

Integrated Health Service Plan 2010-2013 *Engaged Communities. Healthy Communities*

November, 2009

To view the entire document go to the Central East LHIN website at
www.centraleastlhin.on.ca

The 2010-2013 Central East Local Health Integration Network's (LHIN) Integrated Health Service Plan (IHSP) has been prepared as a local road map for health, care and utilization of the health care dollar, for the residents and health service providers in the Central East region.

"The strategies, projects and improvements presented in the Integrated Health Service Plan (IHSP) are rooted in the common vision and priorities of the Ontario Ministry of Health and Long-Term Care and the Central East LHIN, as well as in evidenced-based and leading edge practice in the planning and delivery of health services.", states the document.

The IHSP is a three-year strategic plan for the Central East health care system. It provides an overview of the current health care system, identifies areas for focused improvement, and sets standards for achievement.

The single most important change in this IHSP is the identification of two system-level strategic aims for the Central East LHIN that are in keeping with provincial and local priorities:

- Save 1,000,000 Hours of Time Patients Spend in Central East LHIN Emergency Departments by 2013.
- Reduce the Impact of Vascular Disease in the Central East LHIN by 10% by 2013.

The Ministry of Health and Long-Term Care Strategic Directions

The Ministry of Health and Long-Term Care is developing a 10-year Provincial Health System Strategic Plan. In 2007, in lieu of the future release of this provincial plan, the Ministry provided direction to LHINs on five initial strategic directions:

1. Renewed community engagement and partnerships in and about the health care system;
2. Improve the health status of Ontarians;
3. Ontarians will have equitable access to the care and services they need no matter where they live or their social, cultural and/or economic status;
4. Improve the quality of health outcomes; and
5. Establish a framework for sustainability of the health system that achieves the best results for consumers and the community.

These directions are consistent with the Ontario Health Quality Council's (OHQC) nine attributes of a high performing health system which have been also adopted by the Central East LHIN performance framework.

The Ministry of Health and Long-Term Care Strategic Priorities

In support of these provincial Strategic Directions, the Ministry has required LHINs to dedicate attention to the achievement of three provincial priorities. This IHSP marks a continuation of the efforts and advancements the Central East LHIN and local health service providers have been making in the pursuit of these priorities.

1. Reducing wait times in Emergency Departments
2. Reducing the time patients spend in alternate level of care beds in hospitals
3. Improving access to integrated diabetes care

In addition to these three priorities, LHINs are participating in other provincial strategies to improve care for mental health and addictions and build an infrastructure through eHealth:

- a. Enhancing Mental Health and Addictions Services*
- b. Building on an eHealth Framework*

The following is a synopsis of data and the actions on how the LHIN plans to achieve and measure the strategic direction to save 1,000,000 hours of time that patients spend in Central East LHIN Emergency Departments by 2013. It illustrates the complexity of the system that is needed to achieve this goal.

Reduce Emergency Department Demand

Did you know?

- Approximately 40% of emergency department visits are made by patients with non-urgent or less urgent needs (MOHLC Emergency Department Reporting System (EDRS) 2008-09)
- 90% of patients across the province are treated within 9.4 hours from registration/triage to discharge, longer than the provincial length of stay guidelines for any patient category (Ministry of Health and Long-Term Care ED/ALC Quarterly Stocktake Report, July 2009)
- Time patients spend in the ED is approximately five times longer for patients admitted to hospital than for non-admitted patients (EDRS 2008-09)



Partners:

Hospitals / Long-Term Care Homes / Community Care Access Centre / Community Based Mental Health and Addictions Providers / Supportive Housing Providers / Community Support Service Agencies / Police Services / Primary Health Care Providers / Community Health Centres / Urgent Care Centres / Individuals, Families and Caregivers

Strategies

- providing housing and care alternatives outside of the hospital setting
- enhancing access to primary care
- preventing, identifying, assessing, treating and managing health conditions in other settings
- increasing awareness and use of health care services available in the community
- increasing the capacity of community agencies and support services
- enabling patients to manage their own chronic conditions

Projects

- Community Crisis Supports for Mental Health Clients
- Supportive Housing Services for at-risk individuals
- Supporting Ministry expansion of primary care models and urgent care
- Nurse-Practitioners to Long-Term Care
- Community-based Comprehensive Geriatric Assessment
- Self-Management Resources
- Resource-matching and education to help clients locate alternatives to care
- Others as identified

Performance Indicator

- Rates of Emergency Department Visits per 1000 population
- Rate of Emergency Department Visits that could be Managed Elsewhere
- # of wait time hours saved/diverted from the emergency department

Improving Emergency Department Capacity and Performance

Did you know?

