Erie St. Clair **LHIN**
**RLISS** d'Érié St. Clair
www.eriestclairlhin.on.ca

# Erie St. Clair LHIN Themed Reports

## Integrated Health Service Plan 2

### Appendix F – Part 2

Ontario
Erie St. Clair Local Health Integration Network
Réseau local d'intégration des services de santé d'Érié St. Clair

# ESC LHIN Themed Reports

## Appendix F – Part 2

## Table of Contents



## *Cautions*

The information contained in this, the Appendices Section of the Integrated Health Service Plan 2 (HSP2), represents a wide range of support documentation to be used as companion publications to the strategic directions presented in the IHSP2 main report. Erie St. Clair Local Health Integration Network (LHIN) staff will use this information to enhance the existing planning process and in some instances to launch new projects and health care directions. Much of the information contained in the Appendices is early in development and will require additional discussion and refinement before approved plans are initiated.

# ESC LHIN Themed Reports

## System Navigation

### System Navigation, ConnexOntario

**PART 1:**

**1. What problems are we trying to solve & for which (sub) populations?**

| Problems: | (Sub or Priority) Population: |
|---|---|
| a) Unnecessary Emergency Department (ED) Admissions/Readmissions; Alternative Levels of Care (ALC) clients; a need to increase effective diversion from ED.<br>b) Increased hospital length of stay (LOS) and ALC numbers.<br>c) General public, health and social service providers lack awareness of available health and social programs and supports.<br>d) Lack of general understanding in how to access the health care system services when they are needed.<br>e) Lack of understanding about specific types of health services (i.e., Geriatric Emergency Management (GEM) Nurses, Rapid Response Teams, etc.)<br>f) Difficulty navigating system.<br>g) Client and/or caregiver lack recognition and/or understanding of their needs.<br>h) Individuals and/or their caregivers are hesitant to access and utilize formal supports.<br>i) Linkage and transfer of patients from acute care setting and community setting to community services and supports needs to be strengthened.<br>j) Lack of regional system capability and ability to track referrals, capacity, and wait times, etc. of HSP programs/services including Community Support Services with accuracy and timeliness.<br>k) Lack of valid planning data.<br>l) Limitations in available and capable information and referral systems to provide effective resource matching and referral to Erie St. Clair (ESC) Health Service Providers. | a) Individuals with multiple chronic diseases including Diabetes, or Chronic Obstructive Pulmonary Disease (COPD), or Congestive Heart Failure (CHF), or Bronchitis, or Mental Health (MH) and Addictions<br>b) Individuals with a change in health condition resulting in a temporary, fluctuating or permanent change in functional independence<br>c) Frail seniors including those with psycho-geriatric issues.<br>d) Clients assessed by a Local Health Integration Network (LHIN) funded Health Service Provider (HSP) agency provider<br>e) Individuals who have contacted a LHIN funded HSP organizations for information and referral, screening assessment and advice<br>f) Specialized populations such as concurrent disorders (CD), and dual diagnosis<br>g) General population, particularly 1st time users of information and referral system |

Appendix F - Part 2: System Navigation, ConnexOntario (cont'd)

**2. What are the system improvement goals (strategic - over the next 3 years)?**

Goals:

1. Improve access and accessibility to all health service providers through appropriate referral of client/patient to services, and wait list management.
2. Improve utilization of Community Support Service (CSS) agency programs and services.
3. Decrease number of inappropriate patient admissions to hospital.
4. Improve health services "road map" with integrated current and accessible resource inventories.
5. Support health planning and system development with a suite of data solutions and enhanced data reporting capacity.
6. Collaborate with partners to ensure that population is served on the basis of "most appropriate" and/or "least intrusive intervention".
7. Increased ability of individuals to manage to live at home and remain in the community with the support of community services.
8. Expanded access to web accessible searchable databases.

**3. What are the performance objectives & targets?**

| Performance Objectives (should be measurable): | Improvement Targets: |
|---|---|
| 1. Improved management of client and caregiver transitions along the care continuum by enhancing the capabilities of the data management systems | System Level:<br>i) Information Technology (IT) systems scan and analysis and project charter plan and mapping with targeted completion in 3-6 months<br>ii) ESC LHIN funded HSP agencies mapped and inventoried<br>iii) Comprehensive I&R system for HSPs services is available for citizens and providers in the ESC LHIN<br>iv) Community Care Access Centre (CCAC) implementation of the Ministry of Health (MOH) mandated Resource Matching and Referral, Emergency Department notification systems in collaboration with Consolidated Health Information Services (CHIS) and the client Contact Assessment Tool within MOH targets.<br>Client Level<br>i) Appropriate matching of individuals to available services and supports (80 – 85% of the time)<br>ii) Health Service Providers including CSS agency acknowledge receipt of referral 100% of time<br>iii) Community Services Network Shared Referral Tool will be implemented by December 2009 |

Appendix F - Part 2: System Navigation, ConnexOntario (cont'd)

**3. What are the performance objectives & targets? (cont'd)**

| Performance Objectives (should be measurable): | Improvement Targets: |
|---|---|
| 2. Increased utilization of CSS programs and services. | System Level:<br>i) Increased utilization of CSS supports reflected by MIS data being reported to ESC LHIN by CSS Agencies<br>ii) Baseline number of individual referrals made to CSS agencies will be identified for a weekly/monthly basis. Target a 5-10% increase in baseline referrals in first 6 months.<br>Identification and tracking of trends and gaps in available programs, services, providers, and identified community needs<br>iii) Measures of number of:<br>a. referrals made to health service providers including CSS agencies;<br>b. referral refusals;<br>c. waiting list measures; and<br>d. gaps identified.<br><br>Client Level:<br>i) Community Services Network Shared Referral Tool will be implemented prior to December 2009<br>ii) Increased satisfaction with utilization of CSS services and supports (measured by CSS satisfaction survey reports) |
| 3. Improve satisfaction of health service providers' and their patients/clients in regard to their knowledge about the health care services and supports available in the ESC LHIN region.<br>. | System Level:<br>i) ESC LHIN health service provider system mapped and inventoried<br>ii) Comprehensive I&R system for Health Service Provider (HSP) services available for citizens and providers in the ESC LHIN<br><br>Client Level:<br>i) Client satisfaction surveys completed by ESC LHIN HSPs. |

Appendix F - Part 2: System Navigation, ConnexOntario (cont'd)

**3. What are the performance objectives & targets? (cont'd)**

| Performance Objectives (should be measurable): | Improvement Targets: |
|---|---|
| 4. Decrease inappropriate hospital admissions, | System Level:<br>i) Appropriate screening, information, linkage to services through referral/electronic referral/appointment booking or warm line/client transfer of individuals to available health services and supports<br>ii) MIS and utilization data as reported by the hospitals.<br>iii) Provide on-line, instantly accessible reports re: client diversion and system education results<br><br>Client Level:<br>i) Clients learn about and access other health care options. Appropriate outcome measures developed in consultation with the ESC LHIN.<br>ii) Introduction of VOIP Phones for warm client transfer will be initiated as a pilot within 6 months |
| 5. Improved flow of patients from hospital to home with shortened LOS and decreased ED admissions | i) CCAC implementation of the MOH mandated Resource Matching & Referral, Emergency Department notification systems in collaboration with CHIS and the client Contact Assessment Tool within MOH targets.<br>ii) MIS and utilization data as reported by the hospitals<br>iii) Community IT systems scan to determine health service providers' ability to interact with information systems. |

Appendix F - Part 2: System Navigation, ConnexOntario (cont'd)

**3. What are the performance objectives & targets? (cont'd)**

| Performance Objectives (should be measurable): | Improvement Targets: |
|---|---|
| 6. Complete mapping of entire ESC LHIN system | System Level:<br>i) Entire ESC LHIN health system inventoried and mapped<br>ii) Web directories made available for public and professionals use.<br>iii) e-Services available for HSPs and other key stakeholders. Outcome measures developed in consultation with the ESC LHIN.<br>Client Level:<br>i) Easier and more appropriate navigation of system Outcome measures developed in consultation with the ESC LHIN.<br>ii) Improved understanding of system outcome measures developed in consultation with the ESC LHIN. |
| 7. Refine wait time/availability dashboards | System Level:<br>i) Establish Dashboards for all types of health services in place for use by Health Service Providers<br><br>Client Level:<br>i) More appropriate referrals made using current, complete and accurate service and availability data. |
| 8. Provide health system planners access to relevant and accurate data on service availability, system user demographics and the identification of service gaps. | System Level:<br>i) e-Services and its components are available for use of service providers and system planners. |
| 9. Establish additional system tools (e.g., Geriatric Emergency Medicine (GEM) Nurse site and web resource) | System Level:<br>i) Develop specialized websites as required<br><br>Client Level:<br>i) Topic specific information available for public and professionals. |

Appendix F - Part 2: System Navigation, ConnexOntario (cont'd)

**PART 2:**

**4. From a system navigation sense, how do the above directions fit (or have issues) with the following:**

a) Acute Care:
- Timely access to inpatient beds.
- Less dependence on acute care inpatient beds (most appropriate, least intrusive)

b) Post Acute Care:
- Information/access provision to all types of services available by phone/web/web chat 24/7/365
- Accurate information on availability by service type

c) Primary Care:
- Facilitate access to Community Health Centres (CHCs) and Family Health Teams (FHTs) through improved client/patient referral to appropriate resources (provincial partnership with Association of Ontario Health Centres (AOCHC) and Ontario Community Support Association (OCSA)
- Provide robust statistical data on resource needs to LHIN and system partners.
- Health care service information easily accessible for use by primary care providers to assist in making informed decisions.
- No direct electronic linkages to primary care providers i.e. General Practitioners (GPs), Family Health Teams (FHTs), Community Health Centres (CHCs) currently exist from community sector

d) Health and Human Resources:
- Aid recruitment by expanding scope of existing Ministry of Health and Long-Term Care (MOHLTC) sponsored web site "workinginmentalhealth"
- Lack of capacity for Information Technology (IT) staffing to complete systems scan and data management system development

e) Information Management/Systems:
- Oracle based system navigation tools provide a robust, proven, and easily expanded solution to improving integration of system knowledge, resource matching and referral.
- Province-wide inventory approach is applied to assure continual utility of system, for the ESC LHIN, in the event of boundary/ jurisdictional changes. Ensures access to provincial resources that are in limited supply.
- Ensures that required depth of data and information standards are in place and readily available for system planning, issues management, and growth with other MOHLTC, LHIN, and e-Health initiatives.
- Potential compatibility issues with CSS agencies will need to be identified to support data management system development

Appendix F - Part 2: System Navigation, ConnexOntario (cont'd)

**PART 2:**

**5. What is the impact (if any) of the above directions on the care continuum elements listed below?**

a) Emergency Department Volumes/Visits:
- Reduction in Emergency Department (ED) admissions due to successful maintenance of individuals in the community.
- Appropriate diversion to Health Service Providers (HSPs) including community supports and services
- Efficient use of primary care resources
- Easily accessible health service provider information available for discharge planning.

b) Acute Care Admissions:
- Reduction in admissions
- Appropriate diversion to HSPs including community supports and services
- Efficient use of primary care resources
- Easily accessible health service provider information available for discharge planning.

c) Hospital Flow to Community:
- Provide service inventory to assist in an integrated solution focused approach to patient discharge
- Provide timely information regarding system capacity and availability for range of services
- Improved system navigation and client education
- Improved speed of flow of patients from hospital into the community with decreased LOS

d) LTC:
- Provide improved solution for availability reporting in Long-Term Care Home (LTCH) sector
- Provide intensely detailed, ESC LHIN leading to province-wide compatible service inventory
- Delayed institutionalization (longer Length of Stay [LOS] in community)

e) Sub-Acute Care Teams:
- Track and inventory tertiary inventory/access
- Increased referral to and utilization of Sub-Acute care team services

**6. Assess the impact of the above directions on the following:**

a) The Patient/Client Experience:
- Improved care and client satisfaction
- Decrease in overutilization and/or inappropriate utilization
- Facilitated integrated access to community services (seamless transitioning)
- Improved utilization of community support services
- Decreased caregiver burnout

b) Quality Improvements/Health Outcomes:
- Least intrusive treatment with services delivered in the right place
- Robust system data instantly accessible
- Right service delivered in right place by right provider at right time

c) Cost Effectiveness:
- Less cost to system as a whole
- Standardized (to Ministry of Health and Long-Term Care [MOHLTC] standards) data available for planning purposes
- ESC LHIN expanded to Province-wide approach to inventories/data collection/service definitions
- System savings by managing individuals in most cost effective setting

Appendix F - Part 2: System Navigation, ConnexOntario (cont'd)

**PART 3:**

**7. Describe specific targets & actions for each priority (sub) population (annual 12 months and 90 days – action plan).**

**a) Annual (12 Month) Plan:**

| Target (milestone) | Key Actions | Anticipated Impact | Lead |
|---|---|---|---|
| • e-Services available | • Determine requirements, plan, design, develop and deploy<br>• Develop/enhance wait time, availability, and other dashboards.<br>• Library of reports developed<br>• Schedule I Bed Board<br>• Documentation and education strategy developed<br>• Communication strategy developed and administered | • Enhance HSPs awareness of services and availability of services and supports.<br>• Enhance system planning<br>• A suite of reports is available online which can be accessed any time by system planners and providers | |
| • Enhance information and referral service available | • Development of an Information and Referral component using technology to support :<br>  • Toll free phone line<br>  • Webchat<br>  • Texting<br>• On-line Appt booking<br>• e-Referrals<br>• warm line transfers<br>• Decision tree created for directing people to non ER services when appropriate<br>• System locates CHCs and FHTs taking new patients by postal code.<br>• Primary Care access improved through MOH Care Connector Program and direct screening and linkage to available primary care providers in ESC LHIN | • Reduce wait times in ED/reduced ED admissions / readmissions through effective system navigation<br>• Data on service availability and system education permits diversion from ERs, getting clients to 'most appropriate, least intrusive' services<br>• Greater ease of access for clients and improved system navigation<br>• Reduce ED admissions / readmissions by referrals to available primary care practitioners, FHTs and CHCs for those without family doctors. | |
| • CCAC implementation of the MOH mandated Resource Matching & Referral, Emergency Department notification systems in collaboration with CHIS and the client Contact Assessment Tool within MOH targets. | • Milestones to be developed with project partners and in collaboration with ESC LHIN and within MOH timelines | • Improved flow of patients from hospital to home.<br>• Improved ED admission avoidance<br>• Improved transition and flow between hospital and community destinations including CCC, Rehab, LTC and Community/In-Home | |
| • Introduction of VOIP Phones for warm client transfer will be initiated as a pilot within 6 months | | • Improved flow of patients to prevent hospital admissions and from hospital to home. | |

