Hamilton Niagara Haldimand Brant **LHIN**

Strategic Health System Plan

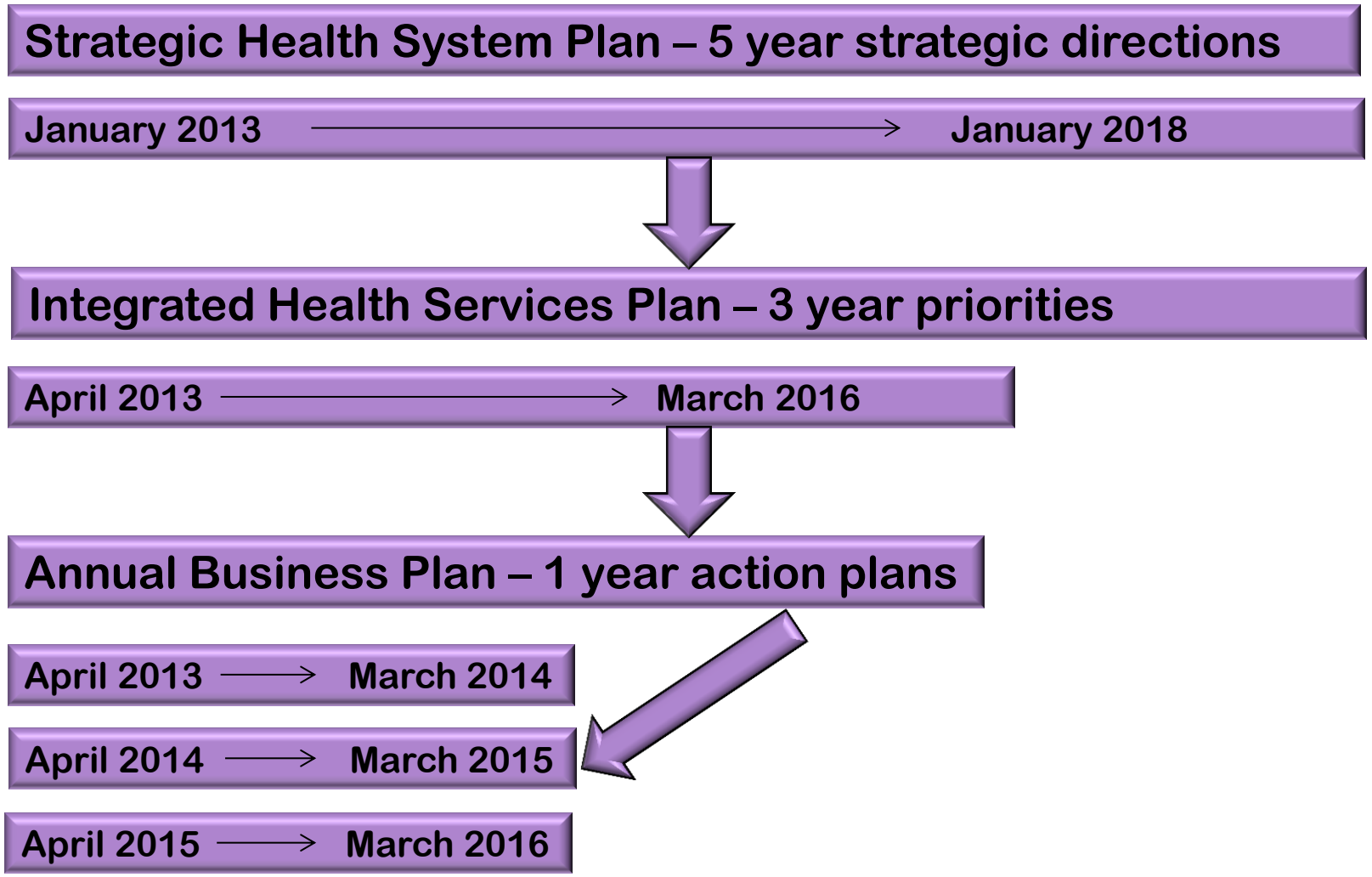
2014-15 Year End Update

Presentation to:
HNHB LHIN Governance Working Group

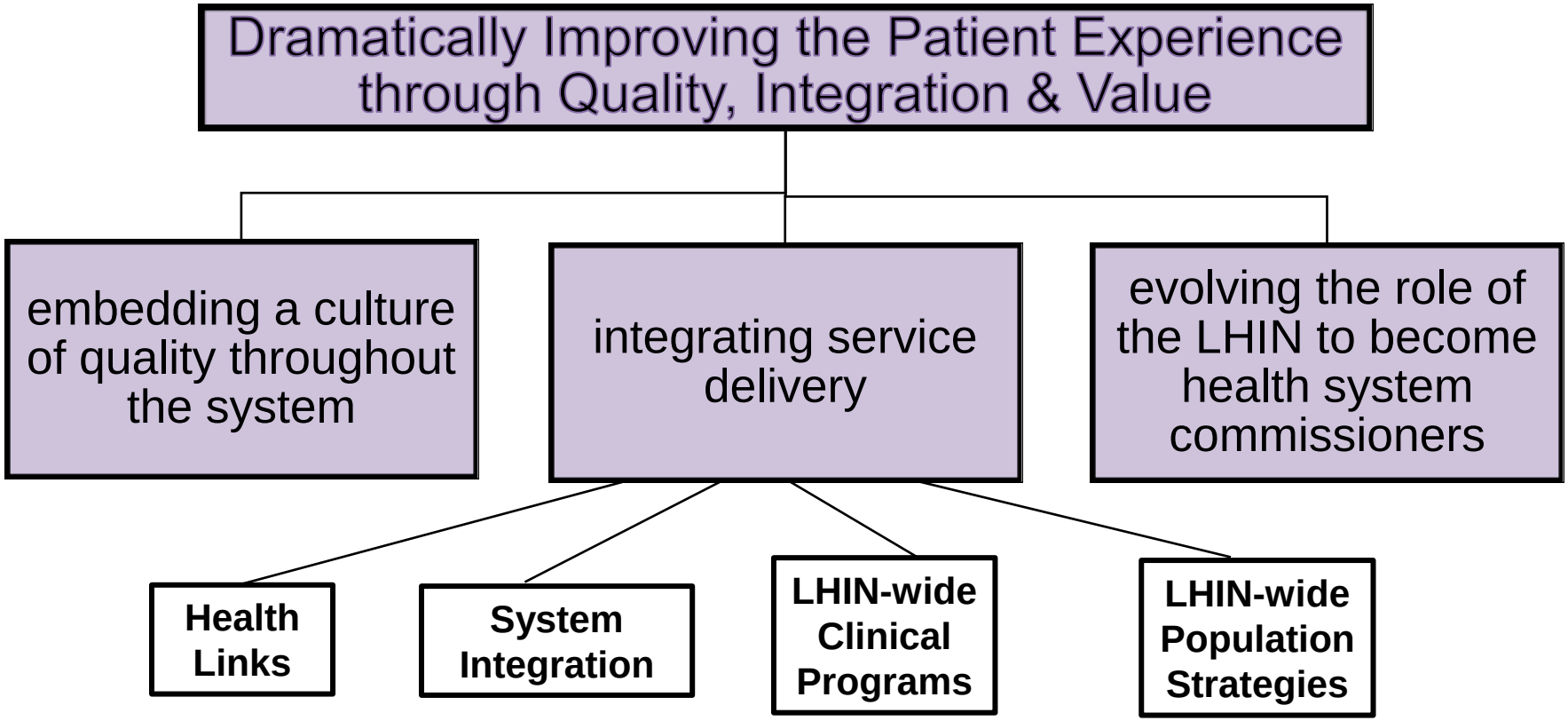
March 18, 2015

Ontario
Local Health Integration Network

Strategic Directions



HNHB LHIN SHSP (Approved December 2012)



2014-15 Deliverables

SHSP Strategic Directions	Goals	Status
1. Dramatically improve the patient experience by embedding a culture of quality throughout the system	1.1. Quality Guidance Council will continue to advise the LHIN on the spread of quality in the LHIN	
	1.2. Health Service Providers (HSP)s will receive feedback from the LHIN on the quality plans in an effort to continually improve	
	1.3. There will be an investment in the leadership within the LHIN (both LHIN staff and HSP's) in an effort to drive change management and capacity planning	
2. Dramatically improve the patient experience by integrating service delivery	2.1. Care for patients will continue to improve through the continued spread, development and evolution of health links	
	2.2. Care for patients will continue to improve through continued spread, development and evaluation of LHIN wide clinical programs, with a common way to implement hospital based LHIN-wide programs	
	2.3. Care for patients will continue to improve through supporting the health care needs and/or optimizing the health status (wellness) of 'specific populations" by providing a coordinated and integrated approach to service delivery.	
	2.4 There will be a framework for social determinants of health, leading to population health.	