Below is a list of the top 5 reasons people visited an emergency department in the Central East LHIN in 2008/09:

Injury, poisoning & other consequence of external causes: 25.9%

Symptoms, signs, & abnormal clinical & laboratory findings: 20.5%

Diseases of the respiratory system: 10.1%

Diseases of the digestive system: 6.8%

Diseases of the musculoskeletal system & connective tissue: 5.9%

From April 2008 through March of 2009, patients in the CE LHIN spent approximately 2.6 million hours in the emergency department, of which over 650,000 were spent by CTAS IV and V patients.

Partners

Hospitals / Community Care Access Centre / Emergency Management Services / Mental Health Crisis Teams / eHealth

Strategies

Emergency department capacity and performance initiatives are hospital based and tend to address administrative and clinical practices such as:

- Improving patient flow and improving efficiency of care practices
- Adding equipment
- Improving access to diagnostics
- Using ancillary support/personnel
- Utilizing eHealth to improve patient flow and referral

Projects

- Geriatric Emergency Management Nurses in the emergency department
- Process improvement programs such as LEAN methodology and the Flo Collaborative
- CCAC Case Management in the emergency department
- Rapid Assessment Units and Clinical Decision Units
- Additional health human resources through the Pay For Results program
- Triage and Assessment and crisis support to mental health clients in the emergency department
- eHealth projects such as ED Patient Self-Registration Kiosk, ED/CCAC Client Notification and Drug Profile View
- Others as identified

Performance Indicator

- Proportion of admitted patients treated within the LOS target of ≤ 8 hours [MLAA]
- Proportion of non-admitted high acuity (CTAS I-III) patients treated within their respective targets of ≤ 8 hours for CTAS I-II and ≤ 6 hours for CTAS III [MLAA]
- Proportion of non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of ≤ 4 hours [MLAA]
 - # of emergency department wait time hours saved (resulting from the achievement of the above targets)

Improving Hospital Bed Utilization

Did you know?

The following statistics are for Peterborough County & City:

Number of long-term care homes = 8

Number of long-term care beds = 1088

Number of interim long-term care beds = 18

Number of convalescent beds = 10

Number of clients of the Central East Community Care Access Centre awaiting placement in long-term care = 801 as of November, 2009 as opposed to the August/06 = 700

Key Facts about the Central East LHIN from the 2006 Census (Statistics Canada):

- Life expectancy at birth for both females and males is above the provincial average (as per population estimates in 2005).
- Central East LHIN has the second highest number of families with children at home.
- Has the second highest percentage of families with children who are headed by a single parent.
- Has the third highest percentage of the population with no knowledge of English or French.
- Has the third highest unemployment rate (above 15 yrs) within the province.
- Is fifth of all 14 LHINs with the percentage of population (age 25+) who have completed post-secondary education.

Partners

Hospitals / Community Care Access Centre / Emergency Management Services / Mental Health Crisis Teams / eHealth

Strategies

- Optimizing the length of time patients spend in acute care beds based on standard of care practices for their condition
- Appropriate distribution of bed types and services within and between hospital providers based on the needs of the patient population to ensure the right care in the right place at the right time
- Reducing ALC by providing community supports and placement alternatives based on population need
- Using eHealth to improve patient flow and referral

Projects

- Implementing the “one acute care network” plan to improve access to specialty services between hospitals
- Providing supportive housing services as alternatives to Long-Term Care
- Providing transitional care options outside of the hospital
- Promoting and supporting senior friendly hospital initiatives such as patient activation
- Improving discharge planning coordination between hospital and community services, such as “Home First”
- Supporting transportation initiatives to support movement to home and to other care providers
- Customizing care plans to support safe transitions in care (e.g., Wrap-Around Services for Seniors)
- Using eHealth solutions to improve patient discharge, notification of patient primary care team, resource matching and referral to expedite movement of clients to the next destination of care
- Others as identified

Performance Indicator

- Percentage of Alternate Level of Care (ALC) Days [MLAA]
- Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC)
- Patient experience (tbd)

Central East LHIN's Strategy to Reduce the Impact of Vascular Disease

Did you know?