Appendix F - Part 2: System Navigation, ConnexOntario (cont'd)

**b) 90 Day Action Plan (where to start):**

| Target (milestone) | Key Actions | Anticipated Impact | Lead |
|---|---|---|---|
| • Complete data collection and data entry | • Hold consultations with key stakeholders to determine data requirements<br>• Develop data collection strategy<br>• Enhance database to accommodate new data<br>• Enhance existing software to accommodate new data maintenance requirements<br>• Collect and enter data. | • Foundation set for core services such as enhanced client/patient referral to appropriate services, public websites, and stakeholder eServices component | |
| • IT systems scan and analysis | • Consultation/survey of HSPs. | • Ensure HSPs have ability to interact with information systems. | |
| • ESC LHIN HSP service information available on website for public consumption | • Public website developed<br>• Communication strategy developed and administered | • ESC citizens have access to complete HSP service information<br>• Improved system navigation and service awareness | |
| • Develop and launch specialized web- based system tools (e.g., GEM Nurse web site) | • Meet with stakeholders to determine content<br>• Design, build and launch | • Stakeholder have ability to disseminate best practice information, clinical discussion networks and clinical chat forums | |
| • Community Services Network Shared Referral Tool implementation and roll out to all Community Support Service agencies | • Contract Project Manager<br>• Initial pilot with volunteer agencies<br>• Confirmation of referral data and statistics | • Improved utilization of Community Support Services (CSS) services and supports<br>• Improved caregiver support<br>• Improved satisfaction of clients<br>• Improved ability to live at home for longer | |

Appendix F - Part 2: ESC LHIN IHSP2 Themed Reports (cont'd)

## System Navigation, ESC CCAC

**PART 1:**

**1. What problems are we trying to solve & for which (sub) populations?**

| Problems: | (Sub or Priority) Population: |
|---|---|
| a) Unnecessary Emergency Department Admissions/Readmissions; Alternate Level of Care (ALC)<br>b) >Hospital Length of Stay (LOS) and > ALC numbers<br>c) General public, health and social service providers lack awareness of available health and social programs and supports<br>d) Client and/or caregiver lack recognition and/or understanding of their needs<br>e) Individuals and/or their caregivers are hesitant to access and utilize formal supports<br>f) Linkage and transfer of patients from acute care setting and community setting to community support services needs to be strengthened<br>g) Lack of regional system capability and ability to track referrals, capacity, etc. of Community Support Service programs/services with accuracy and timeliness.<br>h) Limitations in available and capable Information and Referral systems | a) Individuals with multiple chronic diseases including Diabetes, or Chronic Obstructive Pulmonary Disease (COPD), or Congestive Heart Failure (CHF), or Bronchitis, or Mental Health and Addictions<br>b) Individuals with a change in health condition resulting in a temporary, fluctuating or permanent change in functional independence<br>c) Frail seniors<br>d) Clients assessed by a Community Care Case Manager by telephone assessment, assessment in the community, hospital, Rest and Retirement Home, schools and/or Long-Term Care Home settings<br>e) Individuals who have called 310 CCAC and received Information and Referral screening assessment and advice |

**2. What are the system improvement goals (strategic - over the next 3 years)?**

Goals:

1. Improved utilization of Community Support Services agency programs and services
2. Increased numbers of individuals referred to Community Support Services agencies.
3. Expanded access to 310 CCAC searchable database for Community Support Agencies that were not involved in ESC CCAC Community Support Services Network project
4. Decreased number of inappropriate patient admissions to hospital.
5. Increased ability of individuals to manage to live at home live in community with the support of community services.

Appendix F - Part 2: System Navigation, ESC CCAC (cont'd)

**3. What are the performance objectives & targets?**

| Performance Objectives (should be measurable): | Improvement Targets: |
|---|---|
| Improved management of client and caregiver transitions along the care continuum by enhancing the capabilities of the data management systems | System Level:<br>a) IT systems scan and analysis and project charter plan and mapping with targeted completion in 3-6 months<br><br>Client Level<br>a) Appropriate matching of individuals to available services and supports (80 – 85% of the time)<br>b) CSS agency acknowledged receipt of referral 100% of time |
| Increased utilization of Community Support Services programs and services | System Level:<br>a) Increased utilization of CSS supports reflected by MIS data being reported to ESC LHIN by CSS Agencies<br>b) Baseline number of individual referrals made by CCAC to CSS agencies will be identified for a weekly/monthly basis. Target a 5-10% increase in baseline referrals in first 6 months.<br>c) Identification and tracking of trends and gaps in available programs, services, providers, and identified community needs<br>d) Measures of # of: i) referrals made to CSS agencies; ii) # of referral refusals; iii) waiting list measures; iv) gaps identified<br><br>Client Level:<br>a) Increased satisfaction with utilization of CSS services and supports (measured by CSS satisfaction survey reports) |
| Increased satisfaction of both Community Support Service (CSS) agency and CCAC clients in regards to their knowledge about available community support programs & services and social supports | Client Level:<br>a) CCAC Client Satisfaction Surveys – reported 60 – 70 % satisfied<br>b) 310 CCAC satisfaction – reported 60 – 70 % satisfied<br>c) CSS client satisfaction survey reports |

Appendix F - Part 2: System Navigation, ESC CCAC (cont'd)

**3. What are the performance objectives & targets? (cont'd)**

| Performance Objectives (should be measurable): | Improvement Targets: |
|---|---|
| Decreased Hospital Admissions, LOS and ED admission avoidance with improved flow of patients from hospital to home through the support of CCAC and CSS agencies | System Level:<br>a) MOH mandated introduction of Resource Matching and Referral, ED Notification system and a Client Contact Assessment Tool for anyone interviewed by CCAC will be implemented within fiscal year 2010/2011<br>b) Community IT systems scan to prepare for portal development and increased ability of CCAC to share client data with CSS agencies on a daily basis.<br><br>Client Level:<br>a) Community Services Network Shared Referral Tool will be implemented prior to December 2009<br>b) Introduction of VOIP Phones for warm client transfer will be initiated as a pilot within 6 months |

**PART 2:**

**4. From a system navigation sense, how do the above directions have issues with the following:**

a) Acute Care:

b) Post Acute Care:

c) Primary Care:
- No direct electronic linkages to primary care providers i.e. GPs, FHTs, CHCs currently exist from Community sector

d) Health and Human Resources:
- Lack of capacity for IT staffing to complete systems scan and data management system development

e) Information Management/Systems:
- Potential compatibility issues with CSS agencies will need to be identified to support data management system development
- OACCAC currently owns 310 CCAC database

f) Other: N/A

Appendix F - Part 2: System Navigation, ESC CCAC (cont'd)

**5. What is the impact (if any) of the above directions on the care continuum elements listed below?**

a) Emergency Department Volumes/Visits:
- Reduction in ED admissions due to successful maintenance of individuals in the community

b) Acute Care Admissions:
- Increased redirection of individuals from ED and ALC who can be appropriately managed in the community with supports and services

c)Hospital Flow to Community:
- Improved speed of flow of patients from hospital into the community with decreased LOS

d) LTC:
- Delayed institutionalization (longer LOS in community)

e) Sub-Acute Care Teams:
- Increased referral to and utilization of Sub-Acute care team services

**6. Assess the impact of the above directions on the following:**

a) The Patient/Client Experience:
- Integrated access to community services (seamless transitioning)
- Improved utilization of community support services
- Increased satisfaction of clients
- Decreased caregiver burnout

b) Quality Improvements/Health Outcomes:
- Right service delivered in right place by right provider at right time

c) Cost Effectiveness:
- System savings by managing individuals in most cost effective setting

**PART 3:**

**7. Describe specific targets & actions for each priority (sub) population (annual 12 months and 90 days – action plan).**

**a) Annual (12 Month) Plan:**

| Target (milestone) | Key Actions | Anticipated Impact | Lead |
|---|---|---|---|
| N/A | | | |

**b) 90 Day Action Plan (where to start):**

| Target (milestone) | Key Actions | Anticipated Impact | Lead |
|---|---|---|---|
| N/A | | | |

# Health Human Resources

## Health Human Resources (HHR)

**1) Describe the 'current state' for your area of responsibility including**:

a) Relevant support data (e.g. utilization, population, service, etc. – put this into a Table format where possible distinguishing the 3 geographic areas of Windsor/ Essex, Chatham/Kent and Sarnia/Lambton).

**Physician HHR Status Report**

**1A) GPs by county, % shortage**

| Underserviced Statistics for General/Family Practice<br>Erie St. Clair Region<br>July, August, September 2009 | | | |
|---|---|---|---|
| | **Designated** | **Shortage** | **Percentage** |
| **Chatham-Kent** | 80 | 30 | 37.5 |
| **Essex County** | 233** | 67 | 28.8 |
| **Lambton County** | 90 | 25 | 27.8 |

- Designation as Underserviced for General/Family Practice took place by the Ministry of Health and Long-Term Care (MOHLTC) in 1998 for all three counties.
- All three counties have remained on the underserviced list since 1998.
- **The Underserviced Area designation number for Essex County has not been updated to reflect the increase in population which has taken place since original designation in 1998. Since that time the population has increased by over 22%.

* List of Areas Designated as Underserviced (LADAU) for General/Family Practitioners July, August, September 2009

**1B) Specialist Physicians, actual and shortages (by county)**

The following three tables provide a complete breakdown of specialist needs by county.

## Appendix F - Part 2: Health Human Resources (cont'd)

### Ministry of Health and Long-Term Care Designation Ratios v. Chatham-Kent Physician Human Resource Inventory

| | | | | | | Community Need | Immediate Requirements | | | Future Needs (3-5 yrs) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Specialty | Ratio | Number Required | Full-time Actual | Number Deficient | % of Requirement | Age >65 | | | | | | Notes |
| Anaesthesia | 11,500 | 8 | 7 | 1 | 81% | 1 | | | | | | |
| Cardiology | 32,100 | 1 | 0 | 1 | 0% | | | | | | | |
| Critical Care | | 2.5 | 1 | 0 | 40% | | | | | | | |
| Dermatology | 62,650 | 0.5 | 0 | 1 | 0% | | | | | | | |
| Diagnostic Radiology | 16,000 | 4.5 | 4 | 1 | 78% | | | | | | | |
| Endocrinology & Metabolism | 76,600 | 1 | 1 | 0 | 100% | | | | | | | |
| Gastroenterology | 62,800 | 2 | 2 | 1 | 100% | 1 | | | | | | |
| General Surgery | 13,850 | 5 | 4 | 1 | 80% | | | | | | | |
| General/Family Practice | 1,380 | 78 | 39 | 39 | 50% | 2 | | | | | | |
| Emergency Medicine | | 19 | 8 | 11 | 28% | | | | | | | |
| Geriatrics | | 0.5 | 0 | 1 | 0% | | | | | | | |
| Haematology | 95,850 | 0 | 0 | 0 | 0% | | | | | | | |
| Immunology & Allergy | 140,100 | 0 | 0 | 0 | 0% | | | | | | | |
| Infectious Diseases | 617,000 | 0 | 0 | 0 | 0% | | | | | | | |
| Internal Medicine | 19,300 | 8 | 6 | 2 | 67% | 1 | | | | | | |
| Medical Oncology | 19,300 | 0 | 0 | 0 | 0% | | | | | | | |
| Nephrology | 112,350 | 0 | 0 | 0 | 0% | | | | | | | |
| Neurology | 59,300 | 0 | 0 | 1 | 0% | | | | | | | |
| Neurosurgery | 129,450 | 0 | 0 | | 0% | | | | | | | |
| Nuclear Medicine | 127,500 | 0.5 | 1 | 0 | 100% | | | | | | | |
| Obstetrics & Gynaecology | 15,500 | 4 | 4 | 1 | 88% | 1 | | | | | | |
| Ophthalmology | 29,650 | 3 | 3 | 0 | 100% | | | | | | | |
| Orthopaedic Surgery | 27,500 | 3 | 3 | 0 | 100% | | | | | | | |
| Otolaryngology | 45,700 | 2 | 1 | 1 | 50% | | | | | | | |
| Paediatrics | 26,950 | 5 | 4 | 1 | 80% | | | | | | | |
| Pathology (general pathology, lab medicine) | 25,400 | 3 | 1 | 2 | 33% | | | | | | | |
| Pathology (microbiology, clinic biochemistry) | 79,400 | 0 | 0 | 0 | 0% | | | | | | | |
| Physical Medicine | 85,550 | 0.5 | 0 | 1 | 0% | | | | | | | |
| Plastic Surgery | 85,550 | 0 | 0 | 0 | 0% | | | | | | | |
| Psychiatry | 8,650 | 5.5 | 4 | 2 | 64% | 1 | | | | | | |
| Respiratory Disease | 81,450 | 0 | 0 | 0 | 0% | | | | | | | |
| Rheumatology | 94,100 | 0 | 0 | 0 | 0% | | | | | | | |
| Therapeutic Radiology (incl. radiation oncology) | 131,450 | 0 | 0 | 0 | 0% | | | | | | | |
| Thoracic & Cardiovascular | 158,400 | 0 | 0 | 0 | 0% | | | | | | | |
| Thoracic Surgery | 158,400 | 0 | 0 | 0 | 0% | | | | | | | |
| Urology | 51,950 | 2 | 2 | 0 | 100% | | | | | | | |
| TOTALS | | 159 | 92 | 66 | 58% | 7 | 0 | 0 | 0 | 0 | 0 | 0 |

