Hamilton Niagara Haldimand Brant **LHIN**

Working Together to Make Hamilton the Best Place to Work, Live and Play

Presentation to the Hamilton Board of Health

Michael Shea, Chair and Donna Cripps, CEO
Hamilton Niagara Haldimand Brant Local Health Integration Network
Thursday, July 10, 2014

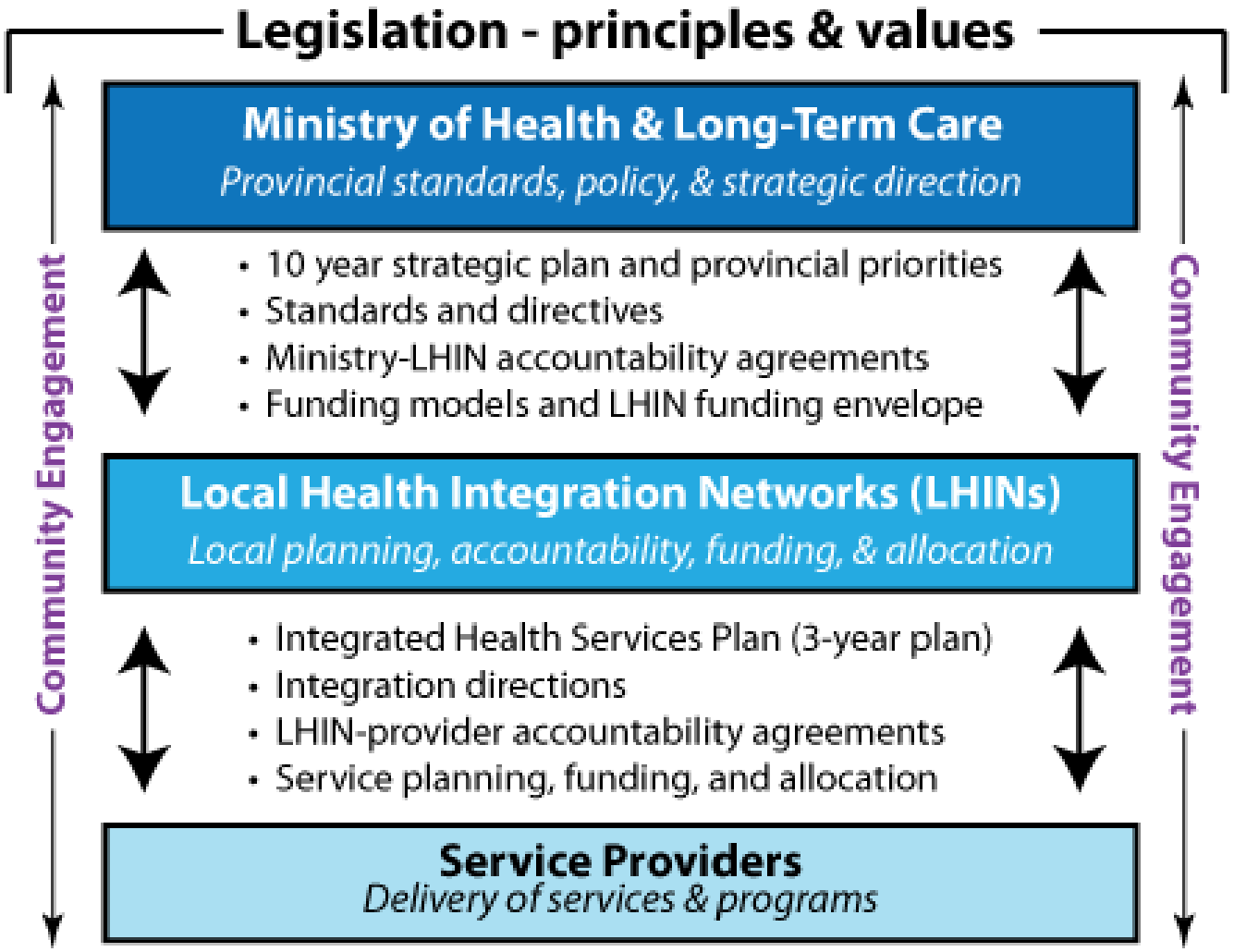
Ontario
Local Health Integration Network

What is a LHIN?

