.
    - At the same time, provincial revenues are falling, likely resulting in a decreased amount of money available to fund health care, for the foreseeable future
- People expect:
    - Timely access to health practitioners and services
    - Accountability for decisions about the local health system
    - Accountability for public expenditures
- Changes in the way services are delivered and utilized must occur. The focus of care must be shifted from the hospital, where appropriate. It is imperative that we re-organize the current configuration of clinical programs, and redistribute resources to realize decreased hospitalization rates and lengths of stay. Funding is contingent upon accountability for improved health outcomes, and tough decisions will need to be made.

3. Themes

- Our plan advocates three foundational themes, along with e-health as a key enabler, for health system improvement:
  - interprofessional care
  - clinical program integration
  - community-based health service capacity
- These themes are interdependent and will support achievement of the LHIN Vision like a three-legged stool, with each leg of the stool providing an essential support to the structure, built on a solid foundation of e-health connectivity
- In each case, the plan provides for specific actions which the LHIN Board can deliberate, and take action as appropriate.

Interprofessional Care:

- “The provision of comprehensive health services to individuals by multiple health caregivers who work collaboratively to deliver quality care within and across settings” (MOHLTC)
- In Ontario, interprofessional care is building on the experience of Community Health Centres and Family Health Teams. Interprofessional teams link services and people including family physicians and specialists, nurses, nurse practitioners, dieticians, therapists, social workers, pharmacists, and others
- Members of the “interprofessional team” might be co-located in one place, or function as a virtual team in multiple sites, connected electronically. Virtual interprofessional teams, enabled by videoconferencing and other e-Health strategies, will be necessary because of the HNHB LHIN’s large geographic area and required linkages with a variety of health care providers.

- The interprofessional model of care will enable all health professionals to work to their full scope of practice allowing providers to focus on care within their realm of expertise. This will optimize workplace satisfaction for primary care providers, and assist with recruitment of new primary care providers.
- Improved collaboration and teamwork through interprofessional care will assist primary care providers in managing increasing workloads, reduce wait times, facilitate access to specialized services, and improve the quality of care they provide.
- Building on existing models, the HNHB LHIN will implement and evaluate a virtual interprofessional care team pilot. The pilot will help identify success factors for interprofessional care, and demonstrate its value-added contribution to comprehensive primary care. An interprofessional care best practice toolkit will be developed to support expansion of virtual interprofessional care across the LHIN, including scope of practice for health professionals. Dissemination and uptake of best practice is foundational to interprofessional care and LHIN-wide projects will be established and implemented.

Clinical Program Integration

- Clinical program integration is linking services, currently provided in different organizations and settings, on a program basis (e.g. cardiac care, maternity, rehabilitation) so that all aspects of care delivery for that program are connected and coordinated across organizations.
- Clinical program integration will result in coordinated, LHIN-wide programs, led by one or more organizations in partnership, and reflect an agreed upon set of attributes:
    - clear roles, responsibilities and accountabilities

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  - a commitment to best practice and the implementation of clinical standards and guidelines
  - common admission, discharge, and referral guidelines
  - elimination of unnecessary duplication, of low volume, high-complexity services
  - LHIN-wide population-based planning, evaluation and performance monitoring.
- Each LHIN-wide clinical program will have, as its goal, equitable access to a coordinated system of evidence-based services across the continuum of care.
- To achieve this, strong clinical leadership, mechanisms that support shared accountability and partnerships, and an enhanced communications infrastructure will be needed
- This means that all residents of the LHIN, regardless of whether they live in a rural or urban community will have equitable access to services, in a way that best meets population need, and optimizes use of available resources.
- The development of common clinical leadership teams, with clear referral patterns and repatriation agreements, will reduce wait times and improve consistent access across our region. It will be much easier for the residents of the HNHB LHIN to navigate through our health system. It will be an expectation that all health providers will use best practice guidelines and clinical standards when providing care.
- As individual organizations realign services to meet budget constraints, clinical program integration will provide mechanisms for organizations to work with their partners to integrate or transfer services more appropriately delivered in the community
- Implementing clinical program integration will be a multi-year, phased undertaking in partnership with leadership from across the HNHB LHIN