Appendix F - Part 2: Health Human Resources (cont'd)

**Ministry of Health and Long-Term Care Designation Ratios v. Sarnia/Lambton Physician Human Resource Inventory**

| not all FT, 1 starting+A1 summer 09 | | Community Need | | | | | Immediate | | | Future Needs | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Specialty | Ratio | Number Required | Full-time Actual | Number Deficient | % of Requirement | Age >65 | | | | | | | Notes |
| Anaesthesia | 11,500 | 0.0 | 8 | 1 | 87% | | 1 | | | 1-2 | | | 1 within a year |
| Cardiology | 32,100 | 0.0 | 2 | 1 | 50% | | 1 | | | | | | Internists with cardiology interest |
| Critical Care | | 0.0 | 0 | 1 | 100% | | 1 | | | | | | |
| Dermatology | 62,650 | 0.0 | 1 | 0 | 100% | | | | | 1 | | | |
| Diagnostic Radiology | 16,000 | 0.0 | 7 | | 100% | | | | | | | | 1 joining summer 09 |
| Endocrinology & Metabolism | 76,600 | 0.0 | 0 | | 0% | | | | | | | | |
| Gastroenterology | 62,800 | 0.0 | 0 | | 0% | | | | | | | | |
| General Surgery | 13,850 | 0.0 | 5 | | 100% | | | | | | | | (6th starting July 09) |
| General/Family Practice | 1,380 | 0.0 | 65 | 25 | 72% | | | | | | | | |
| Emergency Medicine | | 0.0 | 16 | 2 | 87% | | 2 | | | 1 | | | |
| Geriatrics | | 0.0 | 0 | | 0% | | | | | | | | |
| Haematology | 95,850 | 0.0 | 0 | | 0% | | | | | | | | |
| Immunology & Allergy | 140,100 | 0.0 | 0 | | 0% | | | | | | | | |
| Infectious Diseases | 617,000 | 0.0 | 0 | | 0% | | | | | | | | |
| Internal Medicine | 19,300 | 0.0 | 7 | 2 | 71% | | 2 | | | | | | require internist with rheumatology interest, respirology interest |
| Medical Oncology | 19,300 | 0.0 | 1 | 0 | 100% | | | | | | | | |
| Nephrology | 112,350 | 0.0 | 0 | | 0% | | | | | | | | |
| Neurology | 59,300 | 0.0 | 1 | 1 | 100% | | 1 | | | | | | |
| Neurosurgery | 129,450 | 0.0 | 0 | | 0% | | | | | | | | |
| Nuclear Medicine | 127,500 | 0.0 | 0 | | 0% | | | | | | | | |
| Obstetrics & Gynaecology | 15,500 | 0.0 | 7 | | 100% | | | | | | | | |
| Ophthalmology | 29,650 | 0.0 | 2 | 0 | 100% | | | | | 1 | | | |
| Orthopaedic Surgery | 27,500 | 0.0 | 5 | 0 | 100% | | | | | 1 | | | |
| Otolaryngology | 45,700 | 0.0 | 1 | | 100% | | | | | | | | |
| Paediatrics | 26,950 | 0.0 | 2 | 0 | 100% | | | | | 1 | | | expecting 3rd summer 09 |
| Pathology (general pathology, lab medicine) | 25,400 | 0.0 | 3 | | 100% | | | | | | | | expecting 4th summer '09 |
| Pathology (microbiology, clinic biochemistry) | 79,400 | 0.0 | 0 | 0 | 0% | | | | | | | | |
| Physical Medicine | 85,550 | 0.0 | 0 | 0 | 0% | | | | | | | | |
| Plastic Surgery | 85,550 | 0.0 | 1 | 0 | 100% | | | | | | | | |
| Psychiatry | 8,650 | 0.0 | 12 | 0 | 100% | | | | | | | | |
| Respiratory Disease | 81,450 | 0.0 | 0 | | 0% | | | | | | | | |
| Rheumatology | 94,100 | 0.0 | 1 | 0 | 100% | | | | | | | | internist with rheumatology interest |
| Therapeutic Radiology (incl. radiation oncology) | 131,450 | 0.0 | 0 | | 0% | | | | | | | | |
| Thoracic & Cardiovascular | 158,400 | 0.0 | 2 | 0 | 100% | | | | | 1 | | | |
| Thoracic Surgery | 158,400 | 0.0 | | | 0% | | | | | | | | |
| Urology | 51,950 | 0.0 | 3 | | 50% | | | | | 1 | | | |
| TOTALS | | 0 | 152 | 33 | 22% | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

Appendix F - Part 2: Health Human Resources (cont'd)

**Ministry of Health and Long-Term Care Designation Ratios v. Windsor/Essex Physician Human Resource Inventory**

| | Community Need | | | | | | Immediate Requirements | | | Future Needs | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Specialty | Ratio | Number Required | W/E Full-time Actual | Number Deficient | % of Requirement | Age >65 | HDGH | LDMH | WRH | HDGH | LDMH | WRH | Notes |
| Anaesthesia | 11,500 | 35.2 | 30 | 5 | 85% | | | | | 2-3 | | 1 | 22 Operating Rooms WEC |
| Cardiology | 32,100 | 12.6 | 10 | 3 | 79% | | 1 | | | 1 | | 1 | HDGH 1 Int./WRH 1 Gen. |
| Critical Care | | | 3 | | | | | | | | | | HDGH PT ICU staffing req'd |
| Dermatology | 62,650 | 6.5 | 4 | 2 | 62% | | 1 | | 1 | | | | |
| Diagnostic Radiology | 16,000 | 25.3 | 19 | 6 | 75% | | | | | 2 | | | |
| Endocrinology & Metabolism | 76,600 | 5.3 | 5 | 0 | 95% | | | | | | | | |
| Gastroenterology | 62,800 | 6.4 | 7 | | 109% | | | | | | | | |
| General Surgery | 13,850 | 29.2 | 15 | 14 | 51% | | | 1 | | 2 | | 1 | |
| General/Family Practice | 1,380 | 293.5 | 161 | 132 | 55% | 10 | open | 5 | open | | open | | (27 > 60 yrs = 17%) |
| Emergency Medicine | | | 32 | | | | 1 | 2-3 | 4-5 | | 2 | 27 | |
| Geriatrics | | | 1 | | | | | | | | | | |
| Haematology | 95,850 | 4.2 | 0 | 4 | 0% | | 1 | | 1 | 1 | | 1 | Joint recruitment |
| Immunology & Allergy | 140,100 | 2.9 | 2 | | | | 1 | | | | | | |
| Infectious Diseases | 617,000 | 0.7 | 1 | | | | | | | | | | Additional .5FTE desirable |
| Internal Medicine | 19,300 | 21.0 | 14 | 7 | 67% | | 2* | | 1 | 1-2 | .5 | | (*Shanfield Aug 2009) |
| Medical Oncology | 19,300 | 21.0 | 5 | 16 | 24% | | | | 1* | | | 1 | *replace Sicheri |
| Nephrology | 112,350 | 3.6 | 3 | 1 | 83% | | | | | 1 | | | |
| Neurology | 59,300 | 6.8 | 6 | 1 | 88% | | | | | 1 | | 1 | Joint recruitment |
| Neurosurgery | 129,450 | 3.1 | 4 | | 128% | | | | | | | | |
| Nuclear Medicine | 127,500 | 3.2 | 4 | | | | | | | | | | |
| Obstetrics & Gynaecology | 15,500 | 26.1 | 15 | 11 | 57% | 1 | | 1-2 | | | 1 | 2* | *Gyn Onc /MFM preferred |
| Ophthalmology | 29,650 | 13.7 | 5 | 9 | 37% | | | | | | | | |
| Orthopaedic Surgery | 27,500 | 14.7 | 9 | 6 | 61% | | | | | | | | |
| Otolaryngology | 45,700 | 8.9 | 4 | 5 | 45% | | | | | | | 1 | |
| Paediatrics | 26,950 | 15.0 | 17 | | 113% | 1 | | | | | | 2 | |
| Pathology (general pathology, lab medicine) | 25,400 | 15.9 | 11 | 5 | 69% | | | | | | | | |
| Pathology (microbiology, clinic biochemistry) | 79,400 | 5.1 | | 5 | 0% | | | | | | | | No funding |
| Physical Medicine | 85,550 | 4.7 | 3 | 2 | 63% | | | | | | | 1 | |
| Plastic Surgery | 85,550 | 4.7 | 5 | | 106% | | 1 | | 1 | | | | Joint recuitment |
| Psychiatry | 8,650 | 46.8 | 23 | 24 | 49% | 3 | open | | open | | | | Joint recuitment |
| Respiratory Disease | 81,450 | 5.0 | 6 | | 121% | | | | | | | | |
| Rheumatology | 94,100 | 4.3 | 2 | 2 | 46% | | | | | | | | |
| Therapeutic Radiology (incl. radiation oncology) | 131,450 | 3.1 | 5 | | 162% | | | | 1 | | | 1 | |
| Thoracic & Cardiovascular | 158,400 | 2.6 | 3 | | 117% | | | | | | | | |
| Thoracic Surgery | 158,400 | 2.6 | 2 | 1 | 78% | | | | | | | | |
| Urology | 51,950 | 7.8 | 5 | 3 | 64% | | 1 | | 1* | | .5 | | (*Deklaj Aug 2009) |
| TOTALS | | 662 | 441 | 264 | 67% | 15 | 9 | 11 | 12 | 13 | 4 | 13 | |

Appendix F - Part 2: Health Human Resources (cont'd)

**1E) Average Age of Physicians and Percent 5 to 10 year from Retirement for the Erie St. Clair LHIN:**

| Erie St. Clair Physician Demographics * | | | | | |
|---|---|---|---|---|---|
| **Physician Specialty** | **Total Number** | **% 60 years or Older** | **% 50 years or older** | **Average Age** | **Comments** |
| | | | | | |
| Family Medicine | 357 | 26 | 45 | 54.5 | Age range of specialty is 25 to 84 years |
| F.M./Emergency Medicine | 43 | 2 | 30 | 47.5 | Age range if specialty is 30 to 64 years. Numbers peak between 40 to 44 years of age then decline by 30% between 45 to 49 years of age. |
| | | | | | |
| Anesthesiology | 36 | 16 | 47 | 52.5 | Age range of specialty is 30 to 74 years |
| Community Medicine | 3 | 0 | 100* | 59.5 | * % reported is 55 to 64 years of age. Age range of specialty is 55 to 64 years |
| Diagnostic Radiology | 32 | 15 | 53 | 52.5 | Age range of specialty is 30 to 84 years |
| Emergency Medicine | 3 | 0 | 66* | 39.5 | Age range of specialty is 35 to 44 years |
| Nuclear Medicine | 4 | 0 | 25 | 49.5 | * % reported is 55 to 59 years of age. Age range of specialty is 40 to 59 years |
| Physician Medicine and Rehab | 3 | 0 | 100* | 39.5 | * % reported is 35 to 44 years of age. Age range of specialty is 35 to 44 years |
| Psychiatry | 39 | 33 | 74 | 57.5 | Age range of specialty is 30 to 84 years |
| Radiation Oncology | 8 | 25 | 50 | 52.5 | Age range of specialty is 35 to 79 years |
| Internal Medicine | 25 | 12 | 48 | 52.5 | Age range of specialty is 30 to 74 years |
| Cardiology | 12 | 41* | 58 | 57.5 | * % reported is 55 years or older. Age range of specialty is 40 to 74 years |
| Clinical Immunology and Allergy | 3 | 66* | 100 | See notes | * % reported is 70 years or older. 72.5 years is the average age for 66% of the specialty and 32.5 years is average age for 33% of the specialty. Age range of specialty is 30 to 34 years and 70 to 74 years |
| Critical Care Medicine | 1 | 0 | 0 | 32.5 | Age range of specialty is 30 to 34 years |
| Dermatology | 5 | 40* | | 57.5 | * % reported is 65 years or older. There is a gap in age groups from 49 to 65 years with no physicians in this age bracket. |
| Endocrinology and Metabolism | 5 | 40* | 80** | 52.5 | * % reported is 55 years or older. ** % reported is for 50 to 59 years. Age range of specialty is 45 to 59 years |

Appendix F - Part 2: Health Human Resources (cont'd)

**1E) Average Age of Physicians and Percent 5 to 10 year from Retirement for the Erie St. Clair LHIN: (cont'd)**

**Erie St. Clair - Physician Demographics***

| Physician Specialty | Total Number | % 60 years or Older | % 50 years or older | Average Age | Comments |
|---|---|---|---|---|---|
| Gastroenterology | 8 | 62 | 75* | 54.5 | * % reported is 50 to 69 years of age. Age range of specialty is 40 to 69 years |
| Geriatric Medicine | 2 | | 100* | 42.5 | * reported is 40 to 44 years. Age range of specialty is 40 to 44 years. |
| Hematology | 1 | 100* | | 72.5 | * reported is 70 to 74 years of age. Age range of specialty is 70 to 74 years |
| Infectious Diseases | 1 | 0 | 100 | 52.5 | Age range of specialty is 50 to 54 years |
| Medical Oncology | 7 | 42* | 57 | 52.5 | * reported is 55 years or older. Age range of specialty is 35 to 69 years |
| Nephrology | 3 | 0 | 33* | 39.5 | * reported is 40 years or older. 67% are 35 to 39 years of age. Age range of specialty is 35 to 44 years |
| Neurology | 9 | 22* | 33** | 57.5 | * % reported is 65 years or older. ** reported is 55 to 79 years. Age range of specialty is 35 to 79 years |
| Respirology | 8 | 12 | 33 | 47.5 | Age range of specialty is 30 to 64 years |
| Rheumatology | 2 | 50* | 50** | 62.5 | * % reported is 70 to 74 years of age. ** % reported is 50 to 54 years of age. Age range of specialty is 50 to 74 years |
| Pediatrics | 24 | 29 | 54 | 52.5 | Age range of specialty is 30 to 74 years |
| Clinical Immunology and Allergy-Ped | 2 | 50* | 50* | 52.5 | * % reported is 70 to 74 years of age. ** % reported is 30 to 34 years of age. Age range of specialty is 30 to 74 years |
| General Surgery | 26 | 26 | 61 | 52.5 | Age range of specialty is 30 to 74 years |
| Cardiac Surgery | 4 | 50* | 75 | 59.5 | * % reported is 55 years or older. Age range of specialty is 35 to 69 years |
| Neurosurgery | 4 | 0 | 25 | 42.5 | Age range of specialty is 30 to 54 years |
| Obstetrics and Gynecology | 29 | 31* | 59 | 54.5 | * % reported is 65 years or older. Age range of specialty is 30 to 79 years |
| Ophthalmology | 14 | 14 | 64 | 57.5 | Age range of specialty is 35 to 79 years |
| Orthopedic Surgery | 17 | 28 | 58 | 52.5 | Age range of specialty is 30 to 74 years |
| Plastic Surgery | 7 | 14 | 42 | 54.5 | Age range of specialty is 35 to 74 years |
| Otolaryngology | 10 | 40 | 70 | 54.5 | Age range of specialty is 30 to 79 years |
| Thoracic Surgery | 1 | | 100 | 57.5 | Age range of specialty is 55 to 59 years |

