Making it Count: Reinvestment as a Response to Critical Needs

Cal Martell, Senior Director Health System Integration
September 29, 2016
Overview

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2) LHIN Funding Approval Process

3) The Challenge Going Forward

4) Current Health System Priorities
   - Integrated Health Services Plan
   - Sub-Acute Care
   - Health Links
<table>
<thead>
<tr>
<th>Programs</th>
<th>Sector</th>
<th>Annual Allocation</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Hospitals</td>
<td>$1,743,927,300</td>
<td>68.1%</td>
</tr>
<tr>
<td>60</td>
<td>Long-Term Care Homes</td>
<td>$350,024,798</td>
<td>13.7%</td>
</tr>
<tr>
<td>1</td>
<td>Community Care Access Centre (many service locations)</td>
<td>$236,484,027</td>
<td>9.2%</td>
</tr>
<tr>
<td>63</td>
<td>Community Mental Health &amp; Addiction Services</td>
<td>$97,124,111</td>
<td>3.8%</td>
</tr>
<tr>
<td>85</td>
<td>Community Support Services*</td>
<td>$71,934,827</td>
<td>2.8%</td>
</tr>
<tr>
<td>11</td>
<td>Community Health Centres (including satellites)</td>
<td>$62,627,799</td>
<td>2.4%</td>
</tr>
<tr>
<td>240</td>
<td></td>
<td>$2,562,122,862</td>
<td>100%</td>
</tr>
</tbody>
</table>

* Includes funding for Acquired Brain Injury and Assisted Living Services in Supportive Housing
Champlain LHIN Overall Dedicated Funding

- The Champlain LHIN receives dedicated funding allocations primarily in three sectors:
  - Community Care Access Centre;
  - Hospitals; and,
  - Long Term Care Homes.
Health System Funding Reform

What is Health System Funding Reform (HSFR)?

- An evidence-based funding model with incentives to deliver the highest quality, most efficient care
- Funding is based on:
  - How many patients they look after
  - The services they deliver
  - The evidence-based quality of these services
  - The specific needs of the population they serve.
Health System Funding Reform (HSFR)

How does HSFR work?

• **Health Based Allocation Model (HBAM):**
  - Inform funding allocation to health service providers
  - Management tool to assist with health system service planning

• **Quality-Based Procedures:**
  - “Price x Volume”
  - Separate funding streams
  - Evidence-based framework
  - Clinical pathways ensure quality standards
Funding Approval Process

- LHIN staff uses the Priority Setting and Decision Making Framework to help prioritize projects for the Annual Business Plan, which is endorsed by the Board of Directors.

- Projects are identified by LHIN staff that are aligned with the Annual Business Plan and funding requests are approved by the LHIN Senior Management Team.

- Where funding remains, LHIN staff reviews Health System Improvement Pre-Proposal forms submitted by Health Service Providers and use the Priority Setting and Decision Making Framework to help identify those best aligned with our Integrated Health Service Plan.
Priority Setting & Decision-Making Framework

• The framework is built around 4 domains:

  ➢ System Alignment – \textit{Determines alignment with both Ministry and local priorities} \\
  ➢ System Performance – \textit{Contributes to the meeting of system goals and objectives} \\
  ➢ System Values – \textit{Ensures local and system wide attributes are being met including equity, innovation and community engagement} \\
  ➢ Population Health – \textit{Determines contribution to the improvement of the overall health of the population}
Champlain LHIN Strategic Plan, at a glance

**Mission**: Building a coordinated, integrated and accountable health system for people where and when they need it

**Vision**: Healthy people and healthy communities supported by a quality, accessible health system

**Values**: Respect, Trust, Openness, Integrity, Accountability

### Strategic Directions

#### Integration
- Improve the patient and family experience across the continuum of care

#### Access
- Ensure health services are timely and equitable

#### Sustainability
- Increase the value of our health system for the people it serves

### Person-Centred Goals

#### Integration
- People who need multiple services receive more coordinated home, community and primary care
- People experience a smooth transition from hospital to home

#### Access
- People can access quality care no matter who they are or where they live
- People are able to access priority health services when they need them

### Strategic Priorities

#### Integration
- Integrate community and home care services
- Evolve primary care networks
- Integrate mental health and addiction services

#### Access
- Provide for culturally and linguistically appropriate care
- Implement strategies to achieve performance targets
- Expand use of enabling technologies to bring care closer to home

#### Sustainability
- Continue implementing funding reform and innovative models of care
- Enhance palliative care in settings of choice
- Fast-track implementation of Health Links

### Outcomes
- Being Healthy
- Getting Better
- Living with Illness / Disability
- Having Choices at End-of-Life
Population Health Outcomes

- **Being Healthy**: Helping individuals stay physically and mentally healthy and prevent risk of injury, illness, chronic disease or disability.

