

NAVIGATING CHANGE IN THE RIGHT LANE

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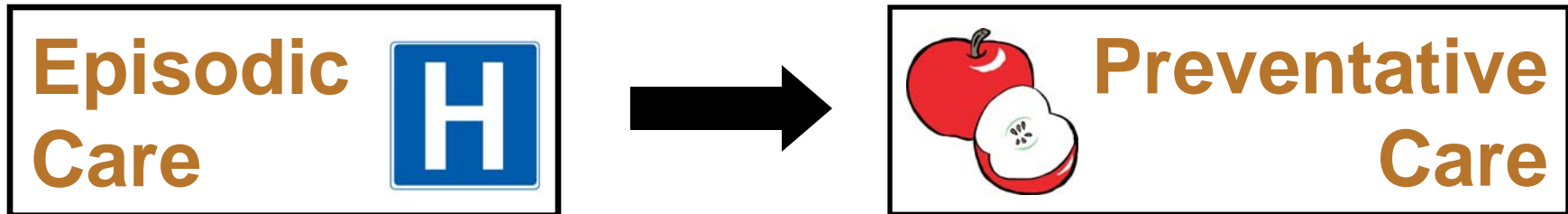
November 30, 2009
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Our Vision

A health care system that helps people stay healthy, delivers good care to them when they get sick and will be there for their children and grandchildren.



Our Guiding Principles



- Change the system's orientation to address people's needs
- Tackle chronic disease management (e.g. diabetes)
- Reduce dependency on hospital services
- Support health promotion / illness prevention
- Provide timely access to appropriate services

What is an Integrated Health Service Plan (IHSP)?



What is an IHSP?

- An IHSP is the central strategic document and is a blue print for LHINs to follow
- It is a **3 year plan**
- It describes priorities, **strategies** and **proposed outcomes** for the local health system



What is an IHSP? cont'd...

- It focuses our efforts on areas of greatest need
- It is aligned with provincial priorities of the Ministry of Health and Long-Term Care (MOHLTC), as described in the MOHLTC Strategic Plan and the health system scorecard



Developing IHSP 2

- IHSP 2 is our second three-year plan
- This plan is based on data we have collected and input from stakeholders throughout our community
- More than just data, we are also looking at:
 - System Pressures
 - System Thinking
 - Action Orientation
 - Resource Constraints
 - Focus on the Patient

Developing IHSP 2 cont'd...

- The plan was assembled over a six month period
- Our community engagement process had been designed to solicit advice, feedback and support from stakeholders in our communities
- Our goal was to use a number of vehicles designed to inform and educate, consult, involve, and collaborate



Purpose of the IHSP2

- Sets out our strategic aims
- Sets out our strategic priorities
- Sets out a potential vision for a modified hospital business model
- Sets out tangible goals

Purpose of the IHSP2 cont'd...

- Sets out the responsibilities that we expect to undertake
 - With respect to segments of the population
 - With respect to setting direction for our Annual Service Plan and funding allocations
- Provides a listing of future projects
- Provides listing of next actions



IHSP 2 Planning Priorities



Challenges by Region

Windsor/Essex

High Rates Of Chronic Diseases

- *44% more likely to have Chronic Obstructive Pulmonary Disease (COPD)*
- *37% more likely to have Cerebrovascular Diseases (e.g. Stroke)*
- *27% more likely to have Arthritis*

Poor Determinants Of Health

- *30% more likely to be obese*
- *27% more likely to have lifestyle limiting pain and discomfort*
- *25% more likely to have a heavy drinking problem*

Source: Based on ICES 2006/07 Report, Statistics Canada 2007/08 and Lambton County 2008 Health Status Report

Challenges by Region

Sarnia/Lambton

High Rates Of Chronic Diseases

- *37% more likely to have high blood pressure*
- *30% more likely to have COPD*
- *27% more likely to have Ischemic Heart Disease*

Poor Determinants Of Health

- *52% more likelihood of suicide and self-inflicted injury*
- *45% more likely to have a heavy drinking problem*
- *27% more likely to be obese*

Source: Based on ICES 2006/07 Report, Statistics Canada 2007/08 and Lambton County 2008 Health Status Report

Challenges by Region

Chatham-Kent

High Rates Of Chronic Diseases

- 66% more likely to have COPD
- 60% more likely to have Ischemic Heart Disease
- 29% more likely to have Diabetes
- 34% more likely to have Circulatory Diseases
- 33% more likely to have Cerebrovascular Diseases

Poor Determinants Of Health

- 46% are daily smokers
- 45% more likely to be obese

Source: Based on ICES 2006/07 Report, Statistics Canada 2007/08 and Lambton County 2008 Health Status Report

Regional Challenges

When compared to Ontario averages, there are significant variances that impact the health service needs of Erie St. Clair residents, including:

- A higher proportion of seniors (65 years of age and over)
- High unemployment rates that increase poverty levels, social isolation and family disruption
- Significantly higher levels of people who are overweight or obese
- Slightly higher proportion of people with poor lifestyle habits, including smoking, poor nutrition, physical inactivity and smoking

Source: Based on ICES 2006/07 Report, Statistics Canada 2007/08 and Lambton County 2008 Health Status Report

Regional Challenges cont'd...

