

Understanding the Ontario Health Care System

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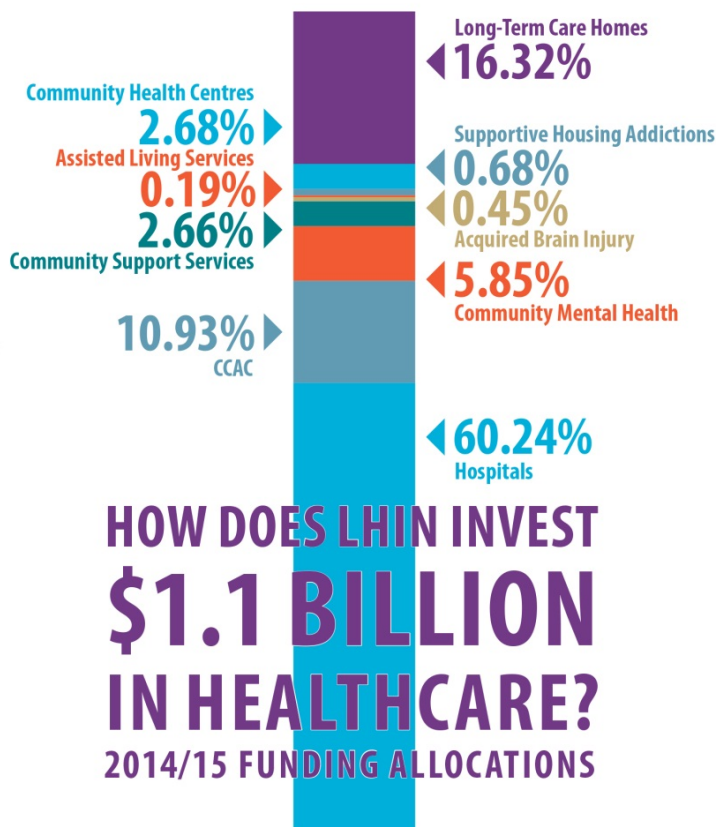
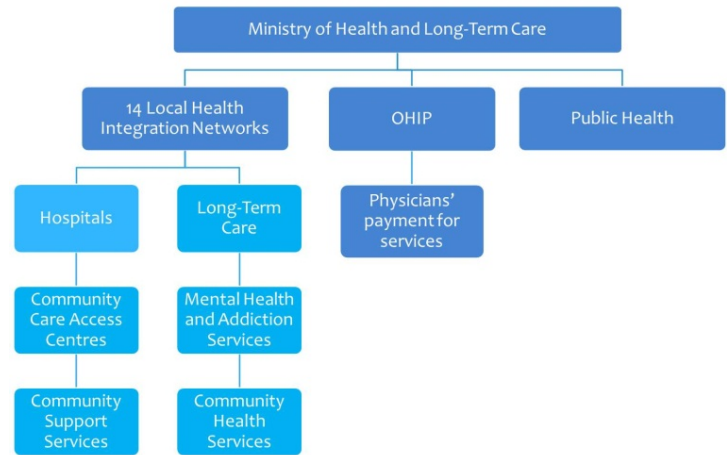
Ontario Health Care System

Structure

The Ontario health care system is a complex network of different health care organizations and providers, working together to meet the health care needs of Ontarians.

The **Ministry of Health and Long-Term Care** (MOHLTC) provides overall direction and leadership for the system. The ministry is responsible for:

- Overall strategic direction and provincial priorities for the health system;
- Developing legislation, regulations, policies, and directives to support those strategic directions;
- Monitoring overall performance of Ontario's health system;
- Establishing levels of funding for the health care system;



The 14 **Local Health Integration Networks** (LHINs) in Ontario were formed in 2006 in order to move health care administration from the provincial level to the local level. In addition to allocating funds to health care providers across the region, the LHINs also work with each provider to plan, engage and make decisions at a local level, with the goal to improve the health care system.

LHINs are responsible for: hospitals, long-term care homes, Community Care Access Centres, Community Support Services, Community Health Centres and Addictions & Mental Health Agencies. ***They do not have responsibility for: physicians, Public Health, ambulance services, or provincial networks (e.g., Cancer Care Ontario).***

The South East LHIN is responsible for investing \$1.1 billion in health care funding in its region, which stretches from Brighton to Prescott, north to Smith Falls and back to Bancroft.

Oversight

Each of Ontario's health care organizations has its own Board of Directors, responsible for strategic planning; quality of care; financial oversight; management performance; evaluation and board effectiveness.

So while the MOHLTC provides the strategy and oversight at the provincial-level, the LHIN is the regional-level oversight and strategy, and the Board of Directors of each health service provider is the organizational-level oversight and strategy.

All hospitals and LHINs sign a Hospital Service Accountability Agreement that enforces accountability for the way provincial tax dollars are used, the number of patients receiving care, and the quality of care delivered.

Action Plan for Health Care

In February 2015, Ontario's Minister of Health, Dr. Eric Hoskins, released an updated Action Plan for Health Care. The focus is on "Putting Patients First", which is defined as:

- Supporting Ontarians to make healthier choices and help prevent disease and illness
- Engaging Ontarians on health care, so we fully understand their needs and concerns
- Focusing on people, not just their illnesses
- Providing care that is coordinated and integrated, so a patient can get the right care from the right providers
- Educating patients to understand how the system works, so they can find the care they need when and where they need it
- Decisions that are based on patients feedback, allowing patients to play a major role in system change
- Providing transparency in health care, so Ontarians can make informed choices

This plan focuses on four key objectives:

1. **Access:** Improve access – providing faster access to the right care.

When people want to take steps to prevent illness, are sick or get injured, they need to be able to get the right kind of help, whether from a family doctor, nurse-practitioner, pharmacist or a number of different care providers.

2. **Connect:** Connect services – delivering better coordinated and integrated care in the community, closer to home.

The foundation has been laid to enable the home and community care sector to meet the needs of today's population with an enhanced focus on seniors and chronic disease management.

3. **Inform:** Support people and patients – providing the education, information and transparency they need to make the right decisions about their health.

For Ontarians, health is also about more than the care they receive from providers. It is about living a healthier life, avoiding getting sick and learning about good ways to manage illness when it happens. Creating a culture of health and wellness will support Ontarians in making educated, informed decisions about their care.

4. **Protect:** Protect our universal public health care system – making evidence based decisions on value and quality, to sustain the system for generations to come.

Our universal health care system belongs to the people of Ontario. Ontarians fund it and depend on it for their health and the health of their children. With an aging population that will have a growing need for health care services, maintaining a sustainable health care system means controlling costs and targeting funding on preventing illness and improving results for patients.

For more information on Ontario's plan for changing and improving Ontario's health system see the [Patients First: Action Plan for Health Care](#).

