Central West **LHIN**

Community update

Spring/ Summer 2014

Together, Making Healthy Change Happen

The Central West LHIN is pleased to publish "Community Update – Spring/ Summer 2014"

It has been a little more than a year since the Central West LHIN launched its third Integrated Health Services Plan (IHSP 3), which lays out the LHIN's plans to improve the local health care system for the period April 2013 through March 2016.

Together with Health Service Providers (HSPs) and community partners, the LHIN has made notable gains during this time. Highlights include the development of five local Health Links; the implementation of a successful Telehomecare program; significant investments in home care supports and community services for seniors; and development of the Caledon Specialist Clinic to name but a few.

Now in year two of IHSP 3, the Central West LHIN's activities will remain focused on holding the gains and supporting the four strategic directions identified in IHSP 3: Improve Access to Care, Streamline Transitions & Navigation, Drive Quality & Value and Build on the Momentum. This edition of *Community Update* provides readers with an overview of the LHIN's planned activities for the coming year.

INSIDE: Improve Access to Care • By the Numbers • Streamline Transitions and Navigation of the System • Drive Quality and Value • Build on the Momentum

Residents and HSPs alike place a high value on their local health care system and its need to be responsive to local communities. The Central West LHIN would like to thank local residents and HSPs who have taken ownership and accountability for meaningful and healthy change. Their dedication, commitment and collaboration toward the aim of providing high quality, person-centered health care is transforming a bold vision into reality.

The LHIN's work is focused on the development of an integrated system of health services aimed at providing residents with better health, better care and better value. As the LHIN moves forward with its activities over the coming year, we move closer to achieving this goal.

Together, we are making healthy change happen!

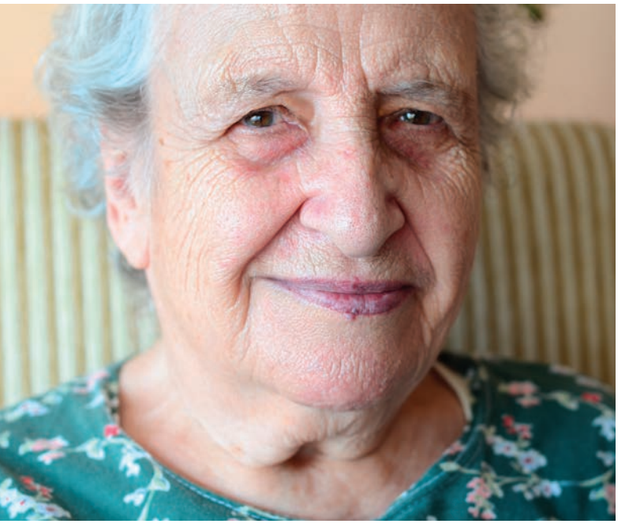
Maria Britto, Board Chair

Scott McLeod, CEO

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Improve Access to Care

Connecting residents with primary health care



"The Health Link has been able to provided coordinated care from multiple providers, tailored to Agnes's specific needs. Working together, with Agnes and her family, this is a true team success story."

– Lead, Dufferin Area Health Link

At 76 years of age, "Agnes" lives with a variety of conditions… diabetes, morbid obesity, Chronic Obstructive Pulmonary Disease… and is awaiting knee replacement surgery for arthritis. With a lack of motivation to self-manage her own health and the likelihood of repeated hospital admissions, Agnes was referred to the Dufferin Area Health Link by her family doctor.

Health Links are tightly knit teams of local health providers who offer seniors and patients with complex conditions, like Agnes, better coordinated care through the development of tailored care plans that meet the specific needs of the patient and, improve transitions between health care providers and/or the health care system.

Following her referral to the Health Link and subsequent access to multiple health providers through more coordinated care, Agnes is self-motivated to follow a home exercise program, has improved her adherence to diet and diabetic management, enjoys the support of her family, is no longer housebound and is looking forward to increased mobility from knee replacement surgery.