2014-15 Deliverables

SHSP Strategic Directions	Goals	Status
3. Dramatically improving the patient experience by evolving the LHIN to become health system commissioners	3.1. There will be a Strategic Execution Framework in place to advance the integration of business planning methodologies and evidence based decision making of a high performing organization	
	3.2. Implementation of ministry defined 'Specialty Clinics' will ensure that services provided reflect population need; incorporate appropriate quality outcomes; integrate with LHIN-wide programs; and reflect value for money	
	3.3. Ensure that programs and services planned through major capital projects best meet population need and are integrated with LHIN-wide programs (e.g. Niagara Health System new South Niagara hospital; West Lincoln site redevelopment)	
	3.4. Enterprise risk management framework will continue to be expanded to move the LHIN further towards a commissioning model	
	3.5. Further spread of the concept of LHIN commissioning within the LHIN office	
	3.6. Health system funding reform will continue to evolve in alignment with the Ministry of Health and Long-Term Care	
	3.7. Administrative costs within the health sector will continually be reduced	

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Dramatically Improving the Patient Experience:

some examples from 2014-15

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Health Links - Foundations

Coordinated and Integrated Care is the Heart of Health Links

- Health Links launched December 2012
- New model of care to improve care for high needs patients
- All providers working at the local level to integrate clinical care and coordinate plans at the patient level
- Initial focus on people with complex health conditions

Health Links

Goals:

- Enhance patient experience
- Improve the delivery and coordination of care for people who have complex conditions

Patient Stories

- *80 year old with multiple chronic conditions (>5) including end stage Parkinson; history of falls and requiring assistance with activities of daily living; walker and wheelchair; lives with family and receives PSW care twice daily*
- *Having recurring emergency visits and hospitalization*

Patient's goal was to be able to communicate with his family and be as independent as possible:

- *Assistance with referrals and follow up on a number of medical issues*
- *Referral to Technology Access Clinic and Voice Clinic*

Health Links Patient Stories cont'd

- *65 year old with multiple chronic conditions (>5); lives alone; limited income; uses a scooter; and home oxygen; receives home care 3 times per week*
- *He is experiencing recurring emergency visits and hospitalization*

Patient's goal was to move somewhere in Hamilton where he could get some help. To make sure people would help him when he needed help:

- *Assistance with referrals and follow up on a number of medical issues including teaching/education; assistance from March of Dimes – repair broken scooter basket (to carry oxygen tank) and for transportation to medical appointments; Patient has accepted a bed at assisted living facility in Hamilton*

"Health links has made a difference in the lives of two of my very complicated patients. I was very impressed with the knowledge of the Health Links facilitator I met with. She provided me suggestions/resources for other patients too. The patients are very very grateful for the level of detail and follow-up and helping them navigate through the complexities that when you are sick sometimes you just don't have the time, energy or resources to do...e.g. getting devices, knowing about funding, knowing what services might help. It feels like I have help taking care of these very complicated patients."

Thank you, Dr. Meghan Davis

LHIN-wide Integrated Clinical Programs - Foundations

- Key concept: ‘one clinical program – multiple sites’
- Goal: improved clinical processes and outcome consistency
- All residents across the LHIN should have access to a coordinated program, with:
  - same approach to care delivery
  - same quality standards
- System management of system level indicators (MLPA)

Laboratory Medicine

Goals:

- To integrate all 9 Hospital corporations to form an Integrated Laboratory Medicine Program, and improve and standardize a focus on quality across all sites.
- Microbiology services have been centralized from Joseph Brant Hospital and Niagara Health System to the Hamilton Regional Laboratory Medicine Program.

In September 2014, at the Regional Microbiology Committee, Joseph Brant Hospital reported that recent turnaround time reviews show an improvement in urine testing from an average of 3-4 days to an average of 38 hours. Improvements result in patients receiving appropriate treatment more quickly.