Health Care Professionals

There are 23 self-regulated health professions in Ontario, such as physicians, nurses, pharmacists and physiotherapists. Each of these professions has their own regulatory college that sets and enforces professional and educational standards for their members.

Doctors are paid by the provincial government, typically on a fee-for-service basis. For example, if a patient needs surgery, the hospital covers the cost of all the required equipment, supplies and all other related costs for the procedure. The hospital also covers the nurses and other healthcare professional that assist in the operating room, and the recovery of the patient. The surgeon who is not paid by the hospital bills the Ontario Health Insurance Plan (OHIP) for performing the surgery and seeing the patient on the surgery ward.

Monitoring Quality of Care

Health Quality Ontario (HQO) is a provincially funded agency of the Ontario government that is mandated under the Excellent Care for All Act. HQO reports to the public on the quality of the health care system, support quality improvement activities and makes evidence-based recommendations on health care funding.

HQO defines six key factors of a high-performing health care system:

- Accessible – Patients should receive timely and appropriate access to services to help them achieve the best possible health outcomes.
- Effective – Patients should receive care that is effective, and based on the best available scientific information.
- Safe - Patients should not be harmed by accidents or mistakes when they receive health care services.
- Patient-centred – Health care providers should offer services in a way that is sensitive to patients' needs and preferences.
- Efficient – Health care providers should look for ways to achieve the highest possible patient outcomes using the most efficient services by reducing waste or duplication.
- Focused on population health – The health care system should be focused on preventing sickness and improving the health of all.

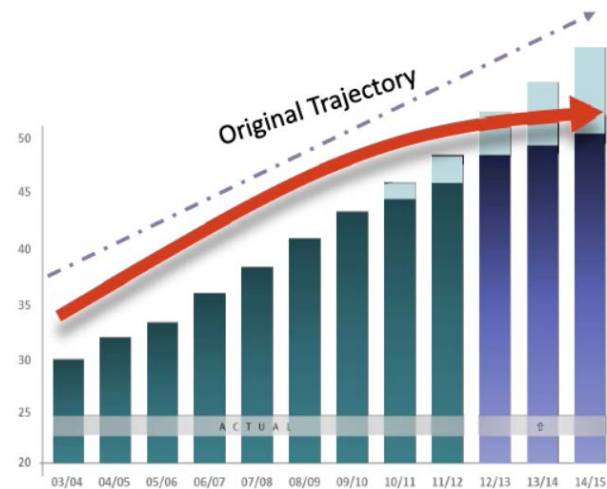
Challenges Facing the Ontario Health Care System

The Ministry of Health and Long-Term Care (MOHLTC) has defined four challenges facing the Ontario Health Care System:

1. Fiscal Challenge

The government cannot afford to continue to fund health care the way they have in the past. As the chart shows, previous levels of investment and growth in health care funding were not sustainable.

Before the province introduced the health system funding reform in 2011, health care was already consuming 42 cents of every tax dollar. Health care costs in general were increasing at about 7% per year. This high inflation was caused by more patients with increasing health care needs, and by more expensive technology and drugs being introduced every year.



At this rate, health care would have been consuming 80% of all government spending by 2030. This would have taken vital money away from education, policing, social services and infrastructure.

With the implementation of health system funding reform in Ontario, the provincial government has reduced health care spending increases to about 2% and been successful in “bending the cost curve” of health care expenses in this province.

2. Demographic Challenge

Ontario is aging as a population and the cost of caring for a senior is three times higher than the average age. Changing demographics alone will add \$24 billion in spending within 20 years.

The population in the South East LHIN is older than the provincial average, which leads to more people requiring the health care system and higher costs. By 2025, over 27% of the population in the south east will be over 65 years of age. This means that health care providers in our region need to ensure the services are better meeting the unique needs of the seniors.

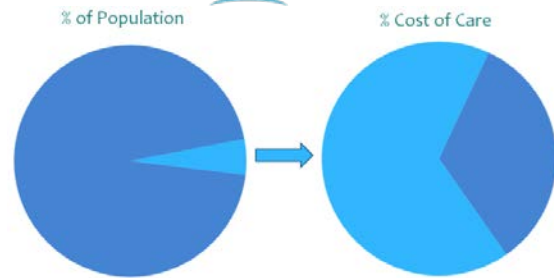
3. Unhealthy Lifestyle Challenge

As a society, we are healthier than ever. On average, people in the south east smoke more, drink more, are overweight, and eat less healthy compared to the provincial average. This leads to more chronic diseases such as high blood pressure, diabetes, cancer and lung problems.

4. Complex Health Needs Challenge

A small number of patients in Ontario use an unequal amount of health care resources. In fact, just 5% of Ontarians account for 66% of health care costs in Ontario. These are people with multiple conditions who have complex health care needs. A new initiative across Ontario –

called Health Links – is providing these individuals with more coordinated care. Health Links brings together the hospital, family doctor, long-term care home, community organizations and others to work on an individual care plan for each patient that better meets their needs.



Health Care Providers and Services in the South East LHIN

For people needing health care in South East LHIN, there are more options than ever before. Health Care in the south east is delivered through:

- 7 Health Links
- 30 Long-Term Care Homes operating 4,050 beds in 37 facilities (including Convalescent Care beds at Lennox & Addington County General Hospital)
- 5 Community Health Centres – operating 8 locations
- 10 organizations with Addictions and Mental Health programs
- 27 Community Support Service agencies
 - Includes 5 hospice agencies
- 7 Hospital Corporations – operating 12 sites
- 1 Community Care Access Centre

A summary of just some of the health care agencies and services available in our region is provided below. For a complete list, use the **South East Health Line** – an up-to-date web-based information portal available 24 hours a day at www.southeasthealthline.ca. This easy-to-search information portal contains over 6,000 records of services available across southeastern Ontario. This information is also available by calling the South East Community Care Access Centre at 613-310-2222.

More information on health care options available in your community is also available on the Ministry of Health and Long-Term Care web site at: www.ontario.ca/healthcareoptions

Primary Health Care Providers (Family Doctors, Nurse Practitioners)

Family Doctor or Nurse Practitioner - Doctors and nurse practitioners are key family health care providers. They focus on family health care: diagnosing and treating diseases, physical disorders and injuries in patients of all ages. Family doctors can either work independently in their own office, with a group of others, or part of a Family Health Team.

Family Health Teams - A Family Health Team brings together different health care providers to deliver high quality, team-based patient care. Family Health Teams are designed to give doctors support from other health care professionals such as nurse practitioners, dietitians and pharmacists. Together they provide you with a range of health care services. Family Health Teams provide care for non-emergency situations and continuous care to help you lead a healthier life.

Nurse Practitioner Led Clinic - Nurse practitioners are registered nurses with additional education and experience. They diagnose and treat most diseases, order and interpret selected diagnostic tests, communicate diagnoses, prescribe medicine and perform specific procedures on patients of all ages. A Nurse Practitioner-Led Clinic can provide you with ongoing primary health care while helping promote disease prevention and healthy living. You can also find nurse practitioners working throughout the province in Family Health Teams and other types of health care settings.

