

South West **LHIN**

*A Healthier Tomorrow:*  
**Integrated Health Service Plan  
2010-2013**

South West Local Health Integration Network  
November 30, 2009

# Executive Summary

Health care in Ontario has experienced year-over-year growth. Reasons for this growth include rising demand and use of services; an increasingly aging population; inflation and new, more expensive treatments and medications; increased public expectations; new diseases; and an increase in the prevalence of chronic diseases.

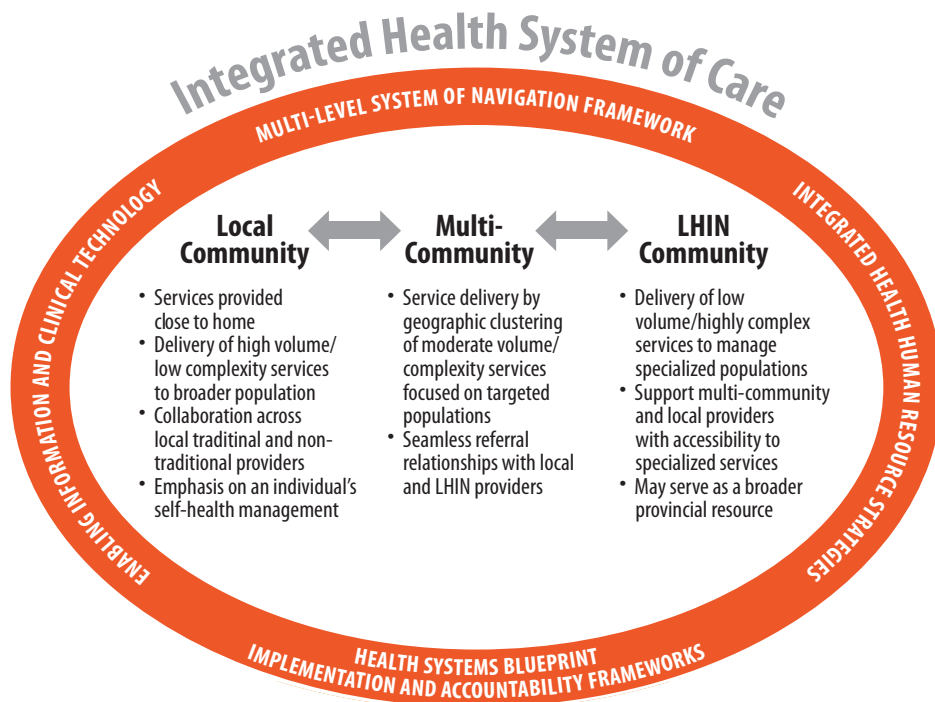
Even though we have experienced considerable growth, it has not always resulted in improvements to how people experience their health care or the outcomes expected by that care. A primary reason for this is new health care resources are often aligned to service structures and delivery models that were created many, many years ago and no longer adequately serve our population. Over time, the health care system has become extremely complicated and difficult to navigate by users and providers of services. We have been continually adding services to a foundation that is based on historical approaches as opposed to current needs and best practices. Hence, it is imperative that over the next 12 years, we address the fundamental elements that need to be reconstructed to ensure that we have an “Integrated Health System of Care” built for 2022.

Great care must be taken and effort made to ensure that accessible, quality and integrated services exist and will be there for South West LHIN residents, their children and their grandchildren.

Providers across health sectors face the following challenges:

- Inequitable distribution of health services across the LHIN pose access challenges for residents, particularly those in rural communities
- Current funding and operating models reinforce a provider-focused versus person-centred approach to health service delivery
- Lack of integration across sectors and of health service providers inhibits the seamless movement of individuals and families across the continuum of care
- The health profile of the South West LHIN necessitates more appropriate, integrated screening and early identification of health risk factors and conditions
- Lack of integrated technology platforms across the LHIN inhibit information-sharing among health service providers across sectors and geography
- Capacity limitations make it difficult to meet the increased demand for health services
- Limited availability of health human resources make it difficult to meet the current and anticipated health service demand

These issues must be addressed to improve the health system and ensure its sustainability in the future.