"I just wanted to thank everyone who worked on moving our microbiological testing to the Regional Microbiology Service. From the front line, the service is now so much better, faster, and more reliable. We don't hear enough 'thank you's in our line of work, so I thought that this one needed to be mentioned. Please do pass it along to those who helped in the background."

June 2014, DR. Rafi Setrak, Chief of Emergency Department, St. Catharine's Site.

Total Joint Replacement – Hip & Knee

Goals:

- Improve timely access to specialist consultation and surgery for joint replacement
- Between April 1 – December 31, 2014 the percentage of patients **offered referral to "first available surgeon"** at the Regional Joint Assessment Program (RJAP) has **increased from 32% to 55%.**

"It was really good to be able to speak with people who understand my specific issues and have a clear explanation of why certain things were happening."

Response from Patient Satisfaction Survey, Regional Joint Assessment Program

"RJAP allows me, as an orthopaedic surgeon, to be more efficient in the triage and assessment of my patients than the traditional office visit, while enhancing patient access for initial consultation."

Dr. Anthony Adili, Chief of Surgery, St. Joseph's Health Hamilton,
Co-Lead HNHB LHIN Orthopaedic Steering Committee

Diagnostic Imaging

Goals:

- To improve timely access to appropriate, high quality MRI and CT services for patients across the HNHB LHIN through integrated planning, and referral redirection for appropriate patients.
- To increase awareness of Choosing Wisely Canada recommendations for Diagnostic Imaging to impact appropriateness of scans requested.

MRI and CT services have continued to demonstrate an increase in demand this year. To meet the needs of patients and physicians, health service providers have collaborated to improve the efficiency of MRI scans by completing more patient scans per hour, and working to improve standardization across sites.

*A total of **46,619 priority 4 MRI scans**, and **28,240 priority 4 CT scans** were completed in the first 3 quarters of this fiscal year. This was a total of **5,084 more MRIs** and **1,242 more CT scans** completed this year than in the same time period in the prior year.*

Diagnostic Imaging Chiefs and Orthopedic Surgeon Chiefs identified quality based plain film guidelines for assessment of osteoarthritis for hips and knees, as opposed to unnecessarily using MRI/CT, and provided physician education regarding recommendations for best use of MRI/CT in November 2014.

Ophthalmology

Goals:

- To develop a LHIN-Wide Vision plan to enhance the integrated planning and delivery of consistent, high quality eye care services across the HNHB LHIN.
- Median wait times for cataract surgery patients have decreased from 146 days in May 2014 to 118 days in January 2015, **a 28 day reduction in median wait time**.

A LHIN-Wide Vision steering committee has been developed to assist with the planning and implementation of the HNHB LHIN vision plan. A major focus has been on timely access and wait list management for cataract surgery.

Physicians and hospitals post individual surgeon wait time information on hospital websites to facilitate referrals to the surgeon with the first available appointment, and improve transparency for patients.

A cataract volume allocation model was developed and implemented to ensure care was delivered where the population most required it, and where surgical efficiency was evidenced, supporting patient access based on need and quality.

Collaboration to Build Sustainable Quality Services for LHIN Residents - Integrated Heart Investigation Unit

Goal:

Establish a heart investigation unit as an integrated one program 2 site model between Hamilton Health Sciences and Niagara Health System (NHS)

- Between April 2014 to January 2015 ;
- 1,250 cardiac catheterization procedures; and
- 312 percutaneous coronary interventions (PCI) completed at NHS

Many people enter the doors of the Integrated Heart Investigation Unit (HIU) with questions and concerns, and leave with answers and reassurance of their future. Ed is one such man.
When Ed came to the HIU, he had recently put his "bucket list" plans on hold. He had been feeling unwell; experiencing chest pain which was unusual for him. Ed is an avid cycler and would be considered to be physically fit. Ed's dream of biking through the rice fields of Vietnam had been put on hold; he knew this chest pain just wasn't right.

During his angiogram, it was discovered Ed did indeed have a serious problem which if left untreated would thwart any further bike riding plans he had. The team in the Heart Investigation Unit inserted stents into Ed's artery in his heart and opened the blockage.