Moving forward, the Central West LHIN will continue to work with Family Health Teams, Community Health Centres and primary care practitioners to ensure local residents have access to the right care, where and when they need it. The Health Links model will be used to better and more quickly coordinate care for seniors and other residents who are living with complex health conditions. Residents will receive faster care, spend less time waiting for care and will be supported by a comprehensive team of providers across the health care system, avoiding unnecessary visits to the emergency department and/or hospitalization.

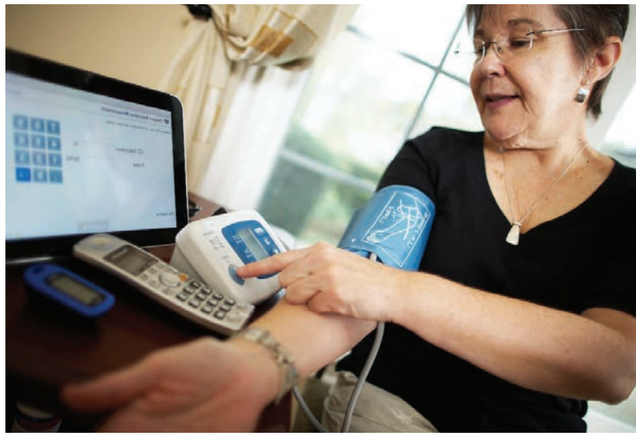
Supporting self-management of chronic diseases

"Elgin" and his wife can't say enough about the Central West LHIN's Telehomecare program, which enables Elgin to self-manage his own care by connecting directly with a Telehomecare Nurse from the comfort of his own home. This service has allowed Elgin to better manage his nutritional needs and medications, while providing him with a better quality of life by avoiding unnecessary visits to the hospital.

The Telehomecare program makes it possible for residents with Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) to self-manage their own care at home. Using wireless technology, residents like Elgin are connected with a nurse who can monitor and coach them between appointments with their regular care provider. This collaborative approach results in faster treatment and greater patient support from all levels of the local health care system.

Helping residents to self-manage their chronic conditions is a key to healthier living, and a way to reduce emergency department visits and hospitalizations. The Central West LHIN's approach to diabetes care has lead to better outcomes for people living with diabetes and is the model being used to introduce self-management and education programs that support residents living with other chronic diseases, including CHF and COPD.

To further improve the ability of residents to self-manage their care from home, the LHIN will continue to work with community partners to increase the number of residents who have access to chronic disease education and self-management programs, including expanding access to the regional Telehomecare program through Health Links.



"It is very reassuring to know there is a trained medical professional available 24 hours a day if required to assess the data sent by the Telehomecare equipment. We are very grateful this service is available to those of us who need and value it."

– E & S Gardhouse

Improve Access to Care *continued*

Delivering mental health and addictions services closer to home

Injured on the job, "Gurbir" was prescribed a narcotic, Tylenol 3, to help manage his pain. Although he was only expected to take the drug for one month, he instead remained on the medication for two years, developing an addiction to its effects as a relaxant. Seeking help, his wife brought him to Punjabi Community Health Services.

The South Asian Addictions Program at Punjabi Community Health Services provides numerous programs and services to clients and their families including group, day, relapse prevention, family enhanced, women's, and disorders programming, all at no cost to the client. To help him better manage his addiction, Gurbir was seen by a case manager who educated him about dependency.

The Punjabi Community Health Services addiction programs, funded through the Central West LHIN, connect residents with the services they need in their local community.

Throughout the coming year, the LHIN will continue to work with Health Service Providers to make sure that children, youth and adults have faster access to the mix of services they need, including services that are integrated within schools, and more care delivered within community settings. Early intervention is one of the keys to ensuring a better quality of life for residents living in the Central West LHIN.

"If I had known that I could access the addiction treatment services at Punjabi Community Health Services, I would have come sooner."