In February 2009, the South West LHIN took the bold step of initiating the Blueprint project. The objectives of the Blueprint project included:

- Provide a response to the first Integrated Health Service Plan (IHSP) priority to ensure access to the right services, in the right place, at the right time, by the right provider
- Facilitate health care providers' and the LHIN's planning for change rather than reacting to health system trends, challenges and best practices
- Develop a framework for how the system should be structured, across programs and geography, based on a detailed understanding of current services
- Broadly and collectively leverage our resources rather than reacting to single issues faced by one organization, sector, or discipline

*The Blueprint describes in detail what we want health service delivery to look like by 2022 and the IHSP 2010-2013 identifies the strategic directions and active steps we need to take in the next three years to begin to make it a reality.*

The Blueprint describes two overarching integrated service delivery approaches that detail how health services will be accessed and delivered by 2022:

- **Population-based Integrated Health Services** is tailored to the collective needs of a local population and its health service providers. It enables local communities to support the health and wellness of its catchment population helping them to better manage their own health and maintain independence. The local community services are supported by the multi-community services and have access to LHIN community services as needed
  - Throughout an individual's life, he or she may access primary care services, home and community care, complex continuing care, long-term care, rehabilitation, chronic disease prevention and management, mental health and addictions services and emergency services coordinated through this service delivery approach
- **Centrally Coordinated Resource Capacity** optimizes the use of targeted resources to improve access and

complement health and wellness management at the more local level

- Throughout an individual's life, he or she may access medicine, surgical and critical care inpatient and ambulatory services coordinated through this service delivery approach

These approaches are not mutually exclusive, but are truly integrated recognizing that as an individual at various points in his or her lifetime interacts with the system, their needs will vary and the system must be able to respond in a seamless and coordinated manner.

The *IHSP 2010-2013*, prioritizes our implementation efforts for the next three years through two strategic directions and their associated actions to work towards our Blueprint goal of an Integrated System of Care by 2022.

## *IHSP Strategic Directions*

### **1. Enhance Capacity and Integration of Primary, Specialized and Community-based Care**

This first IHSP strategic direction aligns with the "Population-based Integrated Health Services" integrated service delivery approach described by the Blueprint and is intended to move the first three years of this approach forward. It describes providing care coordination and inter-professional team based care at the local level to focus on prevention, identification, assessment, treatment, follow-up and providing necessary supports.

Local care delivery will be very important to support those who need assistance with their health challenges such as diabetes, obesity, advanced age, mental illness or addictions issues. As care needs become increasingly complex for some individuals with conditions such as concurrent disorders, Alzheimer's disease and multiple chronic illnesses, referral to specialist care at the multi-community and LHIN levels may be required and coordinated through the inter-professional team.

**The South West LHIN has chosen to focus on the following populations:**

- *Seniors and Adults with Complex Needs*
- *People Living with Mental Health and Addiction Challenges*
- *People Living with or at Risk of Chronic Disease(s)*

We will focus on these populations for a number of reasons. Since the first IHSP, we have undertaken a great deal of planning and a number of initiatives have already been implemented that provide early starts to some of the Blueprint implementation elements. As with all LHINs, our actions related to seniors and adults with complex needs have been leveraged through the provincial Aging At Home initiative, Alternate Level of Care/Emergency Room initiatives and quality improvement initiatives such as the FLO Collaborative.

The South West LHIN also remains committed to improving diabetes care by supporting the roll out of the Ontario Diabetes Strategy. In addition to being selected as one of the first three LHINs to implement the strategy in its first year, we are also one of two LHINs identified as an “early adopter” for the province’s eHealth Strategy. This puts us in the favourable position of fully enabling the provincial eHealth Diabetes Registry.

The South West LHIN’s success with the implementation of the Partnerships for Health program has strengthened our position to be effective in improving diabetes care across the LHIN. Our involvement in the strategy, the registry and Partnerships for Health has given us real applications to test some of the Integrated Health System of Care elements described by the Blueprint. In addition, our learnings from the experiences with diabetes will help us to evolve systems of care for other chronic conditions.