Appendix F - Part 2: Health Human Resources (cont'd)

**1E) Average Age of Physicians and Percent 5 to 10 year from Retirement for the Erie St. Clair LHIN: (cont'd)**

**Erie St. Clair - Physician Demographics***

| Physician Specialty | Total Number | % 60 years or Older | % 50 years or older | Average Age | Comments |
|---|---|---|---|---|---|
| Urology | 13 | 23 | 76 | 52.5 | Age range of specialty is 30 to 74 years |
| Vascular Surgery | 4 | 25 | 75 | 57.5 | Age range of specialty is 35 to 79 years |
| General Pathology | 4 | 75 | 100 | 62.5 | Age range of specialty is 50 to 74 years |
| Anatomical Pathology | 9 | 22 | 77 | 54.5 | Age range of specialty is 40 to 69 years |
| Hematological Pathology | 1 | 0 | 100 | 52.5 | Age range of specialty is 50 to 54 years |
| | | | | | |
| Total | 789 | | | | |
| | | | | | |
| There are 9 specialties out of 41 listed that are not in the 50 and older age bracket - meaning 78% of our physicians are in the 50 and older age bracket. | | | | | |

* All data gathered from the Ontario Physician Human Resources Data Centre - 2007 PIO (Physicians in Ontario) Reports

Appendix F - Part 2: Health Human Resources (cont'd)

**2A) Privileges:**

**No data available at this time.**

**2B Policy Issues:**

The Underserviced Area Program (UAP) is one of a number of supports provided by the MOHLTC to help underserviced communities recruit and retain health professionals.

The government is renewing Ontario's Underserviced Area Program (UAP) by redesigning and strengthening physician recruitment and retention programs in the province. The goals are to:

1. Meet the unique requirements of northern and rural communities that face chronic challenges recruiting and retaining physicians; and
2. Help all Ontario communities experiencing physician shortages.

To achieve these goals the government is proposing:

1. A **Northern/Rural RIO-based financial incentive program** specifically designed to attract physicians to northern and rural communities. Physicians practicing in any community in a census subdivision with a score of 40 or more on the Rurality Index for Ontario scale would be eligible to receive incentive funding. The amount of funding would be determined by the RIO score: the higher the score, the higher the value of the incentive funding. To find more information on the RIO score, visit http://www.health.gov.on.ca/english/providers/program/uap/uap_rio.html

2. A **province-wide return of service (ROS) program.** All Ontario communities – except the Greater Toronto Area (GTA) and Ottawa which are well supplied for physicians – would have access to the growing number of physicians graduating with ROS obligations.

The government is hosting consultations over the summer, looking for input from communities and other stakeholders. To comment online, please review the consultation paper below and complete the online survey. For all other questions, please email uapcomments@healthforceontario.ca.

**2C) Issues on Data Collection:**

Human resource departments within the medical field either did not want to share information or they noted that information is collected differently and there really is not a standard way to compare. HealthForceOntario has recognized this problem and they are in the midst of a database development project.

**Health Professions Database**

Our healthcare system relies on a range of health professionals, each with unique expertise, to meet the health needs of Ontarians. However, we know very little about the 40% of the regulated health workforce in Ontario who provide valuable services in areas such as diagnostics, mental health, obstetrics, oral and vision care, rehabilitation and therapeutics.

Appendix F - Part 2: Health Human Resources (cont'd)

**Database Needed for Sound Health Human Resources Planning**

Staff at the Ministry of Health and Long-Term Care is working with 19 health regulatory Colleges of Ontario to address this gap by creating a database that will provide the evidence we need for sound health human resources planning about this important group of health professionals. The database is an initiative of the HealthForceOntario health human resources strategy.

**Database Development**
Over the summer, the Ministry and 19 health regulatory Colleges worked diligently to develop a minimum data set for the Health Professions Database. Once populated, the database will provide standardized, consistent and comparable demographic, geographic, educational, and employment information on all of the regulated allied health professionals in Ontario.
Over the next two years, the Colleges will be expanding their registration and renewal forms to collect additional information from their members. The process is supported by a recent amendment to the Regulated Health Professions Act that requires the regulatory Colleges to collect information from their members and provide it to the Ministry for health human resources planning.

**Database to be Available in 2010**
The Colleges will begin to submit the data they collected in January 2009. Aggregate data and analytical reports from the database will be available on www.healthforceontario.ca in 2010.*

* Information obtained from: http://www.healthforceontario.ca/WhatIsHFO/evidence_hhr/hpdb.aspx

**2D) Issues on Predictive Data –** remove from discussion as per above

**2E) Recruitment and Retention:**

In May 2006, HealthForceOntario (HFO) was born as a strategy – viewed as a broad umbrella over a series of health human resources (HHR) strategies. As part of HFO, the provincial government created the HealthForceOntario Marketing and Recruitment Agency (HFO MRA). As part of HFO MRA, the Community Partnership Program was launched providing grass roots provincial support for local physician recruitment and retention initiatives. The Community Partnership Coordinator provides support to the communities in the Erie St. Clair LHIN in their efforts to recruit 124 Family Physicians (as identified by the Underserviced Area Program) and 169 specialists from a variety of disciplines. Key to the Community Partnership Coordinator role is communication from the province to communities and from communities to the province.

**2F) Other Issues – Working Environment/Safety Issues:**

**Healthy Work Environments Program**

The Healthy Work Environments Program offers tools and resources to create safer and healthier work environments for Ontario's health care workers and employers.

Appendix F - Part 2: Health Human Resources (cont'd)

**What are Healthy Work Environments?**

A healthy work environment is a work setting that takes a strategic and comprehensive approach to providing the physical, cultural, social, and job design conditions that maximize the health and well-being of health care providers, according to the national Quality Worklife Quality Healthcare Collaborative.

**Why are Healthy Work Environments Important?**

Implementing healthy work environments and a culture of safety for health care workers is key to ensuring quality patient care. Enhancing morale and reducing absenteeism can **reduce adverse events**, **improve patient safety** and **support improved patient outcomes**.

When workplaces are unhealthy, it can have a negative impact on your health human resources:

- 28% of Ontario nurses reported they were physically assaulted at work over the past 12 months by a patient, according to the 2005 National Survey of the Work and Health of Nurses;
- Approximately 46% of Canadian physicians reported they were in advanced stages of burnout, according to the Canadian Medical Association Study on Physician Burnout;
- The average number of days of work lost due to illness or disability was at least 1.5 times greater for workers in health care than the average for all workers, according to Canada's Health Care Providers: 2005 Chartbook.*

***** Information obtained from http://www.healthforceontario.ca/WhatIsHFO/hwe.aspx.

**2G) Medical School Training and Placements**

**Medical School:** University of Western Ontario, Schulich School of Medicine and Dentistry
**Locations:** Main campus – London, Ontario
Windsor campus – Windsor, Ontario

**Unique Programs:** SWOMEN – Southwestern Ontario Medical Education Network

Appendix F - Part 2: Health Human Resources (cont'd)

**Background:**

In 1997 SWORM – South-western Ontario Rural Medicine Education , Research and Development Unit was formed to coordinate rural medical education at Western and respond to the needs of Southwestern Ontario – a region with a growing shortage of physicians in small to mid-sized communities. This trend was evident across Canada and worldwide.

From SWORM developed SWORRM and eventually SWOMEN the program we know today in Southwestern Ontario. Over the past ten years, the success of SWOMEN with first-class rural and regional training opportunities for students and residents has constituted as a full, four-year MD program that has been developed for The Schulich School of Medicine & Dentistry – Windsor Program. SWOMEN is recognized as a national leader in the delivery of distributed medical education. SWOMEN looks to the future in bringing together not only physicians but also other health professionals through inter-professional health education, research and practice throughout Southwestern Ontario.

Annual teaching retreats have been hosted since 2001 and have grown to become one of North America's largest faculty development retreats for distributed medical education programs.

At the end of first year medical studies, all undergraduate medical students participate in a mandatory one-week placement in one of more than 30 participating communities in Southwestern Ontario. Students shadow family physicians and learn with their typical work day encompasses. They also experience a wide variety of medical specialties and practices. This program exposes students to living and working in a rural or regional community, inspiring students to practice in a small or mid-sized community in Southwestern Ontario.

All third-year students must complete a minimum of one month in a rural or regional placement and final year medical students have the opportunity to experience rural regional settings by choosing clinical electives in partner communities.

At the postgraduate medical education level, the major specialty programs include rotations in community settings on a regular basis outside of London. Core specialties in SWOMEN communities are Anesthesia, General Surgery, Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics and Gynaecology, Paediatrics and Psychiatry.

Another program unique to the Schulich School of Medicine & Dentistry is MedQUEST, which was designed to provide first-and second-year medical students with a unique clinical-teaching experience within participating SWOMEN communities. This is a dynamic elective allowing students to showcase their skills and knowledge to hundreds of rural and regional secondary school students (grades 10 and 11) through a one-week comprehensive education program. Early exposure to the practice of medicine can help influence student career plans, ultimately increasing their chance of successfully entering medical school or other allied health professions.

Appendix F - Part 2: Health Human Resources (cont'd)

**Program Statistics for the Past Ten Years in Southwestern Ontario:**

- Since 1998, 101 Schulich Medicine graduates have been recruited to are currently practicing in Southwestern Ontario
- More than 350 rural and regional faculty members have been recruited and developed an infrastructure for medical learners and preceptors
- First year medical class sizes:
  - 1997 – 96 students
  - 2008 – 147 students (including 24 Windsor based students)
- 1,015 residents have completed a total of 1,626 postgraduate training months
- 207 undergraduate medical students have completed a total of 254 pre-clerkship elective training months
- 806 third year medical students have completed a total of 1,888.5 clerkship rotations
- 250 third and fourth year medical students have completed a total of 279 elective training months
- 1,479 first year medical students have participated in the Discovery Week Program
- Summer Studentship Program has provided 70 medical students with rural health research opportunities combined with clinical experience
- 90 medical students have been sponsored in attending the Society for Rural Physicians of Canada Conference
- 2,438 medical students and residents have participated in SWOMEN training programs in small or midsized communities in Southwestern Ontario.

All information obtained from the University of Western Ontario – Southwestern Ontario Medical Education Network, Schulich School of Medicine and Dentistry *'A Model of Excellence – Summary Report'*,

**3) What are the Ministry of Health and Long-Term Care/Others Doing to Address Issues:**

**3A) Introduction of Family Health Teams:**

150 Family Health Teams have been created in Ontario since April 2005. Family Health Teams (FHT) provide comprehensive primary health care services through multidisciplinary teams of doctors, nurses, nurse practitioners and other health care professionals as determined by local needs. Not only do FHTs provide a continuum of care, they have become one of the most sought after practice models for the practice of family medicine and are proving to be a beneficial physician recruitment and retention tool.

**3B) New Roles in Health Care:**

**Physician Assistants (PAs)**

HealthForceOntario has introduced the Physician Assistant Program which assists supervising physicians in delivering medical services within patient care teams in various settings.

Appendix F - Part 2: Health Human Resources (cont'd)

**Clinical Specialist Radiation Therapist**

The Clinical Specialist Radiation Therapist (CSRT) is a medical radiation technologist (radiation therapist) with advanced clinical competencies. The CSRT works in collaboration with radiation oncologists, specialist nurses, medical physicists and other team members to ensure safe and optimal patient outcomes in radiation treatment cancer care settings

**Anesthesia Assistant**

The Anesthesia Assistant is a health professional who participates in the care of the stable surgical patient during anesthesia, under medical directives and under the supervision of the anesthesiologist.

**Nurse Performed Flexible Sigmidoscopy**

A registered nurse with extended specialized education in anatomy, physiology and pathophysiology who works with a physician to perform flexible sigmoidoscopies (i.e., diagnostic procedure used to screen for abnormalities in the lower third of the colon). These individuals can support Ontario's colon cancer screening initiative.

**Surgical First Assist**

Works with the surgeon and the rest of the operating room team to ensure the safe outcome for a surgical patient before, during and after surgery. A registered nurse can perform this role with an additional certification in surgical first assistance.

**3C) Nurse Practitioner Led Clinics:**

As part of the Family Health Care Strategy, it is planned to establish, over the next four years, 25 Nurse Practitioner-Led (NP-Led) Clinics. This new model of care will see nurse practitioners working in collaboration with doctors and other health care providers to provide health care to many Ontarians who previously did not have a primary health care provider. These clinics will not only focus on providing better care to patients, but also will work with patients to educate them about disease prevention and health promotion. The clinics will also help patients navigate the health system – connecting them, if needed, with other service providers and with community-based programs and services. The 25 new clinics will be awarded in two waves.