He went home later that day ready to resume his plans and fulfill his dream.

Population Based Strategies - Foundations

Support the Health Care Needs of Specific Populations by providing ***Coordinated*** and ***Integrated*** approach to service delivery that will include:

- Equitable access to population based strategies
- Evidence based (Expert Recommendations) standardized models of care that will reduce variability
- Maximize opportunities to provide care in community setting
- Provide resource for primary care, hospitals and other health service providers
- Complement or coordinate with other initiatives
- Demonstrate common outcomes
- Provide effective and seamless care transitions

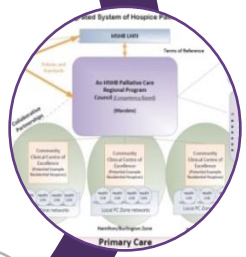
Population Based Strategies - Overview of Key Activities

Older Adults and Caregivers

Access to Hospital ED Services

Chronic Conditions

Population Based Strategies Promote **Coordinated and Integrated** Approach to Service Delivery



Palliative Care

French Language Services

Aboriginal Health

Note Chronic Conditions includes: Stroke, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Diabetes, Acquired Brain Injury and Developmental Disability

Older Adults and Caregivers

Goals:

- **Improve effective and timely transitions**
- Between April 1 – December 31, 2014 the BSO Long Term Care Mobile Team supported 491 residents transition to LTC

The BSO Team has been invaluable to the transitioning of residents from their home to ours and what a dramatic change this usually is – their support, care, and training makes a potentially frightening move into one that eases them into nursing home care. For residents where behaviours escalate, this team "thinks outside the box" to best resolve a challenge that puts the resident first, while keeping our care providers in mind – thank you team, it is a pleasure working with you!

Scott Kozachenko, Assistant Administrator,
Heritage Green Nursing Home (July 10, 2014)

Access to Hospital ED Services thorough Improved System Flow

Goal:

Expansion of wellness programs in congregate settings

- 76 beds established in congregate settings in Retirement Homes and Assisted Living programs.

- As of February - 221 admissions, 142 discharges

When Sara arrived at First Place she was very optimistic about going home, however her family and medical team felt she would be unable to cope in her own apartment. She had spent a number of months in the hospital and after having both legs amputated due Vascular Disease, she required assistance with daily tasks.

During her stay at First Place she gained strength from daily meals, gained independence with staff support by transferring herself to and from her own wheelchair and eventually she gained mobility by transporting herself to the dining room and events throughout First Place.

After two weeks it was decided that she could manage on her own and with the assistance of community supports she was able to move back into her apartment to live independently"

Expansion of Wellness Programs Impact of Innovative Approaches

Supporting clients move to a area that has the potential to improve their quality of life

B's story: B resided at AbleLiving, Binbrook since 1988. He was one of a group which of 36 and enjoyed the rhythm and routine of the large shared accommodation style of living. He engaged with his community and enjoyed riding horses, visiting the local libraries and shopping centres.
Over time his engagement in the community and his interests changed. He became more withdrawn and started at times acting out towards others including his housemates and the staff. He required an admission to intensive inpatient behaviour supports with local police involvement. There were many days he did not get dressed and instead chose to stay in pyjamas and declined attendant services.

In January 2015 space in a nearby townhouse unit with attendant services provided by AbleLiving became available for anyone interested in moving. B indicated his interest and he is now in his new home at Mistywood. He shares the two bedroom townhouse with another man who also moved from Binbrook and they are exploring their new neighbourhood.

Bill now approaches each new day with enthusiasm and is dressed and showered every day without hesitation. Bill taking on additional responsibilities in his home including shopping, meal preparation, laundry and cleaning. He has discovered the joy in planning and cooking his own meals and was so amazed watching his first pizza bake and rise that he couldn't take his eyes off the oven. It is an experience he didn't have before as the meals were prepared for him. He is becoming adept at navigating public transportation with staff assistance and has even left behind his wheelchair and headed to the bank. He has gone out to many places including the local plaza for nail care and errands. He has mastered the new Lifeline system which allows him to reach a staff person when needed. Friends come to visit and he is proud to invite them in and show them his new home.
When you ask him how things are going at his new home, the answer is always the *same*—

"I like it here, this is my new home and it was the right decision to move"

Complex & Chronic Conditions –Chronic Obstructive Pulmonary Disease (COPD)

Goal:

Establish three community COPD programs across the LHINs three Zones

- Four programs established across three Zones
- As of January 2015, 290 individuals enrolled (80 active and 210 graduated)
- Referrals from hospital (197), primary care (135) and other (121).