Local Health Integration Network (LHIN)

- Created by the Ontario government in March 2006
- 14 not-for-profit corporations that work with local health providers and community members to determine the health service priorities for their regions
- Local Health Integration Networks (LHINs) plan, integrate, and fund local health services
- Provincial Vision: A health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren

Accountability



Strategic Health System Plan

Strategic Aim

Dramatically improving the patient experience through **Quality, Integration and Value.**

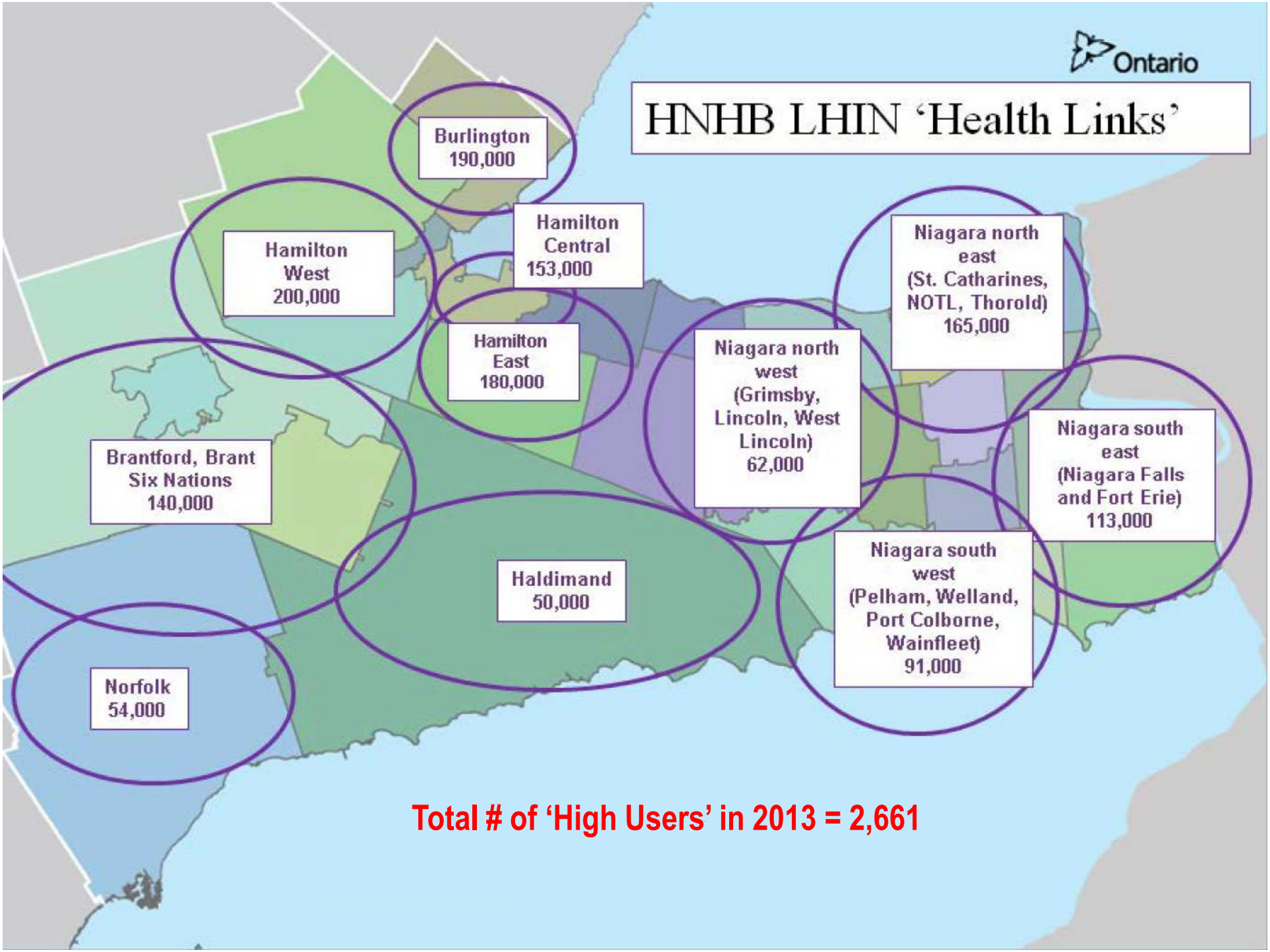
Strategic Directions

Quality	Integration	Value
Dramatically improving the patient experience by embedding a culture of quality throughout the system	Dramatically improving the patient experience by integrating service delivery	Dramatically improving the patient experience by evolving the role of the LHIN to become a health system commissioner