Complications due specifically to vascular disease – such as stroke or heart attacks tend to result in higher hospital utilization. In 2008-09 in Central East LHIN hospitals:

- 26% (25,400) of inpatient discharges were attributable to chronic diseases, more specifically 8,550 of inpatient discharges were a result of heart disease.
- Almost 31% (25,485) of Alternate Level of Care (ALC) days were attributable to chronic disease, with 6,248 days attributable to stroke.
- In critical care, 5,354 (46%) cases were related to chronic disease, with 3,297 (62%) related to heart disease.
- 35,204 (6.7%) emergency department visits were related to chronic disease, with 26,491 attributable to arthritis and related conditions.
- In 2007, hypertension and diabetes were the two top reasons for visits to primary care providers.



Prevention and Primary Health Care

Partners

Ministry of Health and Long-Term Care / Public Health Units / Ministry of Health Promotion / Primary Health Care / Community Health Centres / Community Support Services/ Unattached Patient Programs / Hospitals / Mental Health and Addictions Providers / Aboriginal Communities and Health Advisory Circle / Individuals, Families and Caregivers

Strategies

- Prevention, early identification and screening for vascular disease;
- Support expansion of Primary Care with the Ministry of Health and Long-Term Care;
- Reduce the number of unattached primary care clients and/or provide screening, assessment and referral;
- Partner with other ministries and industry partners to promote healthy lifestyles;
- Metabolic disease screening for people entering Community Mental Health and Addictions Programs or an Acute or Tertiary In-Patient Unit to identify those with or at risk of developing diabetes;
- Work in partnership with Aboriginal communities to develop and implement a comprehensive vascular disease screening, assessment and management strategy that includes chronic kidney (renal) disease, metabolic syndrome and diabetes.

Projects

- Expansion of best/promising practices for Renal Chronic Disease Prevention and Management (Renal CDPM) through early identification, screening and effective disease management for people with chronic kidney disease
- Assessment, Triage and Referral of Unattached Patients to identify asymptomatic disease and provide referral to community and/or specialist resources
- Leveraging the Ontario Shores Metabolic

Screening Program to provide outreach support and increasing the capacity of Diabetes Education Centres

Acute Care Treatment

Did you know?

The ALC designation is defined by the province as anyone occupying a bed in a hospital who does not require the intensity of resources/services provided in that care setting.

| Vascular-related Medical Conditions reported for CE LHIN Residents (Adults): | % Total patient Volumes in ALL Day Hospitals |
|--|--|
| Cerebrovascular | 2% |
| Diabetes | 9% |
| Ischemic heart disease | 24% |
| Peripheral vascular disease | 5% |
| Pulmonary heart disease | 30% |
| Renal disease | 8% |
| Stroke | 17% |
| Other vascular related conditions | 5% |
| Total | 100% |

Note: this table represents the total vascular related hospital days for Central East LHIN residents, including days spent in hospitals outside of the Central East LHIN. 72.7% of total patient days reported for Adult Central East LHIN residents (≥ 15 years) were treated within Central East LHIN, with 21.3% receiving treatment in Toronto Central LHIN.

Partners

Primary Health Care providers / Hospitals / Emergency Management Services / Ministry of Health and Long-Term Care / Other LHINs / Cancer Care Ontario

Strategies

- Continue with the implementation of the One Acute Care Network to improve equitable and timely patient access to an integrated hospital system that provides the highest quality of care across the Central East LHIN

Projects

- Enhancements and integration of regional Cardiac and Vascular Programs in the Central East LHIN
- Continued implementation of the Central East Unified Stroke System which will have improved access to Telestroke on-call support for area hospitals and an improved ability to access Enhanced District Stroke Centre and Regional/Tertiary Stroke Centre supports for LHIN residents
- Continued implementation of the Central East LHIN Renal Network to promote best practices, common reporting and organ transplant

Secondary Prevention of Disease Progression & Adverse Events

Did you know?