- **Getting Better**: Helping individuals return to health after suffering an acute illness or injury.

- **Living with Illness or Disability**: Helping individuals receive appropriate care and support related to chronic illness or disability.

- **Having Choices at End-of-Life**: Helping individuals receive care and support that relieves suffering and improves the quality of living with, or dying from, a progressive, life-limiting illness.
Strategic Foundation

Mission
Build a coordinated, integrated and accountable health system for people where and when they need it

Vision
Healthy people and healthy communities supported by a quality, accessible health system

Values
Accountability, Respect, Integrity, Openness, Trust
Strategic Directions

Integration
*Improve the patient and family experience across the continuum of care*

Access
*Ensure health services are timely and equitable*

Sustainability
*Increase the value of our health system for the people it serves*
Integration

Improve the patient and family experience across the continuum of care

**Strategic Direction**

**Integration**

Improve the patient and family experience across the continuum of care

**Goals**

- People who need multiple services receive more coordinated home, community and primary care, and
- People experience a smooth transition from hospital to home.

**Priorities**

- Integrating community and home care services
- Evolving primary care networks, and
- Integrating mental health and addiction services.
Access

Ensure health services are timely and equitable

Strategic Direction
Access
Ensure health services are timely and equitable

Goals
• People can access quality care no matter who they are or where they live, and
• People have faster access to priority health services.

Priorities
• Providing for culturally and linguistically appropriate care
• Implementing strategies to achieve performance targets, and
• Expanding use of enabling technologies to bring care closer to home.
Sustainability

Increase the value of our health system for the people it serves

**Strategic Direction**
Sustainability
Increase the value of our health system for the people it serves

**Goals**
- People can get service in the most appropriate setting, and
- People receive efficient and effective care.

**Priorities**
- Continuing implementation of funding reform and innovative models of care
- Enhancing palliative care in settings of choice, and
- Fast-tracking implementation of Health Links.
Example of Investments by Priority (cont’d)

More people with mental health conditions and addictions have access to services

<table>
<thead>
<tr>
<th>Item</th>
<th>Annualized Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexible Acute Community Treatment Team (FACT)</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Transitional Aged Youth Services</td>
<td>$600,000</td>
</tr>
<tr>
<td>Targeted Engagement and Diversion Program (TED)</td>
<td>$425,000</td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>$200,000</td>
</tr>
<tr>
<td>Walk-in Counselling (Aboriginal &amp; Immigrant Communities)</td>
<td>$386,200</td>
</tr>
<tr>
<td>Peer Navigators</td>
<td>$280,000</td>
</tr>
<tr>
<td>Withdrawal Management Program</td>
<td>$971,703</td>
</tr>
<tr>
<td>Suicide Prevention</td>
<td>$248,000</td>
</tr>
<tr>
<td>Mental Health Navigation</td>
<td>$150,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$4,760,903</strong></td>
</tr>
</tbody>
</table>

* A portion of this funding is allocated as one-time
** All of this funding is allocated as one-time
Ontario’s health care system is facing significant challenges over the next few years

**Fiscal Challenge**
- Historic levels of investment growth are not seen to be sustainable

**Demographic Challenge**
- The cost of care for a senior is 3x higher than for the average person
- Changing demographics will result in a higher cost to the system

**Complex Health Challenge**
- A small number of patients use a disproportionate amount of resources
- Making better use of our health care resources so people get the most appropriate care

**Unhealthy Lifestyle Challenge**
- Unhealthy eating, lack of activity and smoking levels may lead to increased chronic disease

Source: Ontario Ministry of Health and Long Term Care
The Challenge Going Forward

• We can no longer rely on new investments to respond to the changing needs of our population.
Champlain Sub-Acute Capacity Plan

Overview
Capacity Planning

“A process to determine current and future health service requirements, and is essential to guide strategic decisions regarding where investments need to be made and where shifts of funding are required”.