Caring for My COPD – What the clients told us

"Have had three exacerbations without going to hospital since starting this program".

"Went from 'worry' to 'relief'"

"I go out more in past three months vs last three years".

"It has really helped me, it has changed my life".

"I'm no longer scared to leave the house"

"Invisible condition – good to have help with advocacy"

Complex & Chronic –Diabetes & Stroke

Goal – Diabetes:

Increased access through improved utilization

- Promotion of self referral –
  - Between April 1 – December 2014 462 new clients accessed LHIN funded DEPs across the HNHB LHIN through self-referrals.

- Four DEPs with targeted plans to increase access achieved increases in the number of clients seen within the first 6 months of 2014-15 compared to the previous fiscal year. (projected to year end increases ranged from 54-106%.)

Goal – Stroke:

Establish a Community Stroke Rehab Program for Residents in Haldimand, Norfolk and Brant improved utilization

- 42 clients received evidence based rehabilitative care post stroke in their own homes
- Results – Clients
  - Improvements in functional independence and reintegration to normal living

Aboriginal Health

Goal:

To improve Aboriginal peoples health care experience through access to Aboriginal Navigators

- In 2014 - 3 Aboriginal Navigators served 1,318 people. Top services requested: access to traditional medicines, patient advocacy, mediation and conflict resolution and transportation to medical appointments.

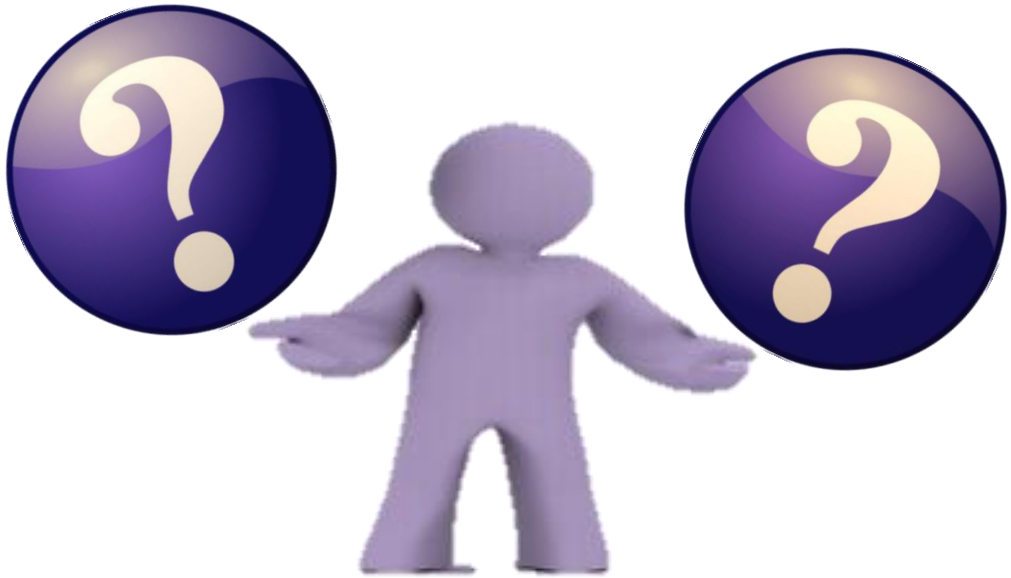
Aboriginal Patient Navigator – Improving patient and family experience through support

Young Autistic patient in hospital ICU after becoming Ill. Family by his side as much as possible. Dad struggling to stay up with University Classes.

"Child has lost his spirit", dad stated that "he is not the same boy he knew, not talking or engaging in things that he once enjoyed. He is very sad that he is alone when the young boys parents can not be there at hospital".

APN was able to visit for support and connected the family to volunteers at the hospital for extra friendly visits. Also arranged for the music therapist from the hospital to visit the young boy. The young boy enjoys this greatly.

Dad saw a great improvement in his son, he was getting back to himself and starting to get well.



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