**3D) Increase in the supply of physicians working in Ontario**

**Fast Facts:**

- record number of new licenses issued in 2008 – 3,467 (pg 13)
- overall supply of physicians in practice is up 16% since 1997 from 20,133 to 23,266 (Ontario) (pg 13)
- Since 2002, the College of Physicians and Surgeons of Ontario (CPSO) Registration through Practice Assessment Committee (RPA) has approved 1,061 practice certificates (pg 13)
- In 2007 – 290 RPA certificates (mostly restricted certificates) were approved (pg 13)

Above information cited from the Annual Report 2007 – College of Physicians and Surgeons of Ontario

- By comparison, in 1995 the Registration Committee approved only 25 certificates (pg 2)

Appendix F - Part 2: Health Human Resources (cont'd)

- 10th consecutive year for CPSO registration increase (3,279) for new certificates and postgraduate certificates issued in Ontario – more than doubling over that time (1997 – 1,637 and 2007 – 3,279) (pg 2)

Above information cited from the Annual Report 2007 – College of Physicians and Surgeons of Ontario
**Key Factors in increased certificate issuance:**

**Ontario and Canadian Graduates:**

- increases in Canadian medical school enrolment and residency positions
- continuing inflow of Canadian physicians from other provinces
- repatriated Ontario physicians
- Ontario government recruitment and incentive strategies
- Positive effect of new CPSO registration policies

Above information cited from the College of Physicians and Surgeons of Ontario – 2007 Registration Statistics and Survey Findings "Reaping the Rewards – Striving for Sustainability"

**3E) Primary Care Models:**

- Yearly from 2000 to 2006, new primary care models were introduced in Ontario
- Until 2002/2003 most primary care physicians continued to practice in a Fee for Service (solo) setting.
- Currently there are 12 different Primary Care practice payment models available to family physicians.
- Under the most recently introduced models, physicians can earn incentives for meeting specific primary care targets for their rostered patients, along with offering after hours care to steer patients away from emergency room visits.

**3F) Schools of Medicine:**

- Between 2002 and 2006 there was a 22% increase in the medical school seats nation wide
- By 2011 the government will have created 260 new first year medical school space – a 38% increase since 2004/2005
- Ontario's six medical schools will welcome 952 first year students when all of the new (100) seats are added by September 2011
- New spaces are being created at five medical schools and nine locations
- Province is investing $35M over three years to help medical schools build specialized rooms, labs and equipment they need to train future physicians
- Between 2004 and 2008 the government increased the number of family medicine residency positions by 75% or 151 positions. As of 2008, 330 additional family physicians graduated as a result.
- A further 170 family medicine residency positions will take place between 2008 and 2014

Above information cited from Ministry of Training, Colleges and Universities – "Ontario Boosts Medical School Spaces Across Province" – May 21, 2009

Appendix F - Part 2: Health Human Resources (cont'd)

**3G) Number of Training and Assessment Positions for International Medical Graduates (IMGs)**

**Fast Facts:**

- Over the past 10 years the number of certificates issues to International Medical Graduates (IMGs) has nearly tripled
- Of the 290 practice certificates issued by the CPSO's Registration Committee, 84% were for IMGs
- For the 4th straight year, more certificates were issued to IMGs than to Ontario graduates

Above information cited from the Annual Report 2007 – College of Physicians and Surgeons of Ontario

**Key Factors in Increased Certificate Issuance:**

**IMGs**:
- Positive effect of new CPSO registration policies
- More Ministry of Health-funded IMG residency positions
- Opening up of both iterations of CaRMS match
- Ontario government marketing and recruitment efforts, e.g. HealthForceOntario
- More clinical fellows (i.e. international specialists doing "topping-off" training
- Increased inflow of qualified IMGs for other provinces

Above information cited from the College of Physicians and Surgeons of Ontario – 2007 Registration Statistics and Survey Findings "Reaping the Rewards – Striving for Sustainability"

**4) On Future Plans/Solutions:**

The development of a LHIN-wide Health Human Resource plan is required. First steps in this process will take place at the Erie St. Clair LHIN Recruiter's Forum, tentatively scheduled for January, 2010. Plan will include all health professionals and will prioritize the focus of recruitment within the areas identified.

**4B) Predictive Models** – has been omitted as per the above.

**4C) Coordinate Our Education System with the Health Care System to Increase the Supply of Health Care Professionals:**

**Synopsis of Best Practices in Southwestern Ontario:**

**MedQUEST**
- Providing inter-professional healthcare learning opportunities in Southwestern Ontario since 2005.
- Program is only available in Southwestern Ontario and has sites in Sarnia, Leamington and Chatham-Kent in Erie St. Clair.
- With almost 70% of participants calling rural communities home. Students from rural/regional backgrounds are more likely to return to practice in their hometowns.
- One week summer program available for Grade 10 and 11 students
- Provides students with realistic experiences in the field of medicine using state-of-the-art advanced simulator training, peer workshops and the opportunity to watch physicians/nurses in a clinical setting.

Appendix F - Part 2: Health Human Resources (cont'd)

**HealthKick Huron**

- Research projects related to this program are being presented nationally and internationally.
- At this time not aware of any other Canadian program delivering this type of camp in the very communities it is designed to serve.
- Program uses a multi-pronged approach to encourage healthcare professionals to live and work in rural Ontario.
- Based in Seaforth, Ontario and co-located with the Huron Community Family Health Team and the Gateway Rural Research Institute
- Project has five (5) strategies:
  - Rural healthcare Exploration
  - Rural Healthcare Work Placements
  - Rural Healthcare Training Programs
  - Rural Healthcare Experience
  - Community Engagement
- Objectives:
  - Educate rural youth about career opportunities in rural healthcare
  - Provide work experience for rural youth at local healthcare employers
  - Improve access to skills development & upgrading for the rural healthcare workforce
  - Engage and educate the community of their possible roles in healthcare attraction and retention to enhance the communities' success
  - Partner with various academic training programs to provide rural centric electives
  - Mobilize a 'best practices' recruitment and retention model to enhance rural Ontario's quality of life and economic viability

**Conclusion** – early and realistic exposure is an essential step in healthcare occupational recruitment. A formal partnership must be developed between the healthcare industry and the education system to promote and encourage healthcare careers of all types.

**Inter-professional Care**

- Inter-professional care is the provision of comprehensive health services to patients by multiple health care professionals who work collaboratively to deliver the best quality of care in every healthcare setting.
- It encompasses partnership, collaboration and a multi-disciplinary approach to enhancing care outcomes and is the cornerstone of the HealthForceOntario strategy.
- The need for inter-professional care resides in:
  - Trend data indicates Ontario faces a significant reduction in its health human resource workforce by 2010
  - Unless new ways of practicing health care are introduced, Ontario will face a significant shortage of health care workers and Ontarians will risk receiving sub-optimal care
  - The education system needs to prepare current and future providers to work in multi-disciplinary, collaborative, team-based models

Appendix F - Part 2: Health Human Resources (cont'd)

  - Inter-professional care can help improve patient care while increasing provider satisfaction with a respectful and collaborative environment.
- Inter-professional Care/Education Fund (ICEF) is a funding program that will provide support to innovative health education or health care projects that foster and build inter-professional teams.
- ICEP is jointly administered by the Ministry of Health and Long-Term Care and the Ministry of Training, Colleges and Universities.
- Objectives:
  - Educate, foster and build IPC teams across health care delivery settings
  - Develop mechanism in health education and health care delivery settings that help to integrate the practice of ICP in Ontario.

**4E) HHR Strategy that is more proactive than reactive:**

**Human Resources for Health – Physician Supply Forecast: Better Than Peering Into A Crystal Ball?**

**Synopsis:**

There are four main forecasting approaches:
- Supply projection approach defines the necessary inflow to maintain or to reach in the future an arbitrary predefined level of service offer.
- Demand-based approach estimates the quantity of health care services used by the population in the future to project physician requirements.
- Needs-based approach involves defining and predicting health care deficits so that they can be addressed by an adequate workforce.
- Benchmarking health systems with similar populations and health profiles is the last approach.

The above different methods can be combined to perform a gap analysis. However, static models are often used and their uncertainty is not assessed; valid and comprehensive data to feed into the models is lacking; and a rapidly evolving environment affects the likelihood of projection scenarios.

There is no single accepted approach to forecasting physician requirements. The value of projections lies in their utility in identifying the current and emerging trends to which policy-makers need to respond. A genuine gap analysis, an effective monitoring of key parameters and comprehensive workforce planning are key elements to improving the usefulness of physician supply projections.

An in-depth evaluation of the current situation in human resources for health includes an assessment of the current stock of physicians and other health care workers; its composition, gender and age structure; its geographical distribution and its deployment between curative and preventative sectors but also between health care activities and other professional activities (teaching, research, administration, etc); its activity profile (productivity levels) and working time; its forecasted evolution according to various scenarios; an analysis of the dynamics of the health labour market in terms of entries (including from national training and migration) and exits (deaths, age-related retirement); the internal mobility between the public and private sector, and between the different health care levels (primary care, general hospitals and highly specialized training hospitals).

Appendix F - Part 2: Health Human Resources (cont'd)

It is also crucial to anticipate the implications of adopting emerging technologies (e-health and innovative treatments including new medicines or day surgeries) and redefining the roles of all available health professionals (distribution of tasks, substitution and delegation). Decision-makers must also review professionals' working conditions and their remuneration (fee-for-service or not) as well as incentives and regulations adopted to attract and retain health professionals in the health sector. How quality of practice would be monitored and ensured is also an important issue to consider. Those choices would have to be validated by the various stakeholders (at the national and regional levels; at the levels of education and training as well as work regulations for professionals) to ensure a reasonable degree of feasibility in their implementation.

There is no accepted approach to forecasting physician requirements. Each of the approaches relies on a number of assumptions and limitations that should be acknowledged because of their large influence on the model outputs.

The value of projections lies not in their ability to get the numbers exactly right but in their utility in identifying the current and emerging trends to which policy-makers need to respond. The requirements for health providers are endogenously determined through the political or social choices that underlie the health care system. Only where the social and political choices about the access to and delivery of care are explicit, can scientific methods be used systematically to derive requirements for health care providers in a particular population. However, responsive planning for the future medical workforce remains necessary, as rapid changes are taking place in the supply of medical practitioners and the requirement for their services. Finding this balance requires continuous monitoring, careful choices given the realities of the country, and the use of research evidence to ensure that population health needs are addressed effectively and efficiently. Flexibility, relevance and validity in planning require both ready access to timely information that is accurate and use of appropriate conceptual and analytical techniques.*

Above cited from Human Resources for Health - "Physician supply forecast: better than peering in a crystal ball?" by Dominique Roberfroid, Christian Leonard and Sabind Stordeur. Human Resources for Health 2009, 7:10, February 13, 2009

**General Information:**

**Practice Trends:**

- increasing proportion of female physicians within the overall physician population
- increasing proportion of female physicians in Family Medicine (32.1% in 2007 compared to 27.8% in 2000)
- younger physicians (predominantly female) who provide full-time primary care practice in group settings
- female physicians are more likely to obtain CFPC (College of Family Physicians of Canada) certification
- younger physicians work fewer hours
- younger physicians see fewer patients
- younger physicians are more likely to be accepting patients
- a slight increase was seen in the number of family doctors accepting patients over previous years

Appendix F - Part 2: Health Human Resources (cont'd)

**Erie St. Clair Primary Care Stats:**

Average age of primary care physicians across Ontario is 50.5 years.*
Average age of primary care physicians in Erie St. Clair is 54.5 years**
* Cited from CPSO 2007 Registration Statistics and Survey Findings "Reaping the Rewards – Striving for Sustainability"
** Cited from OPHRDC 2007 Data

**5) Summary of Key Support Documents:**

**Health Human Resource Issues - August 2009**

| Source | Issues |
|---|---|
| Health Force Ontario – Ontario's New Physician Recruitment and Retention Programs. | UAP (Underserviced Area Program)<br>• Program no longer working to attract physicians to Northern and rural communities – large number of communities are now able to receive funding under the UAP program and therefore the northern communities are unable to attract physicians.<br>• Program created inequities in southern Ontario as non-designated communities cannot compete with neighboring designate communities for return of service physicians<br>***** may affect the designation in the ESC LHIN communities***<br>Return of Service<br>• The number of specialist physicians that require placements outnumbers the available placements. This may lead to the expansion of this program in communities throughout Ontario with the exception of Greater Toronto and Ottawa. |
| College of Physicians and Surgeons of Ontario | E.D Wait times and ALC<br>Family Physicians are the key to reducing ED Wait Times and ALC<br>• Supports to physicians need to be in place in the community from other professionals such as access to diagnostics or labs<br>• Break down in information flow between hospitals and family physicians. Physicians do not receive information about patients in hospital<br>• Training , education and strategies to recruit and retain family physicians in the provision of ED services<br>• Policy, procedures and process that will lead to improvements in hospital and ED functioning and in care transitions.<br>Registering and Training of International Medical Graduates<br>• Training and registering of these physicians and surgeons involves a variety of organizations including college, medical schools, governments, etc, to ensure standards are not comprised |

Appendix F - Part 2: Health Human Resources (cont'd)

## Health Human Resource Issues - August 2009

| Source | Issues |
|---|---|
| Healthkick – A Community Approach to Rural Health Care Human Resources | Healthkick originated in Huron/Perth/Grey/Bruce because 74 % of RPN's were over age 50<br>Medquest<br>• Health Careers Exploration -One week summer program that introduces students from rural communities to health care professions<br>Georgian College<br>• Part time RPN program over 4 years that allows local residents and healthcare staff to upgrade their skills to become a RPN |
| Health Canada – Balancing Supply and Demand, Issue #8 | Primary Health Care Team<br>• Requires adequate supply of health professionals from various disciplines who are educated to work together in teams requires planning, recruitment, retention, and a change to licensure curriculum and clinical practice settings.<br>Nursing<br>• Shortage of nurses due to aging work force, high rates of attrition in some nursing programs and early retirements<br>• Many nurses hold part-time positions and would prefer to work full time<br>• Reduction in nurse leaders at the corporate level has reduced nurses' input into policy and allocation decisions. This trend leaves nurses feeling undervalued and leads to great stress and burnout.<br><br>Internationally Medical Graduates(IMG)<br>• Shortage of doctors is growing in Canada .<br>• Post graduate training is not well known in countries outside of the commonwealth<br>• Insufficient resources have created a backlog of IMG awaiting assessment and mediation<br>• Each time an IMG applies for licensure in a different province their credentials must be verified<br>• There is not database of licensable IMG"S so there is no means to track and locate IMG's who ware landed immigrants<br>• IMG's have a difficulty accessing information about the licensing process in different provinces<br>• The test of English as a foreign language and test of English as a second language lack the capacity to assess the use of English in a medical practice environment<br>• IMG's have been deemed eligible for practice in one jurisdiction and ineligible in others |

