North Simcoe Muskoka LHIN

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Care Connections
Partnering for Healthy Communities

Connecting for Care

October 2010 Edition

Welcome to the ***Connecting for Care*** newsletter - the informative link for all that's happening within the ***Care Connections - Partnering for Healthy Communities*** project.

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We would appreciate hearing from you as to the design of the improved newsletter. Please send us your comments using the **'Feedback Feature'** on the newsletter or by emailing northsimcoemuskoka@lhins.on.ca.

Thanks so much.

Susan French, Communication Coordinator
NSM LHIN

Care Connections - Partnering for Healthy Communities

Getting Ready for the Fall Forum!

The last set of working group meetings concluded at the end of October and finalizing of the care models and opportunities recommendations are being compiled for review and input by the LHIN Leadership council. “A tremendous amount of work and system thinking is evident in these documents. We challenged these experts to come to the table to build a system and to take their organizational hats off – it takes great visionary leadership to do that and they did,” commended CEO Bernie Blais.

Once opportunities are identified and prioritized, there will be lots of work to do yet in planning how those changes come about. “No one is going to just flip a switch and change anything overnight,” states Susan Plewes Care Connections Project Leader.

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Leadership council met and reviewed the draft recommendations on November 4th, noted any additions and changes for developing the final document and will be looking at the remaining framework pieces at their November 10 meeting.

The Forum will outline key findings and recommendations of the groups and mark the completion of the planning and the beginning of the implementation phases of this important project for the sustainability of our health system.

REGISTERING FOR THE FORUM

This **invitation only event** does require everyone to RSVP and register online on the NSM LHIN website. We have capacity for 400 people only and anyone who is not formally registered will not be granted admittance to the event. Planning details are being put into place with the venue and the development of the poster session is well underway.

ICT/eHealth Project

The ICT/eHealth Project is in the final phase nearing completion. Over the past several months, key project deliverables have been created including input from the Care Connections Symposium, Care Connections Working Group validation sessions, ICT/eHealth Community Workshops, ICT/eHealth Working Group and Steering Committee members.

The ICT/eHealth Project has been running in parallel to the ***Care Connections - Partnering for Healthy Communities*** project and continues to synthesize the work being produced out of the nine working groups. The LHIN Leadership Council has had the opportunity to review each of these key deliverables and has supported and endorsed each one to date, including the following: Guiding Principles, Framework, Vision, ICT Current State Assessment and eHealth Council Terms of Reference.

The final focus of the team will be in refining the business model, future state ICT/eHealth model, implementation roadmap and creation of the strategic plan. The final strategic plan (and 3 year tactical plan) will be reviewed by the LHIN Leadership Council in January. Once approved, the focus of our efforts will move toward implementation of the strategy.

The implementation of the strategy will be overseen by the soon-to-be created eHealth Council. Recruitment to this committee will begin in early November. The project is anticipated to be complete by December 2010.

For further information or to get involved, please contact Rod Burns at rodney.burns@lhins.on.ca or at 705-326-7750 Ext. 214.

Congratulations to Mental Health Centre Penetanguishene!

Congratulations to Mental Health Centre Penetanguishene (MHCP) on winning the award for **Innovation in Patient/Resident Centredness** at the recent Celebrating Innovations in Health Care Expo 2010. MHCP's innovative initiative was entitled **"Tips and Tricks to Improve Your Metabolic Health".** Here is information about the program, taken from the Expo's list of exhibitors:

"Statistics (and our experience) have shown that clients with psychiatric illness are at far higher risk than the general population for developing metabolic imbalance and ultimately metabolic Syndrome. apart from the personal suffering for people, the cost to the healthcare system is astronomical as it predisposes to cardiovascular disease, Type II diabetes, sleep apnoea, arthritis, liver disease, kidney disease and dementia. It also contributes to the ways in which our clients are stigmatized in the community. Medications to treat schizophrenia and depression further complicate the picture as they can cause significant weight gain. Clients with serious mental illness are at high risk for Metabolic Syndrome because of their medications, sedentary lifestyle, poor diet, smoking habits, poverty, living conditions, co-morbid addictions and lack of comprehensive medical care. Utilizing committed and enthusiastic staff, peer workers and minimal capital expenditure this venture has proven to be enormously popular and successful with clients."

MHCP was up against Holland Orthopaedic and Arthritic Centre, Sunnybrook Health Sciences Centre with their "Deployment of Remote Pharmacy Technology to Support Patient Care" and Thunder Bay Regional Health Sciences Centre and "Care2Talk".