Health Links – Bring together local health care providers to create coordinated care plans improve the coordination of care for complex patients. Health Links gives family doctors the ability to connect patients with specialists, home care services and other community support, including mental health services. For patients being discharged from hospital, it allows for faster follow-up and helps reduce the likelihood of readmission to hospital. This results in better patient care and strengthens partnership in the community.

There are seven Health Links covering the entire South East LHIN region

Walk-In/After Hours Clinic – A walk-in clinic is a place where you can go to be treated for uncomplicated and non-emergency situations. Clinic hours usually extend into the evenings and weekends, and often do not require an appointment. They provide a range of services similar to those provided in your family doctor's office.

Telehealth Ontario – An easily accessible program that provides confidential telephone service from a registered nurse. The information provided gives health advice or general health information. This 24-hour service can help you decide to care for yourself, make an appointment with your doctor, go to a clinic, contact community resources or go to an emergency room. The number is [1-866-797-0000](tel:1-866-797-0000).

Health Care Connect – It is estimated that 96% of South East LHIN residents have a primary care physician. However, for people who don't have a family doctor or nurse practitioner Health Care Connect can help. Simply register online or by phone with Health Care Connect and you'll be assigned a Care Connector who will help you find family health care in your community. Call 1-800-445-1822 or go to Ontario.ca/healthcareconnect

Community-Based Health Care Programs and Services

Community Health Centres (CHC) – The CHC provide health care and health promotion programs for individuals, families and communities. CHCs are especially helpful for people who have difficulty accessing primary health care due to language or cultural barriers, physical disabilities, homelessness, poverty or who live in remote areas.

Aboriginal Health Centres and Programs – The centres provide community-directed health programs and services for First Nations and other Aboriginal peoples. The Mohawks of the Bay of Quinte have a Community Wellbeing Centre that provides family medical care and community-based health programs through a team of family doctors, nurse practitioners and other health care providers.

Public Health - Public Health Units provide programs that protect and improve the health of the community through comprehensive efforts to prevent, control and eradicate communicable disease. Public Health also eliminates environmental health hazards and recognizes, prevent and control occupational health hazards and illnesses.

Diabetes Education Program – Gives people living with diabetes access to the tools and skills they need to lead healthier lives. The program provides both group and one-on-one counselling services. With access to a team of health care professionals including diabetes nurse educators and registered dietitians. Clients can learn self-management skill, develop life plans to help minimize their symptoms and delay preventable diabetes complications.

Addictions Programs – A variety of assessment resources, referral and treatment services for people with addictions are provided across the region. These resources include support groups, residential facilities and information lines.

Community Mental Health Programs – The program provides a variety of services to help support people who have serious and ongoing mental health issues living in the community. Services offered include information and referral, advocacy, case management, housing advocacy, rehabilitation, employment assistance, counselling, support groups, social and recreational opportunities, and peer support services for consumers and survivors.

Hospice Care – A range of palliative care supports are provided for terminally ill clients and their families who are in the final stages of their illnesses. Services may be delivered in a community or residential setting by volunteers or professional staff.

Alzheimer Societies – Programs and services are focused on education, information and family support for those affected by dementia. The Alzheimer Societies offer education events for people living with Alzheimer's disease and other dementias, caregivers and health care professionals.

CNIB – Provides community-based support, knowledge, and a national voice to ensure Canadians who are blind or partially sighted have the confidence, skills and opportunities to fully participate in life.

Canadian Hearing Society (CHS) – CHS offers counselling, education, communication devices advice and sales and employment services for people who are deaf and hard of hearing.

Physiotherapy Services – Physiotherapy services are publicly funded in designated OHIP-insured clinics, these services also include rehabilitation following a stay in hospital. Patients may be eligible for publicly-funded physiotherapy in a clinic if they have a physician or nurse practitioner referral and meet other criteria:

- Over 65 years of age or under 20
- Following a hospital stay
- A recipient of Ontario Works or the Ontario Disability Support Program.

For a Fact Sheet on Publicly-Funded Physiotherapy Clinics in Ontario, [click here](#).

Services to Help People Remain Healthy at Home

Community Care Access Centres (CCAC) – CCACs provide one-stop access with health and personal support services to help people live independently in their homes. The CCAC also helps children with health needs attend school and assists seniors making the transition to a long-term care home or other residential care option. The South East CCAC provides access to care for residents across all of South Eastern Ontario.

Home Care Services – Home care assist people in maintaining their health and independence at home

There are four main types of home care services:

- 1) Visiting health professionals- Care in the home is provided by nurses, physiotherapists, occupational therapists, social workers, speech language pathologists and dietitians.
- 2) Personal care and support – Services to help eligible clients with their activities of daily living, such as personal hygiene, eating and escorting to appointments
- 3) Homemaking – Services to help you with routine household activities, such as meal preparation, shopping, laundry and light housekeeping
- 4) Community Support Services – Services to help you live safely and independently at home. These services can help you with transportation, meals, help at home, social and recreational services

Services can be arranged through the CCAC. Home Care Services may be funded through the government, by donation to voluntary organizations, by private insurance, or by the client receiving the service.

SMILE – Seniors Managing Independent Living Easily makes it possible for more seniors to remain in their own homes who are frail and elderly. These seniors receive help with activities that are essential to daily living.. This functional support program is managed regionally by VON Canada and includes meals, routine housekeeping, shopping, laundry, running errands, transportation for health care appointments and seasonal outdoor chores.

Long-Term Care Homes – When living independently is no longer possible a long-term care home or other residential care option such as a retirement home can provide the extra care and security that may be needed. The CCAC is the point of access for all long-term care homes (formerly called “nursing homes”). The CCAC can help with enhanced home-based care to help people manage while they wait for a long-term care home placement. There are 14 long-term care homes in Hastings and Prince Edward Counties.

Community Support Services – Community support is intended for seniors, or people with disabilities who prefer to stay at home. Services can be offered at the client’s home or in the community and are provided by a number of different agencies across our region. Some examples the community support services available in our region include:

- Adult Day Programs – Available for seniors with dementia or Alzheimer's. These programs are provided through Personal Support Workers and volunteers at locations across the region. The program allows respite for caregivers while the senior is in a safe and controlled environment. Assessment and referral is through the South East CCAC
- Meals on Wheels – Meals can be hot and/or frozen depending on the agency set-up and are delivered by volunteers to the clients home
- In-Home Respite – This service brings someone to a client's own home to provide help with needed services (e.g., personal support), allowing a family caregiver to have a break, complete errands or attend a medical appointment
- Volunteer Transportation – Medical based transportation is provided by agencies through volunteers using their own vehicles.
- Home Maintenance or Home Making – This service can be provided through a volunteer or another company to provide house cleaning, laundry, driveway shoveling, grass cutting, etc.
- Footcare – Agencies provide a designated space and equipment for a footcare nurse to see clients on an appointment basis
- Congregate Dining – Also called Diners Club, provides a meal once a week or month in a group setting, such as a church or town hall.