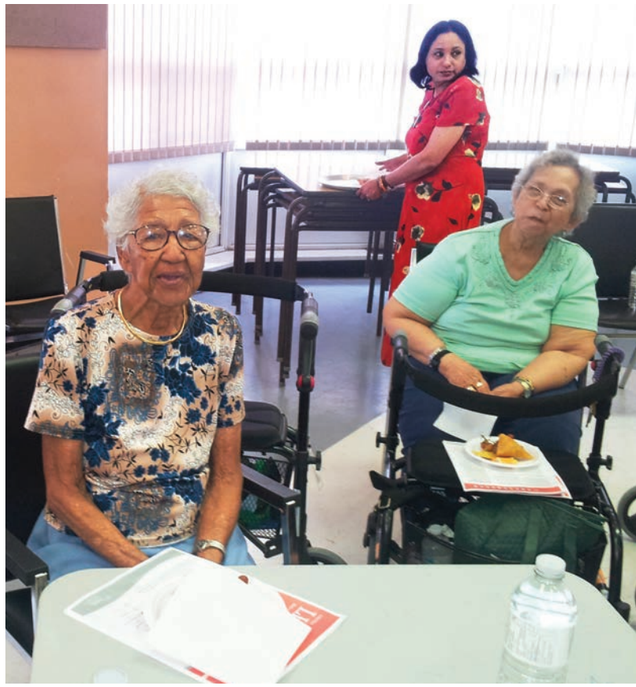
– Gurbir

Helping seniors to stay healthy and active

At 99, Amy continues to enjoy living on her own, taking great joy in the simple things in life like getting her hair done or walking over to the local shopping mall. The Rexdale resident, who lives in a Toronto Community Housing Corporation building, savours her independence and is thankful for the additional support she receives from the CANES Community Care Assisted Living program.

Assisted living programs support seniors through daily visits from a Personal Support Worker who, depending on individual need, performs a variety of personal care and/or light housekeeping tasks. While some seniors may need help with medication reminders, escorts to medical appointments, bathing or getting dressed, others may need support with laundry, grocery shopping, meal preparation and/or light housekeeping. Whatever the need, assisted living programs are an effective way to help seniors remain living independently at home as long as possible.

In the coming year, the Central West LHIN will continue to work with the Central West Community Care Access Centre, Health Links, Long-Term Care homes, local hospitals and community-based service providers to support seniors to stay healthy, live at home longer, and stay out of hospital. We will also help seniors to move more easily between services by integrating more nurses into community-based settings.



"I have been and continue to be very independent, and living on my own is a big part of that. The Community Care Assisted Living Program through CANES helps me to do just that."

– Amy Porter

Central West LHIN... By the Numbers

Residents

840,000+ PEOPLE
7% of Ontario's total population*

86% URBAN

8% SUBURBAN (urban/rural)

6% RURAL

Source: Canadian Census

POPULATION GROWTH BY 2021 23%
Compared to 13% Ontario*

Over 50% VISIBLE MINORITIES
Source: Canadian Census

SENIORS GROWTH 64% BY 2021 Age 65+*

36% OF POPULATION HAS ONE OR MORE CHRONIC CONDITION
Source: LHIN Environmental Scan 2012

*Source: Ministry of Finance, Estimates and Projections 2012

Health Service Providers

23	14	8	2	2	1
LONG-TERM CARE HOMES (LTC)	COMMUNITY SUPPORT SERVICES (CSS)	MENTAL HEALTH & ADDICTIONS AGENCIES	HOSPITAL CORPORATIONS ACROSS 3 PEEL SITES	COMMUNITY HEALTH CENTERS (CHC) ACROSS 5 LOCATIONS	COMMUNITY CARE ACCESS CENTRE (CCAC)
Over 750,000 Resident Days/Year	Over 40,000 clients/year		Over 70,000 admissions and 233,500 Emergency Department visits/year	Over 25,000 primary care visits/year	Serving 32,500 clients/year

Plus 500 primary care physicians, including 6 Family Health Teams, funded by the Ministry of Health and Long-Term Care.