- A "LHIN-wide charter" will reflect organizational commitment to a shared change agenda for clinical program integration
- Implementation plans for clinical program integration will optimize access, quality and efficiency across the continuum of care. Components of the implementation plan will include:
  - recommended sizing and siting of programs and services
  - mechanisms, structures and elements needed to foster shared accountability across the continuum of care (e.g. MOUs)
  - implementation of appropriate best practice guidelines (assisted by our academic partners)
  - identification of key enablers to implementation (e.g. standardized processes, information/communication technology)
  - resource requirements, both human and infrastructure to support implementation.

Community-Based Service Capacity

- This theme is about strengthening the base of health services provided in the community
- Community-based health services
  - support independent living (e.g. supportive housing, food, transportation, congregate programs)
  - prevent hospitalization (e.g. falls prevention, palliative care, alternative medicine, and ambulatory services)
  - sustain early detection and intervention initiatives (e.g. case finding programs, wellness programs, diabetes education, foot care for people with diabetes)

- We need:
  - community services that are linked with primary care to provide a comprehensive basket of care and support close to home
  - standardized tools, protocols, and a culture of continuous quality improvement (e.g. consistent eligibility, assessment and referral criteria, and outcome-based performance benchmarks)
  - Clarity regarding the services available and how to connect to these services
  - Linkages across the care continuum that will facilitate a more coordinated approach to care delivery and seamless transitions across care settings.
- Demand modeling tools will identify gaps in service and required supports (e.g. supports in the home, transportation)
- Improved client matching processes will link people with the right care in the right place.
- Required enablers include:
  - adoption of common assessment, referral and performance metrics
  - readily available client/patient information for timely and appropriate care planning
  - infrastructure investment for integrated communication technology (e-Health)
  - linkages with public health (promotion, prevention, screening), and municipalities (housing, social services).

E-health

- e-Health is a critical success factor for implementation of these 3 themes. The LHIN, in partnership with HNHB providers, is well under way in the following three areas:
  - The **"ClinicalConnect"** provider portal, allows appropriate providers anywhere, anytime, web-based, real time access to hospital and CCAC patient clinical information (with all the appropriate security, privacy and audits)
  - Diagnostic Images from LHIN hospitals are being stored in a central **Diagnostic Imaging Repository**. Again, appropriate health care providers can access their patient's images, in their own office, via the ClinicalConnect portal
  - The **Integrated Decision Support System** will allow organizations and clinicians to make evidence based planning and operational decisions using data that is less than 3 months old (as opposed to 18months currently)
- Benefits already being realized include:
  - 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

4. Priorities for Action and Early Starts

- The Clinical Services Plan is a roadmap for change and a call for action – it signals that change is coming and that tough decisions will be made. It outlines what needs to be different in each of the key theme areas, and proposes specific priorities for action and early starts over the next three-plus years, based on the Decision Making Framework Readiness Screen.
- Need for flexibility – adapt to changing environment

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

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- establish LHIN-wide hospital common credentialing to support clinical program integration for physicians, dentists, midwives, and nurses.

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 Hamilton
- 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 within HNHB LHIN 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.

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

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

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Year 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

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

5. Conclusion

- I understand we'll have opportunity to dialogue tomorrow – address questions etc
- At that point it will be 'over to you' LHIN!
- This plan provides us in this LHIN with a glimpse of a 'new future', based on new collaborations – be that between professionals through IPC, within and across sectors in health care (eg hospital-community) or with the broader health and human services sectors through municipalities – enabled by new communications and the use of information, through e-health
- As a final comment, the St Committee would like to stress the need for evaluation and ongoing performance monitoring – a report card that will show us all where we are at in implementing this 'new future' and what difference its making.