Convalescent Care Beds – Some Long-Term Care Homes offer convalescent care beds, on a short stay basis, for individuals recuperating after surgery or illness. The Lennox & Addington County General Hospital in Napanee has a 22-bed long-term care home that is available for convalescent care for eligible patients from across the region

UNDERSTANDING THE HEALTH CARE SYSTEM

RURAL HASTINGS - HEALTH LINK



Community Care for Central Hastings
613-473-9009



Community Care for North Hastings
613-332-4700



Mohawks of the Bay of Quinte
613-967-3603



South East CCAC - Bancroft
TF: 1-800-717-2344

QUINTE - HEALTH LINK



Alzheimer Society of Hastings-Prince Edward
613-962-0892



Canadian Hearing Society
613-966-8995 or TTY: 1-877-872-0586



Canadian National Institute for the Blind
613-966-8833



Community Care for South Hastings Inc.
613-969-0130



South East CCAC - Belleville
613-332-2444 or TF: 1-800-668-0901



The Prince Edward County Community Care For Seniors Association
613-476-7493



VON - Victorian Order of Nurses
613-392-4181

Better Access in the South East LHIN

What community services are available in your Health Link?

RURAL KINGSTON - HEALTH LINK



Land O'Lakes Community Services Corporation
613-336-8934



Northern Frontenac Community Services Corporation
613-279-3151



Southern Frontenac Community Services Corporation
613-376-6477

RIDEAU-TAY - HEALTH LINK



Alzheimer Society of Lanark County
613-264-0307



Community Home Support - Lanark County
613-267-6400



South East CCAC - Smiths Falls
613-283-8012 or TF: 1-800-6041

THOUSAND ISLANDS - HEALTH LINK



Alzheimer Society of Leeds-Grenville
613-345-7392



Community & Primary Health Care - LLG
613-342-4076



South East CCAC - Brockville
613-283-8012 or TF: 1-800-267-6041

KINGSTON - HEALTH LINK



Alzheimer Society of Kingston
613-544-3078



Canadian Hearing Society
613-544-1927 or TTY: 1-877-817-8209



Canadian National Institute for the Blind
613-542-4975



Providence Care
613-549-4164



South East CCAC - Kingston
613-544-7090 or TF: 1-800-869-8828



VON - Victorian Order of Nurses
613-634-0130

SALMON RIVER - HEALTH LINK



Lennox and Addington Seniors Outreach Services Inc.
613-354-6668



South East CCAC - Selby
613-388-2488 or TF: 1-800-412-6250

Adult Day Programs

Available for seniors with dementia or Alzheimer's; provided through a combination of PSW and volunteer's at specific locations across the South East LHIN. Number of days per week and times vary but standard is at least 5-6 hours; this allows respite for caregivers while the senior is in a safe and controlled environment. Assessment and referral, including wait list management, is completed by South East CCAC as part of CCAC expanded role.

Meals on Wheels

Depending on how the agency is set up meals can be hot and/or frozen; and are delivered by volunteers to the clients home.

In-Home Respite

This service brings someone to a service recipients' own home to provide help with needed services (e.g. personal support), allowing a regular family caregiver* to take a break. The service may include homemaking, some personal care, light housekeeping, attendant care, monitoring, supervision, and/or activation. The provider assists with activities of daily living that normally would be provided by a caregiver. This allows the caregiver a break; often to complete errands such as grocery shopping, medical appointments, etc. In the majority of cases the caregiver is also a senior.

Volunteer Transportation

Medical based transportation is provided by agencies through volunteers using their own vehicles. Trips require prebooking, usually at least 48 hours in advance.

Home Maintenance Home Making

Home maintenance (also called Home Making) refers to the activities required to maintain a residence e.g. cleaning house, doing laundry, shoveling driveway, cutting grass, etc. This service can be provided through a volunteer or 3rd party company depending on the agency policy.

Footcare

Agencies provide a designated space and equipment for an external footcare nurse to see clients on a preset schedule. The agency completes the scheduling and billing of all clients in exchange for a reduced fee for the footcare nurses time. In some rare cases the footcare nurse will do home visits.

Congregate Dining

Congregate dining (also called Diners Club) provides a meal to seniors at specific times; often once a week or month depending on the agency, in a group setting such as a church or town hall.

Alzheimer Societies

Programs and services are focused on education, information and family support for those affected by dementia. The Alzheimer Societies offer education events for people living with Alzheimer's disease and other dementias, caregivers, and health-care professionals.

CNIB

Provides community-based support, knowledge and a national voice to ensure Canadians who are blind or partially sighted have the confidence, skills and opportunities to fully participate in life. (Serves Entire LHIN Region)

SMILE

SMILE (Seniors Managing Independent Living Easily), makes it possible for more seniors who are frail and elderly, and most at risk of premature institutionalization, to receive help with activities that are essential to daily living, so they can remain in their homes. This long-term functional support program is managed regionally by VON Canada. Services that are covered include: Meals, routine housekeeping, shopping, laundry, running errands, transportation to and from health care appointments, and seasonal outdoor chores. (Provided by VON for entire LHIN region 1-888-866-6647)

CHS

Offers counselling, education, communication devices advice and sales, and employment services for people who are Deaf and hard of hearing. (Serves Entire LHIN Region)

South East CCAC

The South East Community Care Access Centre (CCAC) is mandated to provide community-based health services, Long-Term Care Home Placement Coordination and Information & Referral services to the almost 500,000 residents of the South East. For general CCAC inquiries, contact us toll free at 310-2222 (CCAC) - no area code required. This will call the office nearest to where you are calling from.

Emergency and Hospital Care

Ambulances – Services available for emergency and non-emergency medical transportation (sometimes called patient transfer) between hospital, home and residential facilities. Ambulances are equipped and staffed to provide medical care during transit.

Emergency Room (ER) – ERs are responsible for providing medical and surgical care to patients in need of urgent medical attention, including serious or life-threatening illnesses or injuries.

- About 46% of patients seen in emergency rooms across the LHIN have minor illnesses or injuries, which highlights an opportunity for some of these patients to be seen in other care options.

Behavioural Support Transitional Unit (BSTU) – is a 20-bed inpatient program located at QHC Belleville General Hospital. It specializes in enhancing the lives of older adults living with dementia or age-related cognitive impairments and behavioural challenges. The BSTU is a resource for individuals to stabilize their condition and successfully transition to the most appropriate home setting whether their own home in the community, retirement or long-term care.

