Hamilton Niagara Haldimand Brant Local Health Integration Network

Presentation to:

Niagara Health System Board of Directors

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

What is Primary Care?

Primary care is defined as:

- The first point of contact between a patient and the health care system

Primary care is:

- The navigator of the health care system
- Providing clinical services, referral and care coordination close to home
- Providing system access and continuity of care

Primary care includes:

- Illness prevention
- Health promotion
- Diagnosis
- Treatment
- Rehabilitation and counselling

Ontario's Primary Care Models

Fee for Service (FFS)

Blended Models

Examples include:

- Family Health Groups (FHGs)
- Family H ealth Networks (FHNs)
- Family Health Organizations (FHOs)

Interprofessional Models

Examples include:

- Family Health Teams (FHTs)
- Nurse Practitioner Led Clinics (NPLCs)
- Community Health Centres (CHCs)
- Aboriginal Health Access Centres (AHACs)

Specialized Models

Examples include:

- First Nations Agreements
- GP Focused Practice Models: Palliative Care, HIV Care, and Care of the Elderly
- Midwifery

Teletriage Programs

Examples include:

- Telehealth Ontario
- Telephone Health Advisory Service (THAS)

Primary Care in Ontario

- Ontario's primary care system is made up of a wide range of provider groups and clinicians, each with their own funding and accountability relationships.

Primary Care Physicians: 14,823

- Primary Care Physician Groups: 700+

Inter-professional Primary Care Providers:

- Family Health Teams: 184
- Community Health Centres: 74
- Aboriginal Health Access Centres: 10

Sources: Health Analytics Branch, Ministry of Health and Long-Term Care, January 2016; HealthForceOntario November 2016; Ontario Association of Health Centre website; Ministry of Health and Long-Term Care website.

Primary Care Physicians in the HNHB LHIN and Niagara Sub-Region

HNHB LHIN

5.8 Primary care physicians per 10,000 people

834 Primary care physicians
14 Family Health Teams
20 Family Health Groups
32 Family Health Organizations/Networks
7 Community Health Centres
1 Aboriginal Health Access Centre

Niagara Sub-Region

5.6 Primary care physicians per 10,000 people

213 Primary care physicians
5 Family Health Teams
12 Family Health Groups
14 Family Health Organizations/Networks
4 Community Health Centres
0 Aboriginal Health Access Centres

Definitions:
Family Health Teams (FHT): FHTs are primary health care organizations that include a team of family physicians, nurse practitioners, registered nurses, social workers, dietitians, and other professionals who work together to provide primary health care for their community.
Family Health Groups (FHG): a group of at least 3 family physicians agree to work together to provide primary care to a group of registered patients. Physicians in the group must agree to provide comprehensive ongoing care to their set of registered patients.
Family Health Organizations/Networks (FHO/FHN): a group of family physicians who work together to give the patient timely access to quality primary services. Physicians receive monthly comprehensive care capitation payments for all enrolled patients. Capitation is based on a defined basket of primary care services provided to enrolled patients.

Source: Based on data validated January 2016.

Number of Primary Care Physicians in the Niagara Sub-Region

Practice Location	Number of Primary Care Physicians
St. Catharines	91
Niagara Falls	43
Welland	28
Fort Erie	14
Niagara-on-the-Lake	12
Port Colborne	11
Pelham	7
Thorold	7
Total	213

Source: Based on data validated January 2016.

Niagara Sub-Region - Primary Care Physicians Age 60+ Years

Practice Location	Number of Physicians Age 60+ Years	Enrolled Patient Count
St. Catharines	30	48,800
Niagara Falls	15	28,710
Welland	7	11,219
Fort Erie	4	7,970
Niagara-on-the-Lake	2	2,315
Port Colborne	3	5,154
Pelham	3	3,710
Thorold	2	3,156
Total	66	111,034

Sources: Corporate Provider Database (CPDB); Client Agency Program Enrolment (CAPE), November 30, 2014.
Criteria: Includes physicians in patient enrollment models: CCM, COE, CSA, FHG, FHN or FHO.