As our population characteristics and health status show, the South West LHIN has a significant proportion of seniors and people living with chronic conditions. Other data show us that South West LHIN residents have experienced challenges accessing coordinated addictions and mental health services. A substantial amount of work is currently taking place to facilitate divestment of mental health and addictions specialty hospital services and enhance capacity in local and multi-community settings. This is in addition to a number of mental health and addictions’ early identification, health promotion and disease prevention initiatives across our LHIN.

Generally, these populations tend to access and use a substantial portion of our health care resources. But the system doesn’t always support them to use these resources at the right time, in the right place and by the right provider which often leads to crisis intervention that could have been prevented if early identification, management and supports were in place. Currently, 58% percent of all emergency room visits in the South West LHIN are for non-urgent patients.

**2. Enhance Access and Sustainability of Hospital-based Treatment and Care Related to:**

- Emergency Services
- Medicine, Surgical and Critical Care Services

The Blueprint development process included undertaking an assessment of the current state and future health care system in the South West LHIN. The information, insights and strategies profiled in the Emergency Department Human Resources (EDHR) Project Final Report, May 2009 (see EDHR study), commissioned by the South West LHIN, contributed greatly to the current state assessment. As for the future, the Blueprint’s “Centrally Coordinated Resource Capacity” integrated service delivery approach heavily influenced the IHSP action steps we will take in the next three years.

The actions below will allow people to flow through the system equitably, minimize backlogs and optimize the use of available resources:

- **EMERGENCY SERVICES**

Based on the recommendations of the Emergency Department Human Resources Study and in full alignment with the Blueprint's integrated service delivery approach, the LHIN will engage key local and multi-community stakeholders to initiate a process to develop and implement strategies tailored to their communities' emergency services needs, with a focus on:

- *Emergency services recruitment and retention capability*
- *Emergency services coverage with current resource pool*
- *Emergency services health care personnel capacity*

- **MEDICINE, SURGICAL AND CRITICAL CARE SERVICES**

Engage key local, multi-community and LHIN community stakeholders to develop an action plan for creating and implementing Centrally Coordinated Resource Capacity for medicine, surgical and critical care services, with a focus on:

- *A LHIN-wide resource capacity management system*
- *A centralized coordinated referral system, evidence-based care pathways and order sets, tools and quality guidelines*

Recognizing that achieving an Integrated System of Care, as defined by the Blueprint, requires a dedicated journey involving planning and implementing, the Health System Design Steering Committee will immediately undertake the following key initial action steps:

- **Identification of leadership to guide and lead change efforts**, both at the system-wide level and within targeted implementation initiatives
- **Framework for implementation planning** to be completed by March 31, 2010. This framework will guide the development of detailed implementation plans. As part of this process, the LHIN will work with stakeholders within the context of the IHSP strategic directions to identify those opportunities that are innovative, align to the Blueprint and can serve as "success stories" and in doing so be an example of positive change. While we will work with health service providers to proactively identify these groups, we urge all stakeholders to engage in seeking out opportunities as well

The LHIN, in collaboration with its health system partners, will also continue to provide overall direction to our health system design process. More specifically, we will work to take action on the following:

- Developing future IHSPs aligned to the vision of the Health Services Blueprint
- Creating incentives for health service providers and partners as we are able and deemed appropriate
- Maintaining a transparent process with open lines of communication to enable easier collaboration
- Modifying future new accountability agreements to include elements of the Health Services Blueprint and IHSP. As appropriate, these agreements will reflect transformative elements and initiatives which will prompt health service providers towards enacting change. These agreements will reflect the partnerships involved across providers in making change through joint accountability statements

Acknowledging the resource limitations of today and potential pressures of the future, transforming the health care system is even more imminent. Under the Local Health System Integration Act, 2006, providers now have an accountability to look for opportunities to integrate the local health system. We are a single health system and thus need to be vested in the “success of all” including people who deliver and receive health care, the success of organizations that we have an affiliation to, in addition to the success of other organizations and the services they deliver.