SOUTH EAST LHIN PROJECTS AND INITIATIVES

Addictions and Mental Health Redesign

In the development of the South East LHIN's *Integrated Health Service Plan 3, Better Integration, Better Health Care*, the South East LHIN learned about options and concerns residents had with the delivery of addictions and mental health services throughout this region.

The South East LHIN heard that residents, clients and patients, and primary care providers felt the addiction and mental health services received were very good but identified that the problem was finding and then travelling through those offered services, and more specifically:

- Repetition of services
- Repetition of assessments (multiple story telling)
- Difficulties in changing between providers
- Difficulty in obtaining access to these services
- Not enough availability of services to satisfy the community need
- Stigma often faced in accessing these and other health services.

Addictions and mental health services redesign started by addressing these specific issues. The South East LHIN works together with community services to reach improvements in care and better the client's ease of flow through these services.

The South East LHIN, over the last year and a half, has come together with 22 Addictions and Mental Health providers, clients and caregivers, and stakeholders to redesign the system and create the Ideal Individual Experience for clients and their caregivers. Over the last two years, the South East LHIN and many other stakeholders involved 102 unique stakeholder groups and over 200 clients and caregivers experiencing addictions and mental health challenges.

Throughout the Addictions and Mental Health Redesign process, it has been a priority that all conversations, recommendations, feedback and insights maintain the client as the focus. The AMH Redesign is in the first stage of implementation with seven of the existing AMH agencies combining into three new agencies. They are:

- Addictions and Mental Health Services, Hastings Prince Edward
- Addictions and Mental Health Services, Kingston Frontenac Lennox and Addington
- Lanark, Leeds and Grenville Addictions and Mental Health Services

These three agencies will provide a major portion of the community based Addictions and Mental Health services. They will work closely with hospitals providing in-patient services, and ensure any changes for clients are supported and seamless.

Specialty services will continue to be maintained and serviced by the three new agencies. The South East LHIN will continue to work over the next two years with the Addictions and Mental Health system to complete the implementation, ensuring that the Ideal Individual Experience is achieved for clients and their caregivers.

Alternative Level of Care

Alternative Level of Care (ALC) is when a patient is treated for an acute treatment in a hospital. Once the treatment is complete the patient is unable to move to the next level of care. While these patients are in the hospital bed, it prevents new patients from being admitted to that hospital bed. There are multiple reasons why a patient can get caught in a bed that is not the right one for the care needed. Some factors as to why a patient ends up being in an ALC bed:

- Certain events happen in the patient's life before they enter hospital
 - Disease getting worse
 - Growing health problems
 - Social situation
 - Lack of connection with their family physician or team
 - Poor coordination of care between people who help with the patient's health care
 - Family situation
 - Money situation
 - Location to where the patient or family/friends lives)
- Practices during the hospital stay
 - Planning the client discharge home and working together as a team to ensure the care is right and at the right time
 - Care that supports physical strength and mental improvement
 - Family and caregiver available to support the client
- Options available after the hospital stay
 - Mistaken old beliefs or views of what place the client should go,
 - Family/friend support and available
 - Money and social situation

What we need to do in the next three years to reduce these ALC patients:

1. Better understand what situation these patient are living with
 - a. Who is there to care and support them?
 - b. What things are needed to help this patient live as long as they desire at home?
 - c. Understand what the patient wants.
2. Help educate people who work in health care.
 - a. Health team's perception can sometimes go against patient's wishes.
 - b. The need to understand all patients should be given the chance to return home after the hospital care.
3. Improve communication between the patient, their family and all the people who provide care
 - a. Patient's health goals need to be met
 - b. Ensure the patient doesn't get forgotten when they need support and care
4. Teamwork to make sure the patient's hospital care needs are met at the right time,
 - a. Plan the patient's discharge home on their admission to hospitals there is no waiting to go home

Behavioural Supports Services

Behavioural Supports Ontario (BSO) is services for older individuals living with responsive behaviours due to dementia, mental health needs, addictions, and other neurological disorders.

Providence Care is the provider of BSO and has three main components

- Mobile Response Teams providing around the clock support as required to residents and staff in long-term care homes throughout southeastern Ontario
- Geriatric Psychiatry Outreach Teams providing specialized assessment and consultation for people living in long-term care homes, retirement homes, hospital, or their own homes
- Psychogeriatric Resource Consultants supporting staff across the continuum of care through consultation and education.

BSO use the three main components above to enhance the quality of life for older people living with mental health needs and also to support for their caregivers. The Behavioural Support Services assist clients in Leeds, Grenville & Lanark, Frontenac, Kingston, Lennox & Addington and Hastings and Prince Edward County.

Behavioural Supports Transition Unit

The South East LHIN invested in the Behavioural Supports Transition Unit (BTSU) to provide additional support to seniors living with challenging behaviours. This 20 bed, inpatient program put the patient and family at the centre of the care team and is located at Belleville General Hospital. The BTSU works together with the patient, family and identified care team to:

- Assess the emotional, social, environmental and physical needs of each patient
- Develop and implement treatment and care plans based on what that senior needs to balance behaviours
- Transition the patient to the most appropriate home setting (community, retirement or long-term care)

The identified care team can be made up of many professions, which can include:

- Nurses
- Personal Support Workers
- Recreation therapists
- Social Workers
- Physicians, including Consulting Geriatric Psychiatrists
- Pharmacy consultants
- Physiotherapist and occupational therapist
- Speech-language pathology
- Spiritual care

- Registered dietitians

Throughout the patient's stay, the team will work with individuals and services who were already involved with the patient prior to admission. This helps to gather the best possible history to inform the care plan. The BSTU also works with health care teams who provide care upon the patient leaving to ensure the care plan can be carried out in the discharge. This way, the patient, family and receiving team is supported through the discharge process.

Chronic Disease

Chronic Disease is a long-lasting condition that can be controlled but not cured. In the South East LHIN, people living with a chronic disease can receive ongoing support to help manage their condition.

Services, such as specialized clinics and self-management programs are available in communities. This ensures that the public receives education and management in a timely fashion for diseases such as:

- Diabetes
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)

The specialized clinics provide expert care to the patient. The regional self-management programs assist in strengthening a person's ability to set goals and be active in their own health care process.

The South East LHIN has created a Chronic Disease Framework so all parties have a common vision so health care partners can work together. This vision will ensure that all parts of the patient's plan are covered, such as:

- Prevention
- Screening
- Diagnosis
- Primary Care management
- Specialty care
- Acute care in the hospital

Health care providers continue to work together with patients to ensure patients have a great quality of life while living with chronic diseases. Some great examples of work include:

- The High-Risk Foot Care Initiative, helping patients with soft tissue/skin infections and amputations;
- The making of more than 800 coordinated care plans for patients through Health Links; and
- Exercise and Falls Prevention programs in communities across the region.

Health Care Services in French in the South East LHIN

The French Services Program is a Provincial Designation Process designed to ensure access and continuous improvement of services offered in French to the communities.