L-R: Tom Closson, OHA President, Dr. Jacqueline Brown, The Honourable Deb Matthews, Minister of Health and Long-Term Care, Sue Fraser, RN and

Mary Lenio, RN

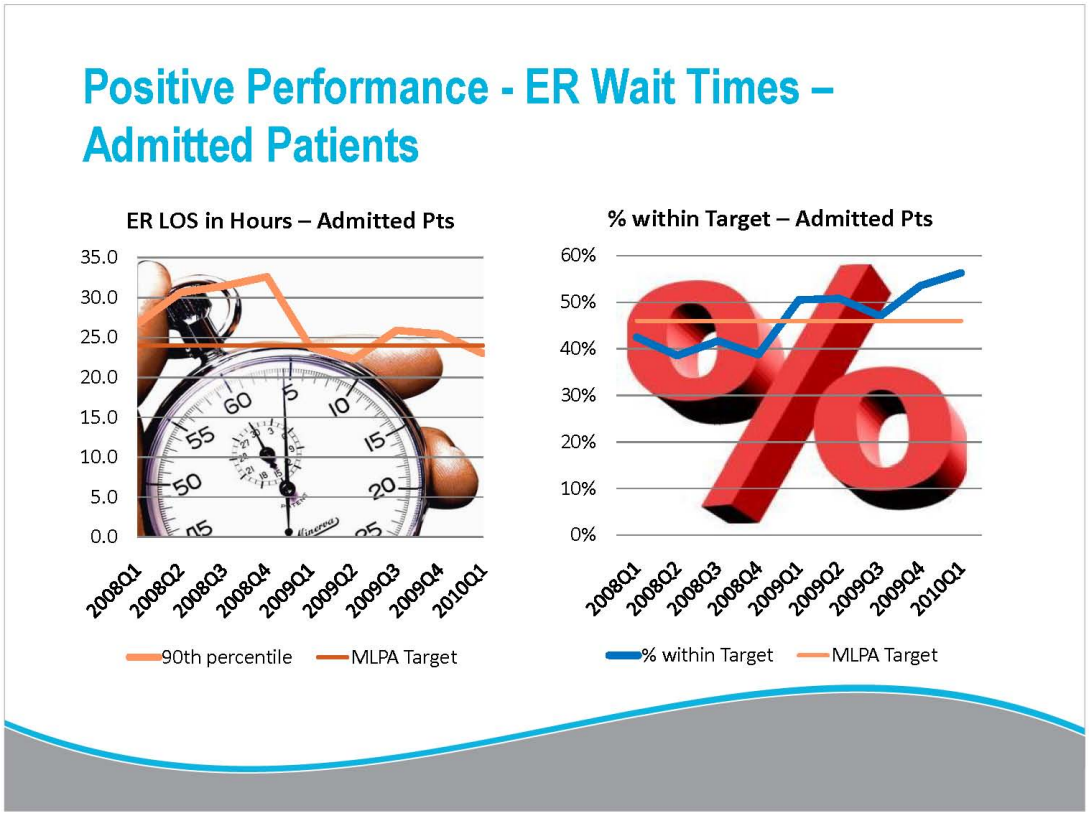
LHINs Working Together for Better Performance

All 14 LHINs came together to talk about opportunities to share best practices and focus on key strategies for improving performance targets as a provincial system. The performance tracking the LHINs use to report to the Ministry on its performance targets is referred to as Stocktake. The Stocktake Forum Exchange gave each LHIN an opportunity to discuss their challenges and opportunities.

Each LHIN gave a 15 minute presentation on their challenges resulting in under performance of their initiatives/strategies, how the LHIN will meet the indicator targets going forward and best practices where the LHN is meeting or exceeding the indicator targets. After five presentations were completed a group discussion followed. From these discussions came common themes of best practices, challenges and concerns. The LHINs collectively agreed to further the work of some existing electronic tools, such as the resource matching and referral tool and those tools that allow for an integrated decision support to health care providers. The LHINs will begin to explore what a senior friendly health system would look like; gain a further understanding of why some patients are admitted to hospital and then designated ALC within only 2 days and review the overall utilization of inpatient resources. These are seen as key items for improving performance metrics.

Below is NSM LHIN's performance on Emergency Room Wait Times for admitted patients and represents the length of stay (LOS) in the ER for patients waiting to be admitted as well as the percent of time that the LHIN is meeting our target. Emergency Room wait times for admitted patients experienced a 27.6% improvement from March 2009 to March 2010.

Fiscal year and reporting Quarters reflect April 1 to March 31 fiscal year of the government.



ER Wait Times Worth Cheering About

By Dr. Howard Ovens

A couple of weeks ago, Health Minister Deb Matthews announced that St. Michael's Hospital had lowered its emergency room times from 26 hours in April 2008 (inception of the Ontario ER/ALC strategy, a program to reduce ER crowding and waiting) to 10 hours in June of this year. The public and media reaction was muted, reflecting widespread confusion about what exactly was measured and whether this was anything to cheer about.