Appendix F - Part 2: Health Human Resources (cont'd)

## Health Human Resource Issues - August 2009

| Source | Issues |
|---|---|
| A Physician Human Resource Strategy for Canada – March 2006 | Education and Training – continued education for practicing physicians to meet the changing need of the population<br>Inter-professional Practice and Education – work with all health care providers as a team<br>Recruitment and Retention – lack of a concrete plan to recruit and retain physicians<br>Improve Licensure, Regulatory Issues and Liability – consistent licensing practices<br>Infrastructure and Technology – use of computers and up to date medical equipment available to physicians |
| IHSP II Physician HHR Status Report<br>Health Force Ontario | Average Age of Primary Care Physician across Ontario is 50.5 years<br>Average Age of Primary Care Physician in Erie St. Clair is 54.5 years<br>(CPSO 2007 Registration Statistics and Survey Findings) |
| Canadian Medical Association – More Doctors. More Care. A Promise Yet Unfulfilled<br>April 28, 2009 | • One third of Canadian physicians are over age 55 and most are not accepting new patients<br>• Aging population has increased the demand for health care professionals.<br>• 27% of international medical graduates are successful in obtaining a license to practice in Canada.(1,300 applied and only 350 were successful)<br>• 1,500 medical students study abroad,<br>• For every student accepted into a Canadian medical school 4 candidates are turned away<br>• Physicians who teach and mentor experience lost productivity in their practice and receive little or no remuneration.<br>• 25% of all physicians will experience some form of mental health challenge |
| Canadian Nurses Association<br>Review of the 10 year Plan to Strengthen Health Care<br>May 27, 2008 | • Average age of nurses is rising and many are eligible for retirement<br>• Nurses spend a great amount of time doing non-nursing duties that could be performed by support staff ex/ housekeeping duties or RPN duties–<br>• SCO Health Services in Ottawa found 30% of the work of registered nurses did not require their advanced level of skills or knowledge<br>• Resources such as technology are not used effectively. |
| Canadian Healthcare Association<br>A progress on Ontario's Health Human Resource Initiatives<br>December 2005 | • Colleges and Universities have difficulty expanding nursing programs due to a lack of faculty. ( Ontario reached its enrollment in nursing in 2007/08)<br>• Challenges to provide care to an aging population and to groups within the population such as Aboriginal, Francophone, rural and remote communities. |

Appendix F - Part 2: Health Human Resources (cont'd)

## ESC LHIN Health and Human Resources Conclusions

It is clear from the information presented in this section of the report, that the Erie St Clair LHIN continues to experience a number of challenges related to health and human resources (HHR). Additional work is required to improve this area.

Key Challenges:

- Chronic shortages of General Practitioners and Specialists
- Shortages of Registered Nurses (RNs), Occupational Therapists (OT), Physiotherapists (PTs), and Speech Pathologists expected to deteriorate
- Ongoing concerns regarding recruitment and retention
- Competition for scarce health and human resources
- Increased demand for skilled health care workers exceeding supply
- Aging health care workforce
- Increasingly transient workforce
- Education and training issues
- Need for improved collaboration, communications and information sharing

Future Directions:

- LHIN-wide coordination of recruitment and retention strategies/efforts
- Continued (increased) recruitment of international health professionals
- Expanded mentorship programs
- Introduction of new/expanded HHR roles (in high need areas)
- Collaborative HHR planning between hospitals
- e-Health solutions to improve management and information sharing
- Begin to address inequities in remuneration for same workers across the health care system
- Standardized curricula and training programs for non-regulated workers
- Better sharing and consolidating of education and training resources
- More focus on system level issues (planning and performance)
- Improved processes for informing consumers and providers about service availability and how to access them
- More coordinated/consolidated information management strategies
- Better link between HHR planning efforts and LHIN planning

# Surgical Advisory Network Proposed Plans

## Surgical – Anesthesia Assistant Enhancement Windsor/Essex Hôtel Dieu Grace Hospital

**PART 1:**

**1. What problems are we trying to solve and for which (sub) populations?**

| Problems: | (Sub or Priority) Population: |
|---|---|
| -Lack of funding for Anesthesia Assist role in the OR.<br>-Increase in anesthesia prep time of patient before anesthesia induction, resulting in increase OR room time<br>-No trained personnel available to relieve Anesthetist during long operative cases<br>-Potential loss of Anesthetists due to burn out and fatigue | -surgical patients requiring insertion of arterial lines, epidural catheters, treatments, prior to anesthesia induction |

**2. What are the system improvement goals (strategic - over the next 3 years)?**

Goals:
1. Improvement in efficacy of surgical time i.e. time needed to prepare patient for anesthesia induction
2. decrease number of OR cases cancelled due to no time left in elective block
3. Stabilize the number of Anesthetists within our LHIN

**3. What are the performance objectives & targets?**

| Performance Objectives: | Improvement Targets (actual measures): |
|---|---|
| 1. Increase OR volumes<br>2. Support the retention and recruitment of Anesthesia | a) System: Complete one additional case per day in OR;<br>b) Client Level: Reduced potential risk of sentinel events while temporarily unsupervised by Anesthesia |

**PART 2:**

**4. Does your submission have issues with any of the following that the LHIN should know of:**

a) Acute Care: increase access to timely surgery as increase efficiency in OR achieved
b) Post Acute Care: N/A
c) Primary Care: N/A
d) Health and Human Resources: Require 1.0 FTE for RT/ AA ( Respiratory Therapist/ Anesthesia Assist) ~ $101,200.00
e) Information Management/Systems: N/A
f) Other: N/A

**5. What is the impact (if any) of your proposed submission on the care continuum elements listed below?**

a) Emergency Department Volumes/Visits: No Impact
b) Acute Care Admissions: decrease LOS of patient pre-op (either inpatient or those waiting for surgery):
Anesthesia assistants assisted in orthopedic/ general/ thoracic /procedures.
Once regional anesthesia was established, the procedure started and the patient stabilized, the patient was monitored by an anesthetic assistant while the
Anesthesiologist prepared the next patient. In other centres, the use of anesthetic assistants resulted in a 33% increase in productivity allowing one additional joint procedure per day
c) Hospital Flow to Community: Reduced risk of sentinel events results in better health outcome for patients returning to the community.
d) LTC: N/A
e) Sub-Acute Care Teams: N/A

## Appendix F - Part 2: Surgical – Anesthesia Assistant Enhancement Windsor/Essex Hôtel Dieu Grace Hospital (cont'd)

**6. Assess the impact of the above directions on the following:**

a) The Patient/Client Experience:
Timely surgical intervention;

Access to service improves because other health professionals assist in the provision of anesthesia services thereby freeing up anesthesiologists to provide additional clinical and other services.

b) Quality Improvements/Health Outcomes:
Potential to increase patient safety. In the operating room, during preparation, induction of anesthesia and extubation, the assistant provides support to the anesthesiologist.
On the acute pain service, the nurse under the supervision of the anesthesiologist.
AA becomes an important resource to the unit staff thus improving the quality of care. In the pre-anesthetic clinic, systematic review and patient preparation by specially trained nursing staff and anesthesiologists will continue to reduce the possibility of ill-prepared patients and operating room cancellations.

c) Cost Effectiveness:

**PART 3:**

**7. Describe specific targets & actions for each priority (sub) population (annual 12 months and 90 days – action plan).**

**a) Annual (12 Month) Plan:**

| Main Objective(s) - milestones | Key Actions | Anticipated Impact (state as a measurement if possible) | Lead |
|---|---|---|---|
| Reduce room turnover time by 20% | Sustain AA role in OR | Increase OR volumes by 5 cases per week. | V. Walsh. |

**b) 90 Day Action Plan (where to start):**

| Main Objective(s) - milestones | Key Actions | Anticipated Impact (state as a measurement if possible) | Lead |
|---|---|---|---|
| OR room turnover decrease by 5% | Implement AA function | Increase OR volume by 2 cases per week | V. Walsh |

## Surgical – Joint Clinic Windsor/Essex Hôtel Dieu Grace Hospital

**PART 1:**

**1. What problems are we trying to solve & for which (sub) populations?**

| Problems: | (Sub or Priority) Population: |
|---|---|
| - ALOS > ELOS for surgical patients | - Elective Joint Replacement patients |

**2. What are the system improvement goals (strategic - over the next 3 years)?**

Goals:
1. Reduction in Surgical Patients LOS and ALC days
2. Prepare each surgical patient for joint replacement discharge planning

## Appendix F - Part 2: Surgical –Joint Clinic Windsor/Essex Hôtel Dieu Grace Hospital (cont'd)

**3. What are the performance objectives & targets?**

| Performance Objectives: | Improvement Targets (actual measures): |
|---|---|
| 1. Reduce LOS of Total Joint patients<br>2. Reduce ALC days of Total Joint Patients<br>. | a) System: Maintain a balance between ELOS and ALOS;<br>b) Client Level: Patients have appropriate knowledge of discharge destination at time of surgery |

**PART 2:**

**4. Does your submission have issues with any of the following that the LHIN should know of:**

a) Acute Care: Potential reduction of Acute care LOS
b) Post Acute Care: Better health outcomes due to prepared patients
c) Primary Care: none
d) Health and Human Resources: Increase Social Work/Discharge Planner by 0.4 FTE
e) Information Management/Systems:
f) Other

**5. What is the impact (if any) of your proposed submission on the care continuum elements listed below?**

a) Emergency Department Volumes/Visits:
b) Acute Care Admissions: decrease Length of Stay (LOS) of patient pre-op (either inpatient or those waiting for surgery
c) Hospital Flow to Community: Improves communication of discharge destination and decrease in LOS and ALC days
d) LTC:
e) Sub-Acute Care Teams:

**6. Assess the impact of the above directions on the following:**

a) The Patient/Client Experience: Patient will have discharge destination plan at the time of surgery b) Quality Improvements/Health Outcomes: Well informed patient will have increase in patient satisfaction and a decreased impact in hospital LOS

c) Cost Effectiveness: decrease in conservable days.

**PART 3:**

**7. Describe specific targets & actions for each priority (sub) population (annual 12 months and 90 days – action plan).**

**a) Annual (12 Month) Plan:**

| Main Objective(s) - milestones | Key Actions | Anticipated Impact (state as a measurement if possible) | Lead |
|---|---|---|---|
| Reduction of LOS of total joint replacement patients | Ensure appropriate and timely Social Work/Discharge Planner intervention | 100% of patients with a Blaylock score ≥ 10 will receive a pre-admission discharge intervention. | T.Morris |

**b) 90 Day Action Plan (where to start):**

| Main Objective(s) - milestones | Key Actions | Anticipated Impact (state as a measurement if possible) | Lead |
|---|---|---|---|
| Decrease LOS by 1% | Redirect completed Blaylock screening tools with a score ≥ 10 to Social Work/discharge planner for intervention. | Reduction of post-op LOS by 1% | T. Morris/ V.Walsh |

Appendix F - Part 2: ESC LHIN IHSP2 Themed Reports (cont'd)

## Surgical – Comprehensive Spine Centre Windsor/Essex Hôtel Dieu Grace Hospital

**PART 1:**

**1. What problems are we trying to solve & for which (sub) populations?**

| Problems: | (Sub or Priority) Population: |
|---|---|
| - inappropriate mechanical spine patient referrals to neurosurgeons and orthopedic surgeon | - |
| Problems: | (Sub or Priority) Population: |
| Lengthy wait times (wait one) for clients with back pain to see surgeon. | - |

**2. What are the system improvement goals (strategic - over the next 3 years)?**

Goals:
1. educate family physicians about criteria for appropriate referral to surgeons
2. develop a streamlined referral and assessment and treatment process for patients with mechanical spine injuries
3. minimize surgeon wait times (wait 1) for patients who suffer from chronic back pain

**3. What are the performance objectives & targets?**

| Performance Objectives: | Improvement Targets (actual measures): |
|---|---|
| NA | a) System:<br><br>b) Client Level: |

**PART 2:**

**4. Does your submission have issues with any of the following that the LHIN should know of:**

a) Acute Care:

b) Post Acute Care:

c) Primary Care:

Currently clients who suffer from back pain are referred to the offices of neurosurgeons (Windsor Essex) and/or orthopedic surgeons. Wait times to see these specialists often exceeds 12 months or more. Only 8 -10% of clients referred to the surgeon's office are actual candidates for back surgery.