In 2006 Kingston became one of the 25 designated areas to offer public services including health care in French. The Kingston area offers health care services in French from 12 providers and/or work toward the development of such services. These providers are:

Hospitals

- Kingston General Hospital
- Hôtel Dieu Hospital
- Providence Care (including Providence Manor for long-term care)

Community Care Access Centre

- South East Community Care Access Centre

Community Support Services

- Victorian Order of Nurses – Greater Kingston
- Canadian National Institute for the Blind
- The Canadian Hearing Society – Kingston Region
- Alzheimer Society of Kingston

Addiction and Mental Health Agencies

- Frontenac Community Mental Health & Addictions Services
- Peer Support South East Ontario
- The Salvation Army Kingston Harbour Light
- Sexual Assault Centre Kingston

The South East LHIN has Accountability Agreements with the organizations listed above in order to help them achieve a development plan to roll out and provide services in French to the public. Once the Designation Plan is achieved, the provider will have a designation status under the French Language Services Act. Through this status, the Francophone population will be aware that:

- French-language services are available in that organization
- The organization is committed to providing French-language services on a permanent basis

The South East LHIN works closely with the French Language Health Services Network of Eastern Ontario (the Réseau) to ensure the 12 organizations get the support they need to start their Designation Plans.

This working partnership with the Réseau is important to support the development of new programs and services in French. Together we promote existing services to improve access for the Francophone community living in the South East. The South East LHIN and the Réseau work together toward the following goals:

- Improving the quality of data for better French-Language health services planning

- Strengthening Francophone participation in health services planning
- Including the Francophone perspective in regional strategy and initiative planning
- Improving the active offer of French-language health services through designation
- Measuring the impact of our actions on French-language health services

Health Links

The Health Links aim is to improve care for people living with complex conditions. The intent is to better coordinate care for people with complex need and improve information sharing. This is done by bringing together the following health care providers:

- Primary care providers
- Specialists
- Hospitals
- Long-term care
- Home care
- Other community supports

By bringing these organizations together Health Links patients receive more timely care. Family physicians and nurse practitioners are able to connect patients with specialists, home care services and other community supports, including mental health services.

When patients are being discharged from the hospital Health Link helps with timely follow-up and referral to services like home care, and reduced risk of re-admission to hospital. Better care for the patients is provided when health care providers, patients and their caregivers work as a team, to allow for a smooth patient journey through the health care system.

Health Links promote the philosophy of “one patient, one plan, one team.”

The entire South East LHIN geography is covered by seven Health Links all led by the following Primary Care organizations:

- Four Community Health Centres
- Two Family Teams
- One Family Health Organization

Hospitals, Community Care Access Centre, and Community Support Services are very involved in Health Link’s Steering Committees, Working Groups and Collaborative Care Planning. Health Links small governance model guides relationship building between Health Links partners, which has been successful through:

- High level of primary care provider engagement
- Multiple planning sessions with Primary Care groups
- Planning meetings of the Health Link partners to establish the vision, values, priorities, activities and timelines of the Health Links

- Regular Steering Committee meetings at the local Health Link level as well as broader stakeholder meetings
- Regular meetings of the 7 Health Link Lead organizations with the South East Community Care Access Centre and the South East LHIN

To help measure the early outcomes of Health Links a regional Health Link evaluation are underway. There are early indications of success in the areas of care coordination, acute hospital inpatient and emergency department utilization, partnerships, and provider and patient engagement. Three of the Health Links reported that coordinated care for patients with complex conditions reduces the number of admissions to acute hospitals and the number of visits to emergency departments

Patients are finding the health link approach to coordinated care is helping them be better informed and self-aware, knowing that their care is more respectful, personal and compassionate, and they feel less alone.

The Health Link care coordinators also established a learning community to exchange knowledge, share and spread ideas and best practices.

High Risk Screening Tool

Seniors living in the community can find it difficult to get the services and care they need to stay at home. Seniors can experience being lonely, helpless, fearless and at time feel unsafe.

Adapting to changes in their health, social need, and care becomes more difficult as seniors age, making them more at risk for poor outcomes that can lead to trips to Emergency Department for non-emergency issues. It is also common for identifying “at risk” seniors earlier and providing them with the appropriate care and services will aid in support, safety and the ability to connect with their care team when they don’t feel well or scared.

Every South East LHIN acute care hospital will be screening “at risk” seniors when they arrive for non-emergency care. The hospital care team will talk with their community care team to assess the client and links them with appropriate services and care upon their discharge home. For “at risk” seniors who are to be admitted for in-hospital care, the hospital team will know about the high risk and provide care suitable for preventing physical weakness and confusion. When the patient is ready to return home after their hospital stay, they will be connected with the community team. The patient will receive the right care to help the senior’s health and desired needs.

Within a year of identifying the “at risk” seniors, over 1,000 clients have been identified as high-risk, with most of these seniors receiving supports and care at home. The senior’s care team work together to make sure all team member and patient are aware of service and care plan. This high risk identification tool will be shared for use in family physician office with their care teams and post-acute care hospital over the next three years.

Home and Community Care

Assisted Living Services for High-risk Seniors

The Assisted Living Services helps high-risk seniors maintain independence and remain in their home for as long as possible. The South East LHIN addressed the need of seniors and carried out the Assisted Living Services for High-risk Senior service by enabling them to stay in home and out of a hospital or in a long-term care home.

The Victoria Order of Nurses (VON) in three geographical areas: Belleville, Kingston and Brockville provided the funding for the operations of this program. Seniors in these areas are able to receive the following services on a 24-hour basis:

- Personal support
- Homemaking
- Care coordination
- Security check (available 24 hours a day, seven days a week)

Overnight Respite is an offered service that gives a senior the option to stay at a location over night with a health care professional. This available option offers relief of potential stress for the caregiver.

The South East LHIN continuously looks to improve this service for seniors and caregiver as the organization understands the importance of the work the caregiver does.

SMILE

The Seniors Managing Independent Living Easily (SMILE) program is funded by the South East LHIN and has been run through Victoria Order of Nurses (VON) for the past six years. This program supports the aging at home and is community-level coordination of services that work with the Community Care Access Centers (CCAC) and other community organizations.

SMILE places the client at the centre of care and allows them to self-control their care plan. It is directed towards seniors that are at risk of early dependency. The client receives help with activities of daily living that encourages independence. An in home assessment identifies the need that clients are able to access a consistent basket of services.

SMILE is based on clients having a choice and providing input for managing their own needs. The most frequently-requested service by far is household management, which includes all services required to maintain a home and include housekeeping, laundry, errands, transportation and meals.

Hospice Palliative Care

Hospice Palliative Care strives to help a person and families address physical, mental, social, spiritual and practical issues, and identify their expectations, needs, hopes and fears during the end of a person's life.