Role

To plan, fund, integrate and manage the local health care system with the aim of providing residents with the right care, at the right time and in the right place.

Vision

To create a health care system that helps people stay healthy, delivers good care when people need it and that will be there for our children and grandchildren.

Values

Local Decision-Making and Transparency

- Important health care decisions, including funding, are now made locally at Board meetings open to the public and media.
- All Board materials are posted on our website one week prior to Board meetings.

Increased Accountability and Performance

- Ontario's health care system is more accountable than ever due to accountability agreements between the LHIN and the Ministry of Health and Long-Term Care, and between the LHIN and Health Service Providers, that outline responsibilities and performance requirements
- We set targets to improve the lives and services of patients/clients/residents and holding organizations accountable for achieving results.
- We ensure public reporting of all of our performance results.

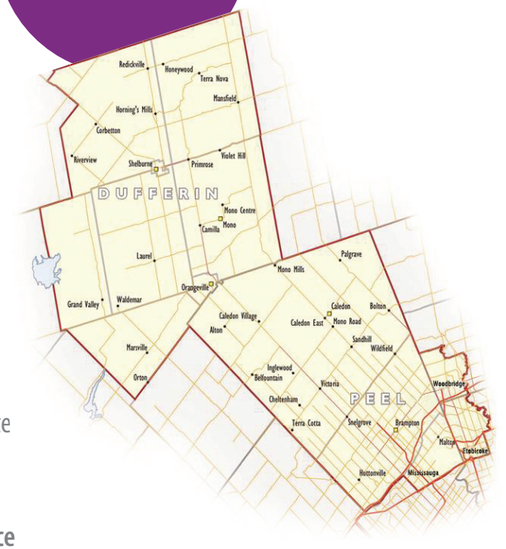
A "System" Approach to Health Care

- LHINs break down silos by providing a structure to connect Health Service Providers.
- LHINs ensure that Health Service Providers not only do what is right for their own organization, but also for the patient/client/resident and health care system.

Community Engagement

- The health needs of local communities are best understood by those who live and work in them. LHINs engage residents and Health Service Providers in a variety of ways to educate, inform, consult, involve and empower the health service planning and decision-making processes.

Geography



Streamline Transitions & Navigation of the Health System

Improving timely access to patient information

Dr. Sanjeev Goel of the Wise Elephant Family Health Team knows what an important role information technology can play in helping practitioners to provide faster, more efficient care to their patients. His family practice has been completely paperless since 2009 relying on technology as a way to securely share patient information with other Health Service Providers and to gain quick access to patients' test results.

Today, more than 87% of family doctors and 51% of specialists within the Central West LHIN have adopted use of an Electronic Medical Records (EMR) system, the highest rate of adoption among family doctors and specialists in Ontario. Health Service Providers have also been early adopters of information technology that supports the secure exchange of electronic information between health care professionals.

This year, the LHIN will continue to work with health system partners to further expand the adoption of available technology that connects providers locally, regionally and provincially. By sharing timely patient information, including laboratory and diagnostic tests, clinical records and discharge summaries, health care professionals, like Dr. Goel, will be able to make quicker diagnoses, initiate treatments faster and develop care plans that support the best patient care.

"My colleagues and I could never go back to paper. The EMR has added efficiency that allows us to manage our patients better, ensures more effective disease screening and prevention, and ultimately improves the patient's journey by linking Health Service Providers to share the information."

– Dr. Sanjeev Goel

Helping residents to navigate the health care system

When "Shirley", was diagnosed with Alzheimer's disease, her husband initially found the support he needed to help manage her care at home through the Central West Community Care Access Centre (CCAC).