According to the Canadian Community Health Survey of 2007, the Central East LHIN has the highest prevalence rate of diabetes in Ontario at 8.9% for youth and adults.

It is estimated that supporting one person with Diabetes to control their blood glucose (A1C) when it was not controlled before, will avoid:

- 1 in every 109 Heart Attacks (Acute Myocardial Infarctions [AMIs]),
- 1 in every 111 foot amputations,
- and prevent 1 in every 343 deaths.

Similarly, reducing the blood pressure of one person who had diabetes and coronary artery disease (CAD) to the recommended level of 130/80 will avoid:

- 1 in every 169 heart attacks,
- 1 of every 1250 amputations,
- 1 in every 238 strokes,
- and prevent 1 in every 224 deaths.



Partners

Hospitals / Community Care Access Centre / Community Support Services / Primary Health Care providers / Rehabilitation Providers/ Industry and Chronic Disease Associations / Individuals, Families and Caregivers

Strategies

- Support consumers and caregivers to effectively manage their chronic conditions in partnership with their health care team
- Improve access and coordination of care by building interdisciplinary care delivery teams and partnerships/coalitions between community agencies, hospitals, pharmacy, primary and specialty care providers, allied health professionals and non-health funded community providers such as education, social services and business
- Improving supports in community and primary care settings to reduce avoidable or non urgent/less urgent Emergency Department visits for vascular diseases, including ED visits related to completion of routine lab-work
- Reducing hospital in-patient admissions and re-admissions for complications of vascular disease that could have been managed effectively elsewhere in a community or primary care setting

Projects

- Creation of an integrated Cardiopulmonary Rehabilitation program across the LHIN
- Continue Self Management Training opportunities for Consumers and Caregivers and expanded capacity for follow-up
- Development of Self Management Support tools/toolkit to better enable health care providers/clinicians to support their clients to self-manage their chronic conditions
- Monitor, test and spread the Peterborough Comprehensive Vascular Disease Prevention and Management Initiative (CDVPMI)
- Address relevant recommendations of the Central East LHIN Rehabilitation Services Report and pursue integration opportunities and enhancements

Policy and System Design

Did you know?

In 2008/09 Central East LHIN residents spent a total of 98,456 days in hospital as a result of their vascular condition. Based on population projections, the anticipated total number of patient days related to vascular conditions will be:

- in 2009/10: 100,936 patient days
- in 2010/11: 103,357 patient days
- in 2011/12: 105,856 patient days
- in 2012/13: 108,538 patient days



Partners

Ministry of Health and Long-Term Care / eHealth / Hospitals / Community Care Access Centre / Community Support Services / Primary Health Care providers / Individuals, Families and Caregivers

Strategies

- Support local implementation of the Ministry of Health and Long-Term Care's Diabetes Strategy, specifically through the regional coordination of diabetes programs
- Pursue service enhancements to increase to 50% the proportion of people with diabetes supported by primary care and specialty resources such as Diabetes Education Centres
- Pursue eHealth strategies that will support integration of clinical care, self-management and performance monitoring of chronic disease management
- Increasing consumer, caregiver and clinician capacity to follow best practice care guidelines and achieve recommended health outcome targets
- Integration/coordination and improved consistency of service delivery across the Central East LHIN

Projects

- Continue to distribute the Living Well with Diabetes – Resource Guide and develop complementary tools to continue to support the uptake of best practice and self care
- Improve coordination and consistency of the service delivery system that supports people with diabetes across Central East LHIN
- Integration eHealth projects that provide: a complete picture of the patient record (e.g., HIS Consolidation); Prevention support (e.g., e-learning, web portal; Disease management (e.g., Diabetes indicator project pilot) and Measurement Support (e.g., clinical documentation)