Hospice Palliative Care also helps to:

- prepare and manage end-of-life choices during the dying process;
- cope with loss and grief;
- treat all active issues and prevent new issues from occurring;
- promote opportunities for meaningful and valuable experiences; and
- create personal and spiritual growth.

The Hospice Palliative Care vision is to help improve the quality of hospice palliative care to help ease the suffering of a dying person, it is important for someone to live life fully until death. It is also important to ensure their loved ones are being assisted through the grief and bereavement.

In 2011, the province of Ontario worked with the more than 80 partners across the palliative care system to review their work and practices.

The following vision for palliative care in Ontario was created:

Adults and children with progressive life-limiting illness, their families and their caregivers will receive the holistic, proactive, timely and continuous care and support they need, through the entire spectrum of care both preceding and following death, to:

- *help them live as they choose, and*
- *optimize their quality of life, comfort, dignity and security.*

Palliative care system transformation is a priority for all the LHINs. At the end of the three year plan the desire goal is:

1. Increase the number of Ontarians who receive palliative care outside acute care.
2. Improve the palliative care experience for clients and caregivers.

The South East LHIN and the South East Hospice Palliative Care Steering Committee created a Regional Work Plan for 2015-2018. Four key priorities for improvement are highlighted below:

Priority One

Strengthen skills being used by local communities providing hospice palliative care

- Goal: Health care providers will provide the right care throughout the palliative and end of life care journey for patients and their families/caregivers

Priority Two

Create tools that identify potential patients that could benefit from hospice palliative care* support and services

- Goal: Patients and families are involved in their palliative care plan through the journey before reaching end of life

Priority Three

Increase the understanding and performance of Health Care Consent and Advance Care Planning

- Goal: Patients are informed by the current Health Care Consent and Advance Care Planning information. People are encouraged to have conversations about future health care decisions with their Substitute Decision Maker(s).

Priority Four

Strengthen caregiver support including bereavement

- Goal: Families and informal caregivers feel supported by the healthcare system in their palliative care journey, including support in their grief and bereavement

The work plan developed from over 25 engagement sessions held across the south east. Participation involved health care providers, community members, volunteers, caregivers and patients. A survey was completed from the sessions that provided feedback on the priorities and identifying the gaps and challenges in the area.

Currently, a number of initiatives have been widely successful in our region. This includes the Symptom Response Kits program, the formation of the Hospice Palliative Care Working Groups within three Health Links, and the alliance of five palliative care Nurse Practitioners.

The South East Hospice Palliative Care Steering Committee is creating a working group to lead and start activities relating to the four key priorities across our region. These groups will work together with the regional Health Links and build relationships with important stakeholders to move priority initiatives forward.

The South East LHIN and the South East Hospice Palliative Care Steering Committee continue to look for opportunities to develop the quality of hospice palliative care for all our residents in our region.

Hospital Services

The Hospital Services is a project that explores opportunities for shared hospital services and new or expanding partnerships. The overall goal is to improve access and patient care in southeastern Ontario from the following organizations:

- Brockville General Hospital
- Hotel Dieu Hospital
- Lennox and Addington County General Hospital
- Kingston General Hospital
- Perth Smiths Falls District Hospital
- Providence Care
- Quinte Health Care
- South East Community Care Access Centre
- Queen's University Faculty of Health Sciences
- South East Local Health Integration Network

These leaders are committed to developing a system of combined care so the needs of patients are met now and in the future.

The South East region is changing as the population grows older and more complex medical needs are identified. All health service providers are working together to change how services are provided while responding to how funding is changing. Providers understand the importance of having the health care system ready for the aging population.

The South East LHIN spends 60% of the \$1.1 Billion budget on hospitals and is increasing due to the limited funds for all health care in Ontario.

The Hospital Services project is unfolding in several phases with health care provider and public engagement. The plan will find opportunities for sharing services or ways to expand existing partnerships.

A Visioning Day event was held that welcomed over 200 people from across the region before the Hospital Service project started. This group, made up of health care providers, patient advisors, Aboriginal communities, and French Language Services participated in conversations discussing best practices. A lessons learned approach from international leaders has allowed a vision of what a high performing and feasible hospital system could look like in the South East region.

September 2014 to June 2015 is reviewing all areas of hospital services to identify where the best opportunities to save money, while still providing excellent care to all. Information collected from community engagement events held in May along with the results of a survey will help tell these opportunities. Additional engagement opportunities and focus groups will also be conducted in 2015.

The Hospital Services project working groups consist of:

- Business Operations – *administration, finance, human resources, and information technology.*
- Diagnostic and Therapeutic – *X-ray, laboratory, pharmacy services, etc.*
- Clinical Services – *exploring opportunities to enhance care in the following four areas:*
 - *Complex Chronic Care*
 - *Elective Care*
 - *Urgent/Emergent Care*
 - *Tertiary/Quaternary Care*

The Hospital Services project formed a Regional Patient Advisory Council with 25 representatives from across south eastern Ontario. The committee brings together patients and family members to discuss and review ideas related to future hospital services. This group is very important in the health care system because it brings the patients point of view to the working group's discussions.

All health care partners are committed to engage with their communities, patients, hospital staff and more.

Enhanced Long-Term Care Home Renewal Strategy

It was announced in July 2007 that the “Long-Term Care Home Renewal Strategy” goal was to enable the renovation and improvement of 35,000 Long-term Care beds in the Province.

In 2014 the Associate Minister of Health and Long-Term Care announced a strategy to help complete the work started. This newly enhanced strategy includes the three following Goals: An increase to Construction Funding to help restore certain Long-Term Care homes, an updated Design Manual to help better house residents, especially those with much different health care needs, the creation of a project office and of a provincial schedule for projects to support Long-Term Care homes that will be in line with local community priorities.

As a first step, a survey was issued to all eligible Long-Term Care homes to rate their interest and readiness.

The results of the survey will tell Long-Term Care Homes and LHIN what activities will help in the renovations schedule. This will make sure that all the projects are done by December 31, 2024.

The Ministry, along with the LHINs, delivered education sessions to help Long-Term Care homes complete the survey. These education sessions started in March 2015 and focused on the three key goals of the new strategy as well as local health system priorities.

Patient Flow Strategy

Patient flow is a system in emergency departments (ED) that monitors the flow of the patient to see the physician and receive ED or inpatient care promptly with minimal wait times. Patient Flow Strategy is measured by how timely patients are seen, treated and if needed admitted through hospital emergency department. Long wait time for this type of care can impact the health of the patient. When proper access to and flow through the ED is timely and successful, the public is confident that the health care system is working well for their care needs.