(OHA.)
Objective

- Develop a region-wide plan to guide the LHIN in the planning and execution of programming and services that will allow timely access to sub-acute care and maximize patient outcomes

Parameters

- **Scope**: all rehabilitation, complex continuing care, convalescent and transitional care beds and publicly funded community restorative care services
- Plan must align with new Rehabilitative Care Alliance (RCA) Planning framework
- Make recommendations on number and siting of sub-acute resources
- Optimize resource utilization (tools and processes to improve coordination)
### Current Supply - Sub Acute Inpatient Services

**(Feb 2015)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex CC</td>
<td>509</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>31</td>
</tr>
<tr>
<td>Specialized Rehab</td>
<td>134</td>
</tr>
<tr>
<td>Short-Term Rehab</td>
<td>89</td>
</tr>
<tr>
<td>Convalescent Care</td>
<td>76</td>
</tr>
<tr>
<td><strong>Transitional Care</strong></td>
<td>32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>871</strong></td>
</tr>
</tbody>
</table>

Approximately 6,450 in-patients (2014/15)
Approach

• Sub-Acute Capacity Planning Steering Committee
• Review literature, evidence and best practice guidelines
• Key informant interviews (75 individuals including patients & caregivers, from across the LHIN and sectors)
• Data analysis
• Modeling
• Testing draft model and assumption in regional planning retreat
• Refinement to model
• Steering committee consensus on recommendations
How Are We Doing (1) ...by the Numbers  
Source: Hay Group Report

**Rehabilitation Services**

- **Access:** 52% of acute pts. ready for rehab experience delays incl. stroke & hip (avg. 12.5 days)

- **Patient Outcomes:** Functional status at admission is highest in Ontario; experience lowest gains, and are more likely to be d/c to LTC.

- **Cost:** Resource Case Weight is 5th highest on Ontario.

**Complex Continuing Care**

- **Access:** Length of stay highest in Ontario (2X); lowest % of assessments categorized as rehabilitative;

- **'Appropriateness:** Very high use for pts. not receiving therapy, nursing activation, not medically complex or palliative.
How Are We Doing \(^{(2)}\) ...by the Numbers Source: Hay Group Report

**Home Care**

- Lowest utilisation for patients categorized as progression;
- Rate of use of service by rehab pts 13/14 in Ontario;
- Highest rate of referral of rehab patients to Long-Term Care.
How Are We Doing (3) : Stakeholder Perspective

• The majority of stakeholders in the LHIN feel that Champlain is currently a 6/10 or 7/10 on “right service, right provider, right place, right time” for sub-acute care.

• Most common challenges cited include:
  
  • Silos, transitions, accountability issues across the different parts of the system
  • Increasing pressures and complexity within this sector
  • CCC resources/infrastructure “not caught up” to new role
  • “Bottlenecks” in system related to capacity, lack of alternative living arrangements
  • Limited outpatient, ambulatory and community based services, particularly outside of Ottawa
  • Limited homecare supports; processes through CCAC generally not timely or comprehensive enough
The Case for Change: Capacity Projections 2019

- If subacute services are delivered as they are now, to accommodate an older and larger population in Champlain:
  - 156 more sub-acute beds will be needed
  - $45 Million increase in funding

- But, with investments to *optimize* and *restructure* the current system, population growth and future need can be accommodated within today’s supply of rehabilitation and chronic care beds.
System Characteristics

- More upstream care to prevent the need for sub-acute care;
- Increase access to care in own communities;
- Accessible transitional and supportive housing options
- Expanded team of providers responsible for delivering sub-acute care, including current primary care and new types of providers
- Capacity to address chronic, long term, life cycle needs of people with disabilities
Mitigation Required to Achieve the Plan

- Reducing length of stays in chronic beds to provincial averages (up to 104 beds)
- Moving patients directly to specialized rehab (5 beds)
- Reducing Alternative Level of Care Days, primarily by avoiding inappropriate admissions and reducing lengths of stay (save 6.6 rehab beds and 18.5 chronic beds)
- Expanding capacity of community hospice to allow the current 31 Bruyère palliative care beds to meet the demand (10 beds)
Key Requirements to Achieve the Plan

- Significant investments in home therapy supports (35% increase overall, with 65% increase in in home progression services), ambulatory and other community sub-acute care

- Redistribution of bed types throughout the system

- Some beds currently designated as chronic care will be used for rehabilitation

- Consolidate highly specialized rehab at single site in Ottawa, and distribute higher volume, less specialized rehab across LHIN in regional hubs

- Greater reliance on convalescent units in LTC for activation/restoration
Also Important...