Together with and through the CCAC, Health Links, Telehomecare and other initiatives, the Central West LHIN is working to make it easier for residents to access the care they need when and where they need it.

The CCAC made arrangements for a Personal Support Worker to visit Shirley's home and help her husband out with Shirley's day-to-day care needs. When Shirley's needs progressed and her husband was no longer able to care for her at home, the CCAC helped them through the application process for placement in a Long-Term Care home.

The LHIN will continue to work with local Health Service Providers to develop coordinated care plans that will help residents to access the care they need after they have been discharged from hospital. The LHIN will also explore best approaches for delivering rehabilitation care, and look at developing a centralized wait list for adult day programs, assisted living programs and respite services, so that residents can access these local health services through one single point of contact. These initiatives will make it easier for residents to quickly identify and access the services that best meet their needs.

Delivering better coordinated care for residents with complex needs

Residents who are disadvantaged, marginalized or have complex needs, often struggle to get the care they need, where and when they need it.

Together with Health Links partners including the Central West Community Care Access Centre (CCAC), primary care physicians, specialist, hospitals and community partners the Central West LHIN will continue to improve upon the sharing of information and between health care professionals at all levels of the health care system, so that local residents who are high users of the local health care system due to chronic or other conditions, will have active coordinated care plans, experience shorter wait times for specialty services and face fewer readmissions to hospital.

Meanwhile, Telehomecare has improved access to care, wirelessly connecting patients with nurses who provide both remote monitoring and regular health coaching sessions, while continuing to have appointments with their existing Health Service Providers (HSPs) as needed. As a result, Telehomecare does not replace but rather supports and/or augments physician services. With this additional level of support, the program provided better quality and value, reducing unnecessary visits (48%) and admissions (76%) to hospital over its first 6 month period.

Building on its proven success to self-manage chronic diseases, the Central West LHIN Tele-homecare program will be expended to align with Health Links and the identification of high use residents, with the aim of becoming a supportive self-management tool for complex needs.

Drive Quality and Value

Driving quality and safety in the delivery of health care

The Central West LHIN is committed to providing quality leadership in support of the Excellent Care for All Act (ECFAA) and Ontario's Action Plan for Health Care.

Throughout the coming year, the LHIN will continue to develop a Quality Framework to help drive improvements in the quality and safety of health care residents receive in hospitals, LHIN-funded community agencies and Long-Term Care homes. The LHIN's Quality Framework will support the principles of ECFAA and its development will be guided by the attributes of a high-performing healthcare system: accessible, effective, safe, person-centred, efficient, integrated, equitable, population-health focused and appropriately resourced.

The LHIN will also work with Health Service Providers to identify system-level aims for the improvement and alignment of existing initiatives, planning of new initiatives/projects and integration of quality improvement plans and methodologies.

Understanding the experiences patients have with their local health care system is critical to future planning and improvement. Moving forward in 2014/15, the LHIN will seek to identify and/or develop meaningful indicators that can help to capture the patient/resident experience and satisfaction with different parts of the local health care system.

Optimizing resources to foster better care

When "Granville" became physically and verbally aggressive towards staff in his Long-Term Care home, staff didn't know how to cope with his behavior. That all changed when Marcia, a Personal Support Worker with the Behavioural Supports Ontario (BSO) program stepped in.

Funded through the Central West LHIN, BSO was created to enhance and improve services for elderly people, like Granville, who have complex behaviours because of dementia, mental health or other neurological disorders.

Marcia was able to work with staff to help them better understand what was triggering Granville's behavior. By doing so, staff are now able to minimize Granville's incidence of aggression by working with him in more appropriate fashion. BSO is one way the Central West LHIN is supporting safe, high-quality, person-centred care while making the most efficient and effective use of available resources. The LHIN is also working closely with local health system partners to make sure patients receive the care they need when and where they need it. This includes improving how patients move through the local health system as they are transition between services.