The South East LHIN patient flow strategy was created to prevent patients being delayed or denied access to the right care at the right time, and in the right place by the right care team. The South East LHIN continues to develop a united, organized, and adaptable plan to address system-wide patient flow issues. Some key areas to focus on:

- identify clients at risk and obtain a better understanding of the patient coming into the Emergency Room (ER) and where they should be going to reduce the length of stays in hospitals, ER wait times and Alternate Level of Care (ALC) patients remaining in hospital beds
- help the senior population to maintain independent living at home and reduce illness or injury that could require the use of ERs or admission to hospital
- understanding the supply and demands of ER patient flow

- review and understand needs of patients coming to ED, where services could be received elsewhere
- improve patient flow transition to other hospitals, Community Care Access Centre (CCAC), and the community sector
- reduce the number of patients returning to hospital less than 30 days after their last hospital stay

Patient flow remains a top priority for all South East LHIN health care organizations. The past two years has seen each organization (hospitals, CCAC, Long Term Care homes and community support sector) imitating several projects to improve flow for the patient. These projects included:

- ED rapid assessment units
- 72 hour express beds
- Patient flow navigators
- 24 hour post-discharge follow up calls to reduce patient from coming back to hospital for non-emergency reasons
- Early discharge planning
- Patient flow data monitoring.

Hospitals and CCAC are working on the in hospital patient flow while South East LHIN senior leadership have also focused on system wide improvements in patient flow. Recently, a Province-wide Life and Limb policy and a LHIN wide patient repatriation policy (return patient to their home hospital within 24 hours of notification) was supported and started. A web based tool to assist in the implementation of the policy has also occurred.

Although some success has been identified the acute care hospital continues to regularly struggle with patient waiting time for ED care, inpatient care and cancelled surgeries. An extensive review of patient flow activities and cultures is underway with the goal of identifying any underlying causes to lessen the wait times.

Physiotherapy and Exercise & Falls Prevention

In February of 2013 the Ministry of Health and Long-Term Care announced changes to the funding and the delivery of Physiotherapy services. This change impacted the delivery of service and billing for:

- community physiotherapy;
- exercise and falls prevention classes;
- Community Care Access Centre (CCAC) in-home physiotherapy services;
- long-term care home services; and
- primary care physiotherapy.

For patients this meant easier entry to high-quality classes for physiotherapy, and exercise and falls prevention. These classes were spread throughout Ontario to help more people.

As part of the South East LHIN'S plan to make access easier, the changes were:

1. **Long-Term Care** – all long-term care homes received more funding to deliver physiotherapy and exercise and falls prevention programs to their residents. To ensure a person's mobility goals are met, the person is first assessed and then a care plan is given based on his or her needs.
2. **Exercise & Falls Prevention** – aimed to improve health, reduce injury and encourage independent living. The classes are held in over 130 community spaces and retirement homes across the south east region, and for seniors there is no cost. These classes are able to grow with a community needing these services.
3. **In-Home Physiotherapy** – in-home physiotherapy more available, and is providing this service for more than 1,500 residents in their place of residence.
4. **Community Physiotherapy Clinics** – the increased funding for Clinic Based physiotherapy has allowed more than 6,000 patients to get this service in a new clinic. These no cost, doctor referred physiotherapy services are provided in 16 places to people who meet the following criteria:
 - are age 19 or younger: contact your doctor or nurse practitioner
 - have been discharged from the hospital after an overnight stay and need physiotherapy for their condition, illness or injury contact your doctor or nurse practitioner
 - receive income from Ontario Works or the Ontario Disability Support Program: contact your doctor or nurse practitioner
 - are age 65 or older: contact your doctor or nurse practitioner
 - are age 65 or older and require in-home physiotherapy (whether in your own home or a retirement home): contact a Community Care Access Centre (CCAC)
 - by phone: (your area code)-310-CCAC (2222)
 - in person: enter your postal code to find your local CCAC office
 - are age 65 or older and living in a long-term care home: contact the doctor or nurse practitioner on staff. As part of your plan of care in your long-term care home, the doctor or nurse will refer you to a registered physiotherapist. The physiotherapist will decide if you need physiotherapy.

Senior Strategy

The South East region has recognized that a high number of senior are living in the communities; this has allowed the South East LHIN to focus on senior care.

In the South East LHIN, senior care starts in the client's home with a focus on how the senior wishes to stay at home as long as possible. This is possible with a health care team's support that keeps the seniors desires in mind. With the seniors wishes in mind, understanding how we age, understanding health related aging disease and recognizing changes to an individual's ability to

move around, be physical, change in behaviors or suffer from memory loss, the South East LHIN Senior Strategy is aligned to support the senior by aiming to provide easy access to service, care and different living/care places as senior age.

There are six main areas of focus for seniors in the South East LHIN:

1. Assist a senior living at home by providing early community supports.
2. Create an alternative “home like” “place for seniors to live.
3. Begin programs that help senior stay strong, keep them moving, slow down memory loss and prevent mood changes while at home or being care for in the hospital.
4. Identify seniors at risk of poor health at home, in a physician’s office or in hospital. In order to provide them with the right care at the right time in the right place.
5. Return seniors home from hospital when ready.
6. Review the special care needs of the seniors and find the right place or program to provide this care.

Currently the South East LHIN has created senior friendly hospitals and all South East LHIN hospitals have senior friendly care plans and understand where to improve their care.

Community health care providers are also leaders in senior care who are continuously linking with seniors to improve the care they provide.

Transportation

Volunteer Transportation

The South East LHIN has 12 Community Support Service agencies providing volunteer transportation. These agencies arrange medical based transportation through the use of volunteers driving their own vehicles.

The volunteer transportation differs from a taxi company.

What is the difference?

- Required to pre-book 48 hours in advance
- Senior is matched with most suitable volunteer
- Service is not free and a senior must reimburse for kilometers driven
- Some subsidy is provided through the agency to those having difficulty paying

Home support agencies provided 118,541 one way trips in 2012 and 2013. This ended up not being enough because of the demand for this service from seniors. In 2014, the South East LHIN set aside funding for 12,000 additional volunteer transportation trips, half of those trips were to be used during that current year and the remaining six thousand to be used the following year. The Community Support Service Volunteer Transportation working group reported additional trips to be approximately 130,000.

Non Urgent Patient Transfer

A Non Urgent Patient Transfer services was established as joint effort from six out of seven hospitals in the South East LHIN with the Community Patient Transport Group in February 2013.

As of February 3, 2014 six of the seven hospitals within the South East LHIN region joined together with The Ministry of Health and Long-Term Care, through the Health Van project (2008-2009) provided seven vans and additional funding. The project continues to grow and focus on the needs of seniors in the South East LHIN.

Health Vans are able to carry many passengers and make long distance trips from rural to urban areas. This is great for specialized medical treatments. With the five vans focusing on patient transportation, and two vans modified for handicap access, it makes transportation of seniors with medical needs a smooth transition.

The service now expands across the region for 24 hours a day, seven days a week, every day of the year. It also increased safety and quality to meet the Ministry of Health and Long-Term Care Non Urgent Patient Transfer standards.