Surgeons do not want to see all clients with back pain. They only want to see those that meet the criteria for surgery. Those suffering from mechanical back injury/pain need access to assessment and treatment much earlier.

d) Health and Human Resources:

The vision is to have streamlined access and referral process to all of the disciplines who are able to help clients with mechanical back injuries. A comprehensive spine centre would involve a nurse practitioner who would assess and triage all referrals (in consultation with a surgeon). Clients would be referred to the optimal professional group for follow-up including surgery if the client met the criteria.

e) Information Management/Systems:

f) Other

Appendix F - Part 2: Surgical – Comprehensive Spine Centre Windsor/Essex Hôtel Dieu Grace Hospital (cont'd)

**5. What is the impact (if any) of your proposed submission on the care continuum elements listed below?**

a) Emergency Department Volumes/Visits:
- Reduced emergency visits for chronic back pain

b) Acute Care Admissions:
- Reduced acute care admissions for chronic pain management

c) Hospital Flow to Community:
- Reduced wait time for community pain clinics – wait times growing

d) LTC:

e) Sub-Acute Care Teams:

**6. Assess the impact of the above directions on the following:**

a) The Patient/Client Experience:
- Timely access and treatment by a multidisciplinary team (physiotherapists, social work, pain management expertise, nurse practitioner, etc)
- Reduced client frustration and despair

b) Quality Improvements/Health Outcomes:
- Patients who suffer from back pain related to mechanical spine injury will achieve a higher level of functioning than currently is the case.

c) Cost Effectiveness:
- Reduced wait times
- Reduced lost work time injuries
- Keeps clients mobile and functioning thus reducing likelihood of other related illnesses/ailments (i.e. depression, chronic constipation, etc) that will further tax the health care system

**PART 3:**

**7. Describe specific targets & actions for each priority (sub) population (annual 12 months and 90 days – action plan).**
**a) Annual (12 Month) Plan:**

| Main Objective(s) - milestones | Key Actions | Anticipated Impact (state as a measurement if possible) | Lead |
|---|---|---|---|
| Within 3 months<br><br>Within in 6 months | Establish a model that will support a comprehensive spine centre<br><br>Implement Model | | |

**b) 90 Day Action Plan (where to start):**

| Main Objective(s) - milestones | Key Actions | Anticipated Impact (state as a measurement if possible) | Lead |
|---|---|---|---|
| Within 3 months | Establish a model that will support a comprehensive spine centre | | |

Appendix F - Part 2: ESC LHIN IHSP2 Themed Reports (cont'd)

## Surgical Windsor/Essex – Windsor Regional Radiology Information System

**PART 1:**

**1. What problems are we trying to solve and for which (sub) populations?**

| Problems: | (Sub or Priority) Population: |
|---|---|
| - All three Windsor/Essex (WE) Diagnostic Imaging (DI) Departments need to replace their RIS within two years<br>- WE share a regional PACS however with two disparate RIS systems (Cerner & McKesson)<br>- Pertinent data collection is manual & cumbersome | - All patients/clients referred to the hospitals for imaging services |

**2. What are the system improvement goals (strategic - over the next 3 years)?**

**Goals:**

1. Single regional workflow that will drive standardization of protocols and overall service delivery across all sites
2. Tight integration between the regional RIS and regional PACS and with other disparate Hospital systems
3. Opportunity to centralize booking of procedures to optimize timely access to imaging services across WE and the LHIN (where underutilized capacity may exist)
4. Enhanced data measurement and reporting to drive continuous service improvements
5. Track/Trend utilization of imaging services to support evidence-based practice

**3. What are the performance objectives and targets?**

| Performance Objectives (should be measurable): | Improvement Targets: |
|---|---|
| 1. Timely access for patients/clients<br>2. Timely diagnostic report to referring Physicians<br>3. Patient/Client Satisfaction<br>4. Evidence-base utilization of imaging Services<br>5. Minimize radiation dose | a) **System:**<br>- CT/MRI Wait time at or below provincial benchmark<br>- Modality/procedure specific report turnaround time<br>- Reduced wait time from referral to booking<br>b) **Client Level:**<br>- Improved Patient/Client Satisfaction (timeliness of appointment and overall service)<br>- Least radiation dose possible |

## Appendix F - Part 2: Surgical Windsor/Essex – Windsor Regional Radiology Information System

**PART 2:**

**4. From a system navigation sense, how do the above directions fit (or have issues) with the following:**

a) **Acute Care:**
Patients/Clients will know what to expect in terms of how quickly the procedure/therapy can be booked, details regarding procedure/therapy preparation and when they can expect their referring physician to have the diagnostic report upon which he/she can base treatment and care

b) **Post Acute Care:**
Patients/Clients will know what to expect in terms of how quickly the procedure/therapy can be booked, details regarding procedure/therapy preparation and when they can expect their referring physician to have the diagnostic report upon which he/she can base treatment and care

c) **Primary Care:**
Regardless of procedure/therapy location, protocols and interpretation quality will be standardized (as much as possible). Referring physicians will have a direct link to medical imaging booking across the city or LHIN, with all resources utilized through a single point of contact for booking and results. The process of booking and preparing a patient for an exam will be greatly simplified which should realize efficiencies in the physician's offices.

d) **Health and Human Resources:**
Performance to targets requires having the available trained human resources to support the various modalities. Partnerships with the University and College will be important in order to support educational/refresher requirements. Establishing a robust service level agreement with practicing Radiologists is also key to support target performance.

e) **Information Management/Systems:**
Diagnostic Imaging relies heavily on information systems to support key functions of the Department. The Radiology Information System is an operational cornerstone for the provision of imaging services.

f) **Other:** N/A

**5. What is the impact (if any) of the above directions on the care continuum elements listed below?**

a) **Emergency Department Volumes/Visits:**
Timely ordering of procedures/therapies and turnaround of diagnostic reports supports timely delivery of appropriate care to patients/clients

b) **Acute Care Admissions:**
Timely ordering of procedures/therapies and turnaround of diagnostic reports supports timely delivery of appropriate care to patients/clients

c) **Hospital Flow to Community:**
Improvement in diagnostic procedure flow within the hospitals will drive out waste and allow for growth using existing resources. Timely ordering of procedures/therapies and turnaround of diagnostic reports prior to discharge will minimize delay in discharge and inform any necessary discharge treatment or follow-up care.

d) **LTC:** N/A

e) **Sub-Acute Care Teams:** N/A

## Appendix F - Part 2: Surgical Windsor/Essex – Windsor Regional Radiology Information System

**6. Assess the impact of the above directions on the following:**

a) **The Patient/Client Experience:**
Patients/Clients will know what to expect in terms of how quickly the procedure/therapy can be booked, details regarding procedure/therapy preparation and when they can expect their referring physician to have the diagnostic report upon which he/she can base treatment and care. The ability to book appointments for patients while they are still in the Physicians office will limit subsequent phone calls to confirm appointment and procedure preparation.

b) **Quality Improvements/Health Outcomes:**
One scheduling data base will assist with balancing utilization, eliminating repeat and dual Bookings resulting in a much simpler process for patients (only one place for information, standard formats and procedure preparation. The variability in the process currently with 3 different providers is complex for patients to navigate. Standardization of protocols and overall service delivery will ensure the delivery of a qualitative diagnostic report that will inform future treatment and care for the patient/client.

c) **Cost Effectiveness:**
Cost-sharing in a capital acquisition of this magnitude ($1.4 million) allows for the availability of a robust Information system leveraging maximum functionality across WE at the least price. Service contract costs will also be shared. Final Vendor contract language will include the opportunity for Chatham Kent and Bluewater Health to be added to the contract at a later date if they so choose.

**PART 3:**

**7. Describe specific targets and actions for each priority (sub) population (annual 12 months and 90 days - action plan).**

**a) Annual (12 Month) Plan:**

| Target (milestone) | Key Actions | Anticipated Impact | Lead |
|---|---|---|---|
| Full implementation 8 months post signing of final contract | To be determined based on signing of final contract | | |

**b) 90 Day Action Plan (where to start):**

| Target (milestone) | Key Actions | Anticipated Impact | Lead |
|---|---|---|---|
| End December 2009<br><br>January 2010 | • Signed Purchase Order (all three WE Hospitals)<br>• Establish Project Manager & Implementation Team and finalize timelines | | Claudia<br><br>RIS Steering Committee |

Appendix F - Part 2: ESC LHIN IHSP2 Themed Reports (cont'd)

## Surgical Chatham-Kent

**PART 1:**

**1. What problems are we trying to solve & for which (sub) populations?**

| Problems: | (Sub or Priority) Population: |
|---|---|
| 1. In order to provide evidence based care; present practice must be continuously audited for quality. This provides the data for effective decision making. There is no available funding to support these expected initiatives | 1. All clinical and administrative practices. |
| 2. The unsustainability of providing multiple surgical specialties in a mid/small sized community hospital. | 2. Other acute surgical care sites within ESCLHIN. |
| 3. The lack of capital (one time) funding for acute pain management. | 3. All admitted post-operative surgical patients requiring continuous acute pain management |

**2. What are the system improvement goals (strategic - over the next 3 years)?**

| Goals: |
|---|
| 1. Implementation and evaluation of best practice for all clinical and administrative that require quality decision making. |
| 2. Meeting the standard for acute pain management |

**3. What are the performance objectives & targets?**

| Performance Objectives: | Improvement Targets (actual measures): |
|---|---|
| 1a) . Minimize / eliminate error in decision making that result from lack of root cause analysis. | a) System: Quality decision making. |
| 1b) . Reduce cost resulting from error and redoing. | |
| 2. Meet standard of pain management. | b) Client Level: Improved patient outcomes at a lower cost. |

**PART 2:**

**4. Does your submission have issues with any of the following that the LHIN should know of:**

a) Acute Care: Has the potential to impact all aspects of the care delivery system.

b) Post Acute Care: Has the potential to impact positively on services such as; CCAC, long term care, rehab beds.

c) Primary Care: Could identify potential for increased primary care screening programs.

d) Health and Human Resources: Improved quality outcomes that potentially assist medical manpower recruitment initiatives (anaesthesia, otolaryngology, gynecology, and orthopedics).

e) Information Management/Systems: A committed resource facilitates the accuracy of data quality.

f) Other Quality monitoring and consistent triggers used by all reporting agencies and the funding for the resources required for this reporting.

## Appendix F - Part 2: Surgical Chatham-Kent: (cont'd)

**5. What is the impact (if any) of your proposed submission on the care continuum elements listed below?**

a) Emergency Department Volumes/Visits: Potential to divert inappropriate visits to most appropriate access point (patients presently accessing ER, can be addresses in an ambulatory, scheduled environment).
b) Acute Care Admissions: Addresses appropriateness of admission and care delivery model. Reduces costs associated with error and re-do.
c) Hospital Flow to Community:
d) LTC:
e) Sub-Acute Care Teams:

**6. Assess the impact of the above directions on the following:**

a) The Patient/Client Experience: Patients experience care delivered within the context of evidence based. Risks to care are identified.

b) Quality Improvements/Health Outcomes: The process of auditing, analyzing and re-evaluating outcomes of care is significantly absent in most systems. The funding for a committed resource to these activities is well documented in the literature will optimize quality patient outcomes.

c) Cost Effectiveness: It is also well documented that quality outcomes impact positively cost effectiveness.

**PART 3:**

**7. Describe specific targets & actions for each priority (sub)**

**a) Annual (12 Month) Plan:**

| Main Objective(s) - milestones | Key Actions | Anticipated Impact (state as a measurement if possible) | Lead |
|---|---|---|---|
| 1. Implement quality auditing process. | a) Recruit resource to lead and co-ordinate auditing process.<br>b) Identify issues of high risk, high problem, and high volume for analysis.<br>c) Determine quality initiative required to improve process.<br>d) Document impact of improvements/findings. | a) Measure quality impact. | Jamie Clark Program Director, Surgery |

**b) 90 Day Action Plan (where to start):**

| Main Objective(s) – milestones | Key Actions | Anticipated Impact (state as a measurement if possible) | Lead |
|---|---|---|---|
| 1. Obtain 1 FTE to provide auditing and analysis for systems quality practice. | | 1. Hire candidate. | Jamie Clark Program Director, Surgery |

Appendix F - Part 2: ESC LHIN IHSP2 Themed Reports (cont'd)

## Surgical Sarnia/Lambton – Integrated Cancer Program, Bluewater Health

**PART 1:**

**1. What problems are we trying to solve & for which (sub) populations?**

| Problems: | (Sub or Priority) Population: |
|---|---|
| 1. Lack of integrated cancer program in Sarnia – Lambton.<br>2. Pockets of quality cancer care being provided at BWH but a coordinated comprehensive direction have not been planned.<br>- | - Patients that require diagnostic, surgical, systemic and palliative cancer treatment or follow up. |

**2. What are the system improvement goals (strategic - over the next 3 years)?**

Goals:
1. Decrease the number of cancer surgeries going out of county.
2. Improve process/flow of diagnostic cancer services to surgical intervention.
3. Develop a plan for community cancer care including hospital care with local community partners and resources.
4. Analyze current hospital cancer programs and coordinate a patient driven program providing cancer care across the continuum.

**3. What are the performance objectives & targets?**

| Performance Objectives: | Improvement Targets (actual measures): |
|---|---|
| 1. Repatriate from London cancer surgery patients with focus on gastrointestinal, breast, genitourinary, and lung. | 100 patients to be repatriated per year. |
| 2. Increased diagnostic interventions | Increase in number of sentinel lymph nodes biopsies by 10 within one year of process implementation. |
| 3. Development of flow map to identify "bottlenecks" areas of improvement in hospital cancer care and in the community. | Cancer care pathway developed and adopted by service providers across program and in community by October 2010. |

**PART 2:**

**4. Does your submission have issues with any of the following that the LHIN should know of:**

a) Acute Care:
Possible issues around base target calculation for breast, colon and prostate surgeries. Number of these surgeries are being referred out of county for surgical care. Lambton residents are being referred back to BWH for systemic treatment.

b) Post Acute Care:

c) Primary Care:

d) Health and Human Resources:
We have recruited a new General Surgeon and have available to provide care.

e) Information Management/Systems:

f) Other

Appendix F - Part 2: Surgical Sarnia/Lambton – Integrated Cancer Centre, Bluewater Health (cont'd)

**5. What is the impact (if any) of your proposed submission on the care continuum elements listed below?**

a) Emergency Department Volumes/Visits: nil
b) Acute Care Admissions: Better coordinated plan of care.
c) Hospital Flow to Community: Better coordinated plan of care.
d) LTC:
e) Sub-Acute Care Teams: Better management of symptoms and treatments

**6. Assess the impact of the above directions on the following:**

a) The Patient/Client Experience:
b) Better patient experience due to timely organized care.
c) Quality Improvements/Health Outcomes:
Patients are cared for in their communities and not required to travel distance for follow up or treatments.
d) Cost Effectiveness: Savings realized for the health care system bringing care back into community hospital rather than a teaching/tertiary hospital.
e) Savings for the patient as they are not required to travel a minimum of 1 hour to receive their cancer surgery and then follow up care or treatments.