Moving forward the LHIN will continue to help residents avoid unnecessary hospitalizations by supporting more community-based services, like BSO, and by making improvements in the way patients are currently admitted to and discharged from hospital.

Build on the Momentum

Aboriginal Health

The LHIN will continue to meet with members of the indigenous community throughout the year to better understand and address local health and service delivery issues, and will work with local Health Service Providers to ensure residents have access to culturally-sensitive services. Planning for the local needs of indigenous communities will build upon work being done at the provincial level.

Diversity and Health Equity

The Central West LHIN is one of the most diverse communities in the province with over half of local residents belonging to visible minority groups. The LHIN will continue to work closely with local Health Service Providers, community partners and residents to ensure the needs and impacts of all groups and communities are considered when planning the local health care system.

Palliative Care

A signatory to the 2011 Declaration of Partnership and Commitment to Action: Advancing High Quality, High value Palliative Care in Ontario, the Central West LHIN is committed to a common vision for palliative care across Ontario.

Using the Declaration as a guide, LHIN will apply work completed at the provincial level toward the development of a local approach to palliative care services. This approach will include enhancing the delivery of high-quality palliative care programs in Long-Term Care homes throughout the LHIN, and working with hospitals to develop resources for inpatients and outpatients that are fully integrated with those used in community-based palliative care.

Women and Children's Health

The Central West LHIN has been working closely with local Health Service Providers and community partners to address gaps in service for children with complex medical conditions. Moving forward the LHIN will work closely with the Provincial Council for Maternal Child Health, aligning its activities with provincial initiatives.

French Language Services

Moving from the Congo to Canada, Marie-Jeanne spoke French but not English. Feeling isolated, she joined a Francophone senior's group "Retraite Active," where she discovered the "Healthy Aging, Enjoy Life" program hosted by Four Corners Health Centre, a satellite of WellFort Community Health Services. The program helps Francophone seniors to build friendships and learn about various services, empowering them to maintain and improve their quality of life while remaining independent, healthy, active and engaged in their local communities. Having since learned English, Marie now volunteers her time to provide advice to other recently immigrated Francophone seniors about the importance of social interaction and community involvement.

The Central West LHIN will continue to build on our collaborative work with Reflet Salvéo and the Mississauga-Halton and Toronto Central LHINs, to engage the Francophone community and improve Francophone access to quality health care services. Health Links will be used to help Francophones connect with family doctors, improving the quality of care and experiences of those with high and unmet needs while addressing gaps in mental health and addictions services.

Central West **LHIN**

8 Nelson Street West, Suite 300
Brampton, Ont. L6X 4J2

centralwestlhin@lhins.on.ca
Tel: 905-455-1281
Toll free: 1-866-370-5446
Fax: 905-455-0427

How are we doing?

If the health needs of local communities are best understood by those who live and work in them, it stands to reason local residents are the best source to inform the Central West LHIN if local planning and investments in high quality, person-centred care are on the right track.

In November 2013, the LHIN conducted its latest public (local resident) poll. An increasing number of local residents feel their health care has changed for the better, including access to and quality of local health care services.

According to results, there has been a steady increase, over the past seven years, in the number of residents who are satisfied with access to their local health care programs and services. Noticeably, 88% percent of residents indicated satisfaction with the quality of their local health care in the Central West LHIN, an 11% percent improvement over the previous public poll conducted in 2009.

This is the third such poll in seven years, an indication of the importance placed by the LHIN on the ongoing assessment of local residents' satisfaction with their health services, their confidence in the health care system and their views of local health priorities.

Residents and Health Service Providers place a high value on their health care system, and over the years Central West LHIN decisions regarding the planning, funding and integration of local health care services have been informed by the voices of patients, family caregivers, residents, Health Service Providers, community partners and those organizations not funded by the LHIN but who play an important role in the design and integration of their local health care system. The consensus is clear…

Together, we are making healthy change happen!