- No increase in long-term care capacity is assumed to achieve this plan
  - but sub-acute system **must** have adequate and timely access to long-term care capacity (priority access may be required)

- Opportunity to be leaders in efforts to reduce future demand for sub-acute services by investing “upstream”
  - early identification and prevention strategies for those in the community to avoid future use of the system
  - prevention of “hospital acquired disability” for those in the acute system
### Recommended Distribution of Sub-Acute Resources 2019 By Bed Type and County

<table>
<thead>
<tr>
<th>Program/Bed Type</th>
<th>Eastern Counties</th>
<th>Greater Ottawa</th>
<th>Renfrew County</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Rehabilitation</td>
<td>12.7</td>
<td>127.7</td>
<td>12.3</td>
<td>152.7</td>
</tr>
<tr>
<td>General/Geriatric</td>
<td>12.7</td>
<td>108.9</td>
<td>13.6</td>
<td>135.2</td>
</tr>
<tr>
<td>Projected Rehabilitation Beds</td>
<td>25.5</td>
<td>236.6</td>
<td>25.9</td>
<td>287.9</td>
</tr>
<tr>
<td>Current Designated Rehab Beds</td>
<td>20.0</td>
<td>197.0</td>
<td>22.0</td>
<td>239.0</td>
</tr>
<tr>
<td><strong>Additional Rehab Beds Required</strong></td>
<td><strong>5.5</strong></td>
<td><strong>39.6</strong></td>
<td><strong>3.9</strong></td>
<td><strong>48.9</strong></td>
</tr>
<tr>
<td>Projected Chronic Beds</td>
<td>65</td>
<td>417</td>
<td>33</td>
<td>515</td>
</tr>
<tr>
<td>Current Designated Chronic Beds</td>
<td>81</td>
<td>424</td>
<td>55</td>
<td>560</td>
</tr>
<tr>
<td><strong>Additional Chronic Beds Required</strong></td>
<td><strong>(16)</strong></td>
<td><strong>(7)</strong></td>
<td><strong>(22)</strong></td>
<td><strong>(45)</strong></td>
</tr>
<tr>
<td><strong>Required Change in Total Sub-Acute Hospital Beds</strong></td>
<td><strong>(11.5)</strong></td>
<td><strong>32.6</strong></td>
<td><strong>(18.1)</strong></td>
<td><strong>3.9</strong></td>
</tr>
</tbody>
</table>

- A net of less than 4 beds will be required to accommodate projected growth and need, if mitigation strategies (optimization and restructuring) are effectively implemented.
## Proposed Investments

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5.6M (more intensive care)</td>
<td>$11.3M</td>
</tr>
</tbody>
</table>

*It is expected that as service volumes increase, and they are provided efficiently, the provincial health system funding approach will allocate additional funds to the Champlain LHIN.*

*Improve access to in-home therapy and support equivalent to provincial average. (combination of new & reinvestments)*
Recommendations

- Develop a new model to improve access to sub-acute care in Champlain that is aligned with the Ontario Rehabilitative Care Alliance Framework and will:
  - Increase the number of rehabilitation beds across the region;
  - Reduce unnecessary use of complex continuing care beds;
  - Reduce the length of stay in complex continuing care to the provincial average;
  - Take measures to reduce the future demand for sub-acute care, including ‘hospital acquired disability’.

- Identify a regional group to advise the LHIN on the direction and stewardship of these system level changes.
Health Links
Proportion of Champlain LHIN Patients and their Associated Health Care Costs
Champlain High Needs Patient Definition

- Champlain residents (1,230,655)
- Champlain patients (1,060,528)
- Top 10% (106,053)
- Multiple Service Needs (28,853)
- Patients with High Needs (26,744)

Target: 10,000

Top 5% → 65% of health care costs
Goal of Health Links

• “Improve the delivery and coordination of care to a defined population and reduce costs…”

…through hospital avoidance
Garth
2011-12 Health Service Use Summary
Example

Demographic Information
- Age: 55-60
- Sex: Male
- Health Link Area: #7
- Language: English only
- Social Determinants: No higher education, farmer living alone with no nearby family, can only afford part-time farm help

Services / Episodes

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Number of services/episodes</th>
<th>Total Cost ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department visits</td>
<td>11</td>
<td>$4,779</td>
</tr>
<tr>
<td>Acute IP stays</td>
<td>7 (58 acute care days, 2 ALC days)</td>
<td>$161,659</td>
</tr>
<tr>
<td>FP visits</td>
<td>16 (8 different FP’s)</td>
<td>$1,235</td>
</tr>
<tr>
<td>Specialist visits/consults</td>
<td>39 (14 different specialists)</td>
<td>$8,442</td>
</tr>
<tr>
<td>CCAC</td>
<td>1 service activity</td>
<td>$2,924</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$187,823</strong></td>
</tr>
</tbody>
</table>