**PART 3:**

**7. Describe specific targets & actions for each priority (sub) population (annual 12 months and 90 days – action plan).**

**a) Annual (12 Month) Plan:**

| Main Objective(s) - milestones | Key Actions | Anticipated Impact (state as a measurement if possible) | Lead |
|---|---|---|---|
| 1. Evaluate current processes in place.<br>2. Work key stakeholders to establish a comprehensive BPcancer program.<br>3. Implement program.<br>4. Evaluate program. | | | Steering committee |

**b) 90 Day Action Plan (where to start):**

| Main Objective(s) - milestones | Key Actions | Anticipated Impact (state as a measurement if possible) | Lead |
|---|---|---|---|
| 1. Hire a project coordinator to assess current status.<br>2. Data collection and market analysis.<br>3. Enlist stakeholders in project with development of steering committee.<br>4. Establish a physician champion. | | Jan/10<br>Feb/10<br>Jan/10<br>January/10 | Surgical Program Committee<br>Steering Committee |

Appendix F - Part 2: ESC LHIN IHSP2 Themed Reports (cont'd)

## Surgical – Bone, Joint & Hip Sarnia/Lambton – Bluewater Health

**PART 1:**

**1. What problems are we trying to solve & for which (sub) populations?**

| Problems: | (Sub or Priority) Population: |
|---|---|
| -Postoperative fractured hip patients having limited access to rehab<br>-Fractured hip patients delayed for surgery due to pre-fall use of plavis and coumadin<br>-Causes of fall not addressed<br>-Osteoporosis risk and care not being addressed<br>-Delirium post falls not being assessed consistently and lack of measures to address delirium. | -seniors who live at home<br>-their families who support them |

**2. What are the system improvement goals (strategic - over the next 3 years)?**

| Goals: |
|---|
| 1.Creating and implementation of BJHN and Safer Healthcare Ontario care plan for fractured hip patients at Bluewater Health<br>2.Creation of electronic fractured hip care map that will begin in Emergency, carry through inpatient surgery and then to rehab<br>3. Education of nursing and medical staff to consistently assess for delirium risk and delirium.<br>4.Development of best practice pre-developed physician orders for delirium<br>5. Development of best practice osteoporosis strategy.<br>6. Patient and family education tool to aid both to navigate the system upon a fractured hip occurrence.<br>7. Change of process how a fractured hip patient navigates the Bluewater Health system from ER to surgery to rehab and home. If a patient is from home, they go to rehab. |

**3. What are the performance objectives & targets?**

| Performance Objectives: | Improvement Targets (actual measures): |
|---|---|
| 1.Creation of best practice pre-developed preoperative fractured hip physician orders<br>2. Creation of best practice pre-developed postoperative fractured hip physician orders.<br>3. Creation of patient and family education tool, written and electronic.<br>4. Education for nursing and medical staff regarding assessment and care of patients with delirium.<br>5.Multi-disciplinary education plan to improve the lives of fractured hip seniors as they return home – stronger and more confident – nutritionally, physically, medically, emotionally, increased awareness of safe medication processes, when and how to ask for assistance, and awareness of importance of follow-up and prevention.<br>6. Hospital staff partner with patient and family to reach preset goals, known to all. Empowering patients to regain their independence and steer their recovery, accepting responsibility for their recovery.<br>7. Implementing best practice to reduce occurrence of delirium, assess for delirium, treat delirium symptoms. Supporting patients and their families when they are overcome with delirium.<br>8. Supporting family to assist patient in making achievable goals. | a) System: Goal December 2009<br><br>b) Client Level: Direct involvement with patient and their families. |

Appendix F - Part 2: Surgical – Bone, Joint & Hip Sarnia/Lambton – Bluewater Health (cont'd)

**PART 2:**

**4. Does your submission have issues with any of the following that the LHIN should know of:**

a) Acute Care: Nursing staff will need education about caring for patients who have delirium or have potential for delirium. Limited rehab beds available to 5 day post-op fractured hip patients. Establishment of an electronic care path for fractured hip patients and education for nursing staff to comply.

b) Post Acute Care: Rehab staff would now be caring for patients who may have delirium. Education would be needed about this best practice. Once patients are in rehab, this is 5 days after their surgery; they are assessed to see if the plan for home in 28 days in rehab is an achievable goal. This assessment occurs on day 7 to 10 in rehab. If a referral to a long term care home is warranted, it is done at this time. Patients, who live in long term care homes, at the time of their fracture, return to their LTCF on day 5 postop. LTCF physio will need to be educated with best practice physio plan, initiated at hospital

c) Primary Care: Family physician will continue the osteoporosis leadership role once patients are in rehab and post discharge home. Best practice care plan will be developed along with family physicians and nurse practitioners.

d) Health and Human Resources: Creation of home wellness program once fractured hip patients return home, based on best practice goals set in hospital. CCAC and/or public health involvement for home follow-up.

e) Information Management/Systems: Change how ER nursing staff document with the creation and implementation of electronic care map for fractured hip patients. This will be initiated in ER and will continue with the patient throughout his hospital stay. Variances can then be monitored when patient care varies from the best practice care map. ER and rehab nursing staff will need education about care map documentation.

f) Other

**5. What is the impact (if any) of your proposed submission on the care continuum elements listed below?**

a) Emergency Department Volumes/Visits: ER nursing staff will initiate the electronic fractured hip care map. ER staff will give the patient and their family the patient/family education book. Consistent information offers patients and their families reassurance and confidence in the system, at a time of tremendous upset.

b) Acute Care Admissions: Pre-developed best practice physician orders will continue the consistent, confident, caring plan. The electronic care map is continued. Any variances are documented. Pre-developed best practice assessment for delirium and treatment for delirium.

c) Hospital Flow to Community: CCAC is a member in the fractured hip working group, ensuring the flow from hospital to community will be a manageable process that will benefit the patient and their family. Our continued goal is to provide a multi-disciplined education tool that will promote stronger, more confident, and healthier seniors.

d) LTC: LTC home will be aware of the care map and the postoperative physio plan, ensuring the flow from hospital to LTC will be a manageable process that will benefit the patient and their families and the LTC staff.

e) Sub-Acute Care Teams:

**6. Assess the impact of the above directions on the following:**

a) The Patient/Client Experience: A hip fracture is a devastating event in a person's life and in the life of their family. Creating a multi-disciplinary, inclusive care plan that is introduced to the patient and their family early in their hospitalization. A care plan that they know they will be an active participant with care givers to support and educate along the way. A care plan that does not see delirium as a barrier but a condition that requires a pre-developed best practice solution. Early in the hospitalization, family is made aware that they are an integral partner in their loved one's care and outcome. Education and support and inclusion will be part of the care plan and discharge plan.

Setting goals with the patient and family and hospital staff will be ongoing and reviewed regularly.

b) Quality Improvements/Health Outcomes: Our projected outcome for the fractured hip patients is a stronger, healthier, more confident senior returning to their home. Quality improvements are osteoporosis management, nutritional education and compliance, greater awareness of medications, fitness awareness of strength and flexibility.

c) Cost Effectiveness:

Appendix F - Part 2: Surgical – Bone, Joint & Hip Sarnia/Lambton – Bluewater Health (cont'd)

**PART 3:**

**7. Describe specific targets & actions for each priority (sub) population (annual 12 months and 90 days – action plan).**

**a) Annual (12 Month) Plan:**

| Main Objective(s) - milestones | Key Actions | Anticipated Impact (state as a measurement if possible) | Lead |
|---|---|---|---|
| Delirium, Dementia, Depression education for nursing, physiotherapy and occupational therapy staff. | Staff education sessions.<br><br>Regular Evaluations | Statistics to track delirium occurrences and durations. Improved outcomes for delirium occurrences. | |

**b) 90 Day Action Plan (where to start):**

| Main Objective(s) - milestones | Key Actions | Anticipated Impact (state as a measurement if possible) | Lead |
|---|---|---|---|
| Pre-developed Best Practice Physician Order Sets based on Safer Healthcare Now and the Provincial Bone and Joint Health Network<br><br>Electronic Care Path for fractured hips based on best practice from the Provincial Bone and Joint Health Network plan of care.<br><br>Fractured Hip Patient and Family Education Tool in word and online. | Collaborative review of the template of Safer Healthcare Now Order set for fractured hips Reviewing Provincial Bone and Joint Health Network plan of care with surgeons, anesthesia, internal medicine, family physicians, nursing managers and nurses of surgery and rehab and emergency, physiotherapists, occupational therapists, pharmacists, dieticians, CCAC managers, nursing educators, computer liaison nurses. Collaborative proposal of a Bluewater Health pre-developed physician pre and postop orders. | Bringing best practice to Bluewater Health fractured hip patients and the staff who care for them. | |

## StrategiCare

At the request of the Erie St. Clair Local Health Integration Network (ESC LHIN), the hospitals of Windsor/Essex (W/E) - Hotel-Dieu Grace Hospital (HDGH), Leamington District Memorial Hospital (LDMH) and Windsor Regional Hospital (WRH) engaged in a facilitated process to explore opportunities for achieving system improvements via increased integration of hospital services.

Known as the "Strategi*Care*" Project, the work which started in January 2008, built on a history of collaboration between the hospitals to develop a high level strategic plan that identified joint strategies to address current environmental pressures while building a platform for future growth and success. While the hospital Boards remained independent, the hospitals worked together as a "Network" to plan and deliver care for W/E.

Ultimately the goal was to design a future model and staged implementation plan for transformation of the local Windsor/Essex health care environment over the next 5 years, in order to achieve:

- Sustainable services required by the local population
- An integrated, coordinated approach to hospital services
- Employment opportunities for the region

All involved recognized that such a strategic plan needed to consider many factors including change management, communication, interdependent projects, clinical priorities, collective agreements and other human resource obligations, and local economic circumstances. It is also noted that Strategi*Care* '08 was not about reducing numbers of staff; it was about redesigning care to make the best use of our critical resources, our people.

The work and outcomes to date by the leadership of the Strategi*Care* '08 initiative are as follows noting that Strategi*Care* had been planned as a 3 phase initiative.

**Phase 1 (completed June 13, 2008)**

In this first phase of the project, the focus was on the development of high-level plans to strengthen integration across the three hospitals. The resulting work is as follows:

- Defined Case for Change, based upon the region's currently reality
- Development of a Vision and future directions
- Agreement on joint initiatives and completion of high-level planning

This was done through many meeting of the leadership group and staff of each hospital and in collaboration with the ESC LHIN. A Current State Analysis and Jurisdictional Review were completed as well as the hospitals and the ESC LHIN developed high-level plans to strengthen integration in the following areas:

- Maternal Child Program
- Health Information Management Services
- IT Governance
- Pharmacy and Diagnostic Services
- W/E Vision and Strategy
- Emergency Room Coordination

Working teams with staff from across the hospitals were formed for each of the areas identified above with the task of completing a high-level planning exercise resulting in the development of a Project Charter for each initiative.

Establishment of the work teams created a sense of excitement around each area and helped to increase the positive momentum of the project. The Project Charters were designed to enable a successor group to continue forward and conduct a more thorough implementation planning exercise.

Each hospital Board of Directors was presented a summary of the completed by these teams to their Boards and the ESC LHIN received approval to move forward with Phase 2.

**Phase 2 (Commenced September 2008)**

Through the second phase of the project, the focus was on the development of more detailed plans to strengthen integration across the three hospitals. The resulting work is as follows:

- Development of a redefined Vision
- Inclusion of the physician group to further support and advance clinical integration
- Continued progress in detailed planning

On Saturday, November 15, 2008, each hospital Board, Senior Executive Team and Medical Advisory Committee members, along with the ESC LHIN Board members, CEO and senior staff came together to participate in a “Revisioning Day”. This day was to advance an effective, functional and coordinated approach, creating an environment for the commencement of a robust mechanism to forge ahead with Phase 2 via further integration of hospital services and improved performance.

From input from the “Revisioning Day”, a new Vision statement was proposed and it was agreed that their should be an oversight/coordinating physician group to help move clinical integration forward as well as support for commencing with the Project Charters and or other opportunities that would enable clinical integration.

Following the “Revisioning Day” the formation of a new Joint Executive Committee (JEC) was formed to represent a core group of leadership personnel to demonstrate ownership and accountability for the decisions and direction made to advance an effective integration. The Committee adopted the

proposed vision for moving forward and agreed to the creation of a three hospital joint Medical Advisory Committee Executive (JMACE) to be represented by the three Chiefs of Staff.

The JMACE met several times over the past 2009 year to work on advancing top priorities for clinical integration and administrative enablers to support the areas of focus identified through Phase 1.

Recommendations put forward by the JMACE were supported by the JEC and are currently being further explored for start up through the commencement of Phase 3 where initiatives will be implemented and monitored.

## Integration of Windsor/Essex Community Health Centres

### Amalgamation of the Sandwich Community Health Centre Inc. (SCHC) and The Phoenix Wholistic Health Centre (Operating as The Teen Health Centre) (THC)

In March 2008, at the request of the Erie St. Clair Local Health Integration Network (ESC LHIN), the Sandwich Community Health Centre Inc. (SCHC) and The Phoenix Wholistic Health Centre (Operating as the Teen Health Centre (THC) began a facilitated process to explore opportunities for integration.

In late 2008 and early 2009, the Community Health Centres (CHCs) passed Board motions declaring their desire and intent to merge recognizing the need for re-aligning the (CHCs) in Windsor/Essex as a key method for delivering primary health care. The realignment would maintain a commitment to individual identity while meeting the needs of the growing population through the expanded services.

In April 2009, a Memorandum of Understanding was entered into by the SCHC, THC and ESC LHIN which demonstrated a commitment to work collaboratively through the process to advance the integration forward.

On September 22, 2009, the ESC LHIN Board approved the integration to proceed to amalgamation and on September 28, 2009, the CHCs signed their amalgamation agreement.

In October 2009, a new CEO was announced for the new corporation and next steps are currently under development.