- Significantly higher rates of chronic conditions such as Cardiovascular Diseases, Diabetes, High Blood Pressure, COPD, Arthritis and Cerebrovascular Diseases
- Significantly higher rates of hospitalization, potential years of life lost, and mortality due to higher rates of Neoplasm, Circulatory Disease
- Significantly higher rates of mortality due to circulatory diseases

These and other local issues are the basis of our plan for improving the local health care system

Source: Based on ICES 2006/07 Report, Statistics Canada 2007/08 and Lambton County 2008 Health Status Report

Our Planning Aims



Our Planning Aims

1. Developing Alternatives to Emergency Department Care

Fact:

Over 90% of Emergency Department Visits in Erie St. Clair are non-life threatening – most relate to the provision of Primary Care

Strategies to consider:

- Increase access and availability of primary care resources
- Promote the importance of self-directed care



Our Planning Aims cont'd...

2. Ensuring Appropriate Access to Surgical, Intensive Care Unit (ICU) and Medicine Beds

Fact: Every day, there are patients receiving care in the wrong place

Strategies to consider:

- Identify and transfer Alternate Level of Care (ALC) reduction strategies and leading practices
- Enhance primary care and community services to support adults who have congestive heart failure (CHF), Chronic obstructive pulmonary disease (COPD) or Diabetes

Our Planning Aims cont'd...

3. Ensuring Appropriate Access to Aging Supports Close to Home

Fact:

It takes longer in Erie St. Clair to transfer patients to long-term care beds than performance targets

Strategies to consider:

- Improve coordination, delivery and standardization of services
- Increase and, potentially, reallocate long-term care resources and identify opportunities for improving the placement process

Our Planning Aims cont'd...

4. Reducing the Impact of Diabetes

Fact: The residents of Erie St. Clair are at a higher risk for developing chronic conditions associated with diabetes than the rest of Ontario

Strategies to consider:

- Enhance the availability of primary care programs for prevention, early diagnosis and management of diabetes
- Improve coordination, utilization and standardization of diabetes programs

Our Planning Aims cont'd...

5. Reducing the Impact of Adult Mental Health & Addictions

Fact:

The economic downturn has significantly impacted the Mental Health and Addictions sector - an area traditionally under-serviced

Strategies to consider:

- Adapt to emerging needs in adult mental health & addictions services
- Increase Primary Care capacity to provide mental health care

Our Planning Aims cont'd...

6. Addressing Chronic Conditions

Fact: ESC residents are less healthy and die sooner than the rest of Ontario

Strategies to consider:

- Enhance the availability of primary care resources focused on supportive/self-directed prevention, early intervention and chronic disease management
- Ensure access to community support services for individuals with Arthritis, COPD and/or heart disease
- Improve the coordination/utilization/standardization of programs for chronic conditions

Our Planning Aims cont'd...

7. Improving System Performance by building on the current strengths of the local health care system

Fact:

LHINs, ideally positioned as the platform for transformation, are committed to facilitating system change for the betterment of the residents of Erie St Clair

Strategies to consider:

- Identify and implement improvements in efficiency and effectiveness through health service provider strengths and best practice
- Establish a network of trained resources to lead and/or facilitate learning of practice methodologies across the LHIN (e.g. Lean, Six Sigma)



Five Strategic Priorities for the Next Three Years

- Improved outcomes in Alternate Level of Care
- Improved outcomes in Emergency Department Care
- Improved outcomes in Diabetes Management
- Improved outcomes in Mental Health and Addictions
- Improved outcomes in Rehabilitation Care and Interventions

Four Additional Strategic Projects Intended for the Three Year Period

- The examination of diagnostic imaging, laboratory, and pharmacy services
- Complex Continuing Care program standardization
- Development of a system-wide clinical services plan
- Attention to health human resources



Examples of Targeted Populations

Alternate Level of Care

- Geriatric Mental Health clients
- Behavioural Problems clients
- Frequently readmitted Congestive Heart Failure clients
- Chronic Obstructive Pulmonary Disease clients

Emergency Department Care

- Patients with known Methacillin Resistant Staph Aureus
- Vancomycin Resistant Infection
- Patients coming for follow up

Examples of Targeted Populations cont'd...

Diabetes

- First Nations Diabetics
- Rural or geographically isolated diabetes

Mental Health

- Crisis populations
- Early intervention clients

Rehab

- Frail individuals greater than age 65
- Heart failure patients

Examples of Targeted Actions

Alternate Level of Care

- Expand ambulation programs
- Development of proactive intervention

Emergency Department Care

- Continue and expand lean strategies
- Support Nurse Practitioner clinics

Diabetes

- Central intake
- Implementation of diabetes teams

Examples of Targeted Actions cont'd...

For Mental Health

- Support expanded tele-crisis service
- Plan alternatives to hospitalization

For Rehabilitation

- Transition to Patient Self Management Programs
- Develop Client Management Programs

ESC LHIN Three Year Strategic Target to Achieve Vision, Mission and MLAA Targets

Measure	Baseline (2010)	Percent Change
Helping us Achieve Provincial Priorities of Emergency Wait Times and ALC Reduction		
All Alternate Level of Care (ALC) Days	31,169	-20%
Conservable Days/1000	131	-10%
Emergency Department (ED) Admissions Percent	10%	-10%
ED Visits by Canadian Triage Acuity Scale (CTAS) CTAS/1000:	476	-12%
ED Total Hours Over Target	221,027	-15%
Percent Discharge Home with or without Services	67%	5%
Percent Transferred to a Continuing Care Facility (Long-Term Care [LTC], Rest + Retirement)	21%	-52%
**Hospital Discharges Safely Defer from LTC to Home (based on weekly ALC Snapshot of individuals for LTC)	151	-50%
Rebalancing Beds		
Acute Beds	907	-11%
Complex Continuing Care Beds	313	15%
Rehab Beds	124	30%
Psych Beds (excludes tier divestment of tertiary)	122	0%
Total Beds	1,466	-1%

Erie St. Clair Local Health Integration Network



Our People

Our Health