Sub-Region Comparison

HIGHEST
LOWEST

	BRANT	BURLINGTON	HALDIMAND NORFOLK	HAMILTON	NIAGARA	NIAGARA NORTH WEST	HNHB LHIN	ONTARIO
% Satisfied with their health care	82%	Data not available	85%	90%	75%	84%	85%	87%
% Report French as mother tongue	1.3%	2.1%	1.2%	1.7%	5.4%	1.4%	2.3%	4.4%
% Identify as Indigenous	4.0%	0.9%	3.9%	1.8%	2.5%	0.8%	2.8%	2.4%
% Age 65+	15.9%	17.7%	19.6%	16.4%	20.5%	17.9%	17.5%	15.6%
# Primary care physicians per 10,000 residents	5.2	6.8	4.7	6.0	5.6	6.3	5.8	Data not available
% Alternate level of care (ALC) days	13.0%	17.4%	9.6%	18.5%	13.3%	7.9%	16.3%	14.5%
Rate of emergency department (ED) visits best managed elsewhere per 1,000 people	37	4	48	16	18	20	20	18
Rate of hospitalizations for conditions that could be treated in ambulatory setting per 1,000 people	5	2	4	4	4	3	4	3
% Repeat unscheduled ED visits within 30 days for mental health conditions	18.9%	18.0%	15.4%	21.2%	17.1%	13.5%	18.8%	20.2%
% ED visits within 30 days for substance abuse conditions	16.8%	22.4%	16.0%	38.2%	24.9%	15.3%	30.1%	33.0%

Sources:
Health Care Experience Survey for data collected between April 1, 2015 and March 31, 2016.
Statistics Canada, 2011 Census.
Statistics Canada, 2011 National Household survey.
Discharge Abstract Database for 2015-16 Fiscal Year. Data based on area of residence.
National Ambulatory Care Reporting System for 2015-16 Fiscal Year. Data based on area of residence.
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Provincial, LHIN & Sub-Region Levels of Activity

Provincial

Ministry
- Vision
- Goals/Outcomes
- Priorities

PanLHIN
- Consistency
- Sharing and spreading emerging best practice
- Common approaches/principles

LHIN (LHIN wide mandate/processes)

- Planning:
  - Population need; service capacity/performance; gaps/opportunities
  - LHIN wide planning frameworks (clinical programs, population strategies, best practice)
  - New models of access and navigation
- Commissioning:
  - Funding allocation/reallocation
  - Coordination/integration
- Delivery: home care services
- Performance monitoring/improvement against outcome measures

Sub-Region (x6)

- Local engagement and planning – gaps and opportunities
- Local implementation of LHIN-wide planning frameworks
- Local delivery of home care services
- Local performance monitoring/improvement
- Local input to, and implementation of new models of access and navigation

Through Transition Towards Transformation

We are here… …planning for here …..to get to here

December 2016 | January 2017 | Summer | 2018

Legislation (Bill 41) passed

Transition

- LHIN governance expanded
- Combined management
- CCAC staff transitioned into LHINs
- Positive common patient-focused culture
- Clinical leadership in place
- Corporate services entity established
- Sub-regions defined and used for planning

Transformation

- Sub-regional coordination of home care
- Home and Community Care Roadmap progresses including Levels of Care
- Increased access to physicians, to care when it is needed, to specialists and to community mental health services in sub-regions
- Improved transitions between hospital and home, including reduced hospital readmissions
- Population health approach integrated into local planning and service delivery across the continuum of health care
- Indigenous partners have a stronger role in system planning and service delivery and access to culturally appropriate care and wellness approaches
- Public reporting of improvement, including patient experience and equity
- LHIN- and sub-regional-specific priorities

Thank you!

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