Conditions documented during hospital visits/stays and doctor visits

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>No</td>
</tr>
<tr>
<td>COPD</td>
<td>No</td>
</tr>
<tr>
<td>Ischemic Heart Dis.</td>
<td>Yes</td>
</tr>
<tr>
<td>Asthma</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes</td>
<td>No</td>
</tr>
<tr>
<td>Other Heart Dis.</td>
<td>No</td>
</tr>
<tr>
<td>Cancer</td>
<td>No</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Yes</td>
</tr>
<tr>
<td>Stroke</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Yes</td>
</tr>
<tr>
<td>Sub. Abuse</td>
<td>No</td>
</tr>
<tr>
<td>Devel. Disab.</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia</td>
<td>No</td>
</tr>
</tbody>
</table>

Specialist Consultations (# of visits/consults, # different specialists)
- Anaesthesia (12,2)
- Cardiology (11,6)
- Gastroenterology (3,2)
- General Surgery (4,1)
- Diagnostic Radiology (32,11)
- Internal Medicine (59,15)
- Neurology (1,1)
- Ophthalmology (3,1)
- Urology (2,2)

CCAC Services
- Nursing visit
Re-Framing the Patient Experience

Focus on effects of illness

Person-centered approaches focus on potential to manage or "live well" with chronic conditions
Patient Impact

- **JACK - Age: 62**
  - Conditions include bipolar disorder, substance misuse, osteomyelitis (recent amputation)
  - Additional challenges: poor living conditions, poor self-care
  - Frequent ED visits & admissions; does not want to be discharged or to follow care recommendations
  - Jack’s Goals: live on his own, walk again, transportation to appointments, learn more about his health care

- **LOUISE – Age: 64**
  - Conditions include diabetes, fibromyalgia, pain, nausea and sleep problems
  - Additional challenges: poverty, family issues
  - Weekly visits to primary care provider
  - Louise’s Goals: transportation to appointments, address family issues, reduce pain and nausea

**Outcomes:**
- Jack has become a partner in his own care; he now has a primary care physician and is following through on care recommendations that help him to achieve his goals; ED visits and admissions have ceased
- Improved health, doctors visits reduced to once a month; most importantly, Louise is now able to participate in culturally-based activities that are important to her
## System Impact: Prescott-Russell Health Link (PRHL)
Hawkesbury General Hospital Example

<table>
<thead>
<tr>
<th></th>
<th>Pre-PRHL</th>
<th>Post PRHL</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average # of Days of Hospitalization per Patient per month</td>
<td>1.69 days</td>
<td>1.22 days</td>
<td>28% reduction</td>
</tr>
<tr>
<td>Annualized for 80 patients</td>
<td>1622 days</td>
<td>1171 days</td>
<td>451 days avoided</td>
</tr>
</tbody>
</table>
Our Path Towards Scaling & Sustainability 2016-19

Number of Coordinated Care Plans

Health Link Three-year Growth

- 2015/16: 233
- 2016/17: 1,325
- 2017/18: 4,375
- 2018/19: 10,000
Health Link Maturity Journey

- Start-up Planning
  - Establish and Test Processes
- Evolving
  - Functional Excellence
    - Best Practices & Engaged Commitment
- Integrated Excellence
  - Integration across all partners
- Population Impact at Scale
  - “New Normal” across all settings
Challenges to Moving Forward

- Sustainable models of care coordination
- Primary Care Engagement
- Connectivity & Data
- Funding Uncertainty

Keep the focus on the Patient!!
The Challenge: Finding Capacity to Coordinate Care

“We need a willingness to think in a different way and to acknowledge that the system as it currently exists is not systematic.

We are looking for our leaders in our local health system to embrace the opportunity to reconsider, re-imagine, and re-invent these partnerships and relationships for a more effective model of care and improved patient experience for better health outcomes. “

Kelly Hollihan,
Board Chair Pembroke Regional Hospital
North Renfrew County Health Link
Board Engagement Session May 2016
Health Care’s Common Morality (Dr. W. Nelson)

Respect for Patients (Autonomy)

• *Promoting self–determination through shared decision-making*....

Promote Patients Best Interest

• *Commitment & accountability to evidence-based care*

Distributive & Social Justice (Equity)

• *Allocating resources fairly and providing value for services rendered*....