I'd like to explain the announcement and tell you why many in the emergency medicine community are indeed cheering the service improvements we are making.

Ontario measures and publicly reports total length of stay in the ER as part of its wait time strategy. Most people would think of their wait time during an ER visit as the time you spent in the waiting room or in a cubicle in the ER, waiting for the doctor to see you. But once you've been seen, many patients continue to have waiting interspersed with care: waiting for tests to be done and reported; waiting for a consultant to see you; waiting for a bed to be ready to receive you if you are admitted.

Much of this time can't be helped; analyzing blood tests, completing careful assessments and many other elements of care just take time. Ontario wanted to capture all those contributors to waiting by measuring total length of stay in the ER from arrival to departure home, or in the case of about one in seven patients, until leaving the ER for your in-patient bed.

Ontario set targets for total length of stay in the ER: four hours for non-complex patients who go home; sore throats, sprained ankles, simple cuts and eight hours for more complex patients who go home or are admitted such as chest pain, strokes, shortness of breath, etc. Ontario also decided to track these measures at something called the 90th percentile, rather than the average or median. The 90th percentile is the maximum time at which nine of 10 patients will have been cared for and released (only one in 10 will stay longer), while the median would be the maximum time for five of 10 patients half stay shorter, half stay longer.

Experts advised that judging ER performance at the median would leave potentially long waits by too many patients unapparent in the data, but reporting at the maximum times (99th or 100th percentile) would include exceptional cases where patients need to stay longer over 24 hours in many cases, because of complexities in their medical or social circumstances that can't or shouldn't be avoided. Thus the 90th percentile was just right for our purposes.

So the St. Michael's announcement highlighted the fact that in 2008 their ER length of stay was 26 hours at the 90th percentile; that is, it took a maximum of 26 hours to get nine out of 10 patients fully assessed, treated and released or admitted, while in June of this year they are getting to the same point in a maximum of 10 hours (their average length of stay went from 10.3 hours to 4.6 hours in the same period, while the median went from 5.6 to 3.6 hours).

Accomplishing this improvement with a modest investment of resources, while maintaining the quality and accuracy of diagnosis and care, is a major achievement. It does not mean that I, or anyone involved in this program, thinks waiting 10 hours is acceptable, but 10 hours to get the more complex patients seen, scanned, treated, counseled and admitted (or released) is pretty good.

With respect to what you consider wait times, this year the median wait to see a doctor in Ontario ERs is one hour (and coming down). However, I have to emphasize that the response on your arrival to an ER varies with the acuity of your problem; the sickest patients will always be seen first, less serious cases may have to wait. But in Ontario this year, almost nine out of 10 patients with non-complex problems receive all their care, complete their visit and are released within the four-hour target.

Individual experience is important, especially if it's you, your loved one or neighbour. But judging the program based on a few anecdotes is dangerous; ER times, whether waiting or total length of stay, are highly variable.

As I've stressed, the sickest patients go to the front of the line, and there remains a lot of variability from day to day and from hospital to hospital in waiting times (although decreasing variability is a measure of the effectiveness of improvement, and in Ontario, variability is decreasing).

Ontario is the first province in Canada to have the courage to tackle ER overcrowding and waiting. We are the only province to have set targets for length of stay and to report publicly on performance, and we have made major improvements over the last two years.

This leads not only to less patient frustration, but is safer also, as some patients will be at risk from delays in care. Patients who are less angry or frustrated also make for happier ER docs and nurses, which helps us keep our best people practicing in the ER; a high-stress environment that burns out a lot of staff. Good ER care will always depend on having good staff, so happier

staff ultimately means better care for you and your family.

Health care in Canada is highly political and it's easy to get caught up in that. My personal interest is in improving the quality of care, and getting the facts right.

But before you come to your own conclusions on our performance, it may be helpful to put Ontario's experience into an international perspective. The United Kingdom was the first major jurisdiction to tackle ER wait times. It set a firm four-hour limit for length of stay and expected it to be achieved 98 per cent of the time. It got there but had to make major changes in the way care was organized and delivered.

Ontario was emboldened by the U.K. success but deliberately decided to go with softer targets for a more evolutionary, rather than revolutionary change.

This spring the U.K. announced it was giving up on the four-hour target because of major concerns about the quality of care being delivered.

I think the Ontario approach, and resulting improvements to care, are indeed something to cheer about.

Dr. Howard Ovens is the Director of the Schwartz/Reisman Emergency Centre, Mount Sinai Hospital, and co-chair, Ontario ER/ALC Expert Panel. This article originally appeared in The Toronto Star on August 25, 2010

Coming in November ....

- ***Care Connections - Partnering for Healthy Communities***
  - **Fall Forum Report**
- **Regional Complex Continuing Care**
- **New Faces**

Ontario
Local Health Integration Network