Integration: Health Links

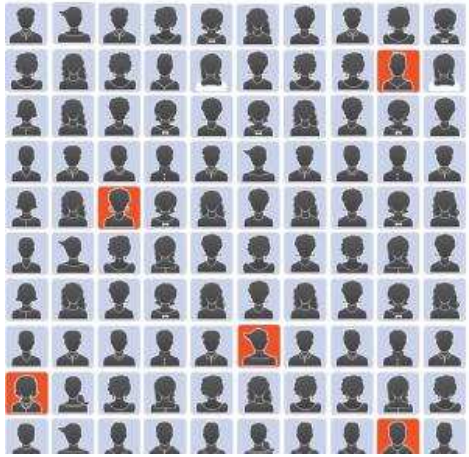
- A new practice of care where **ALL** providers in a community, including primary care, hospital, long-term and community care come together to create a plan for future care at the patient level

- Each Health Link will:
  - Be led by those that live in the Health Links area
  - Base programs on the needs and preferences of local residents
  - Focus on the **patient and their family** through coordinated planning specific to each person's needs and preferences
  - Build services and programs around patients – the right care, at the right time, in the right place


Ontario
HNHB LHIN 'Health Links'
Burlington
190,000
Hamilton
West
200,000
Hamilton
Central
153,000
Hamilton
East
180,000
Niagara north
east
(St. Catharines,
NOTL, Thorold)
165,000
Niagara north
west
(Grimsby,
Lincoln, West
Lincoln)
62,000
Niagara south
east
(Niagara Falls
and Fort Erie)
113,000
Brantford, Brant
Six Nations
140,000
Haldimand
50,000
Niagara south
west
(Pelham, Welland,
Port Colborne,
Wainfleet)
91,000
Norfolk
54,000
Total # of 'High Users' in 2013 = 2,661

Health Links in Hamilton

Health Link	Number of High Users	Proportion of Total High Users
Hamilton East	404	15%
Hamilton Central	397	15%
Hamilton West	254	10%
Total	1,055	40%



5% of the population accounts for 66% of health care spending

Indicators Of Success

Moving the needle

1. Reduce the time from primary care referral to specialist
2. Reduce the number of 30 day readmissions to hospital
3. Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere
4. Reduce time from referral to home care visit
5. Reduce unnecessary admissions to hospitals
6. Faster primary care follow-up after discharge from an acute care setting

Setting the stage for coordinated care straight away

1. All complex patients will have a coordinated care plan
2. Complex patients and seniors will have regular and timely access to a primary care provider

How you'll know you've arrived

1.Enhance the health system experience for patients with the greatest health care needs

2.Reduced ALC rate

3.Reduce the average cost of delivering health services to patients without compromising the quality of care

Opportunities from a Health Links Perspective

- Identifying/capturing the current high users - consistently and connecting them with care (high ED use – acute care use – chronic conditions (COPD, CHF, Diabetes)
- Moving the identification of high users up stream – developing predictive models
- Leveraging technology to enable processes and interaction between the Circle of Care
- Clarifying accountability and expectations for Health Links and local partners

Hospital Emergency Departments (EDs)

- Hospital EDs are the door to urgent/emergent hospital and ED services
- Most people arrive at the ED by foot or ambulance
- The number of admissions to the hospital through the ED is increasing
- LHIN looks at a number of metrics to evaluate hospital ED performance – two key metrics in LHIN Accountability Agreement with hospital:
  - The number of people waiting in a hospital bed for an alternate level of care (ALC rate)
  - Time people wait in the ED for admission to an inpatient bed
- The volume of ED visits and the number of people waiting in the ED for admission to an inpatient bed is a pressure for ED staff which can impact timely acceptance of admissions by ambulance

Hamilton hospitals in 2013-14:

ED visits increased over previous year by 6,687

Total ED visits were 205,851

ED visits by ambulance increased by 1,883

90th percentile ambulance offload time at one hospital increased from 33 minutes in April-June 2013 (Q1) to 120 minutes January-March 2014 (Q4)

Source: ERiPORT accessed June 18, 2014

Hospital Emergency Departments (EDs)

Strategies focus on providing the **right care, at the right time, in the right place:**

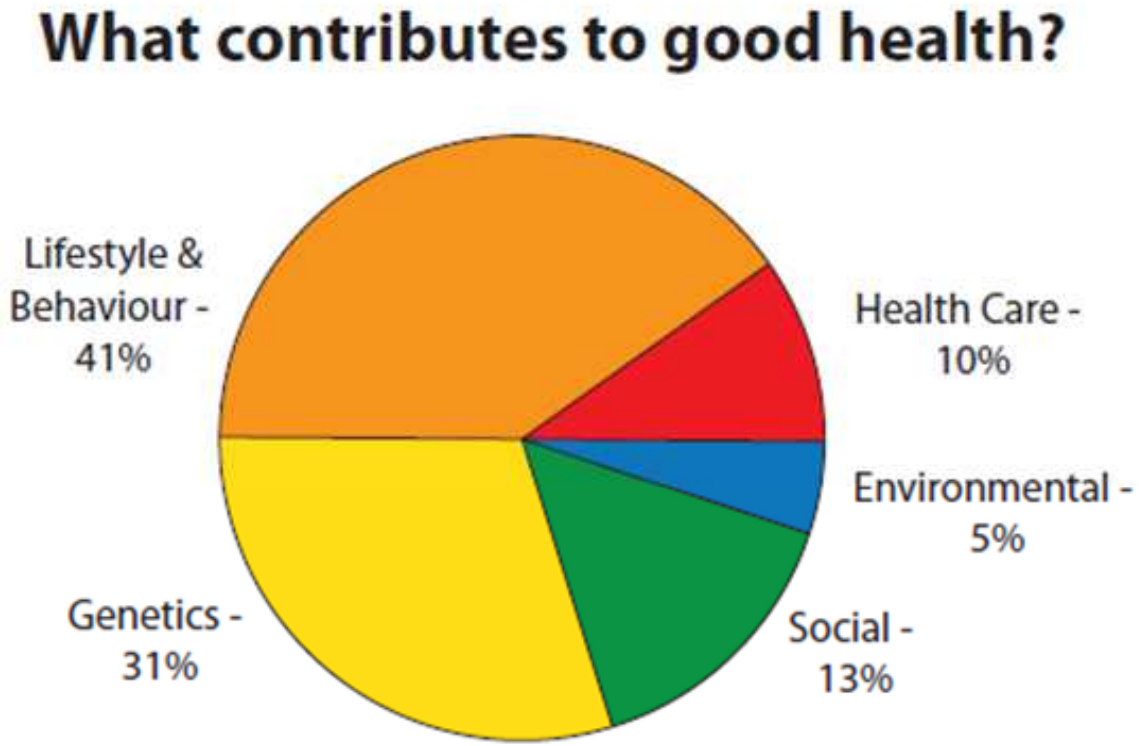
ED Diversion

- Community Referrals by Emergency Medical Services (CREMS)
- General Internal Medicine Rapid Access Clinic (GIMRAC)
- Community Care Access Centre Care Coordinators in the ED
- Screening 'High Risk' Seniors
- Nurse-Led Outreach Team in long-term care homes

Facilitating patients' transition from hospital to the most appropriate care setting

- Home First Philosophy
- Restorative programs
- Transitional bed programs
- Rapid Response Transitional Care Team
- Assisted living services

Health is More than Health Care



Source: New England Journal of Medicine, S. Schroeder (adapted from McGinnis et al.), Vol. 357, No. 12, 2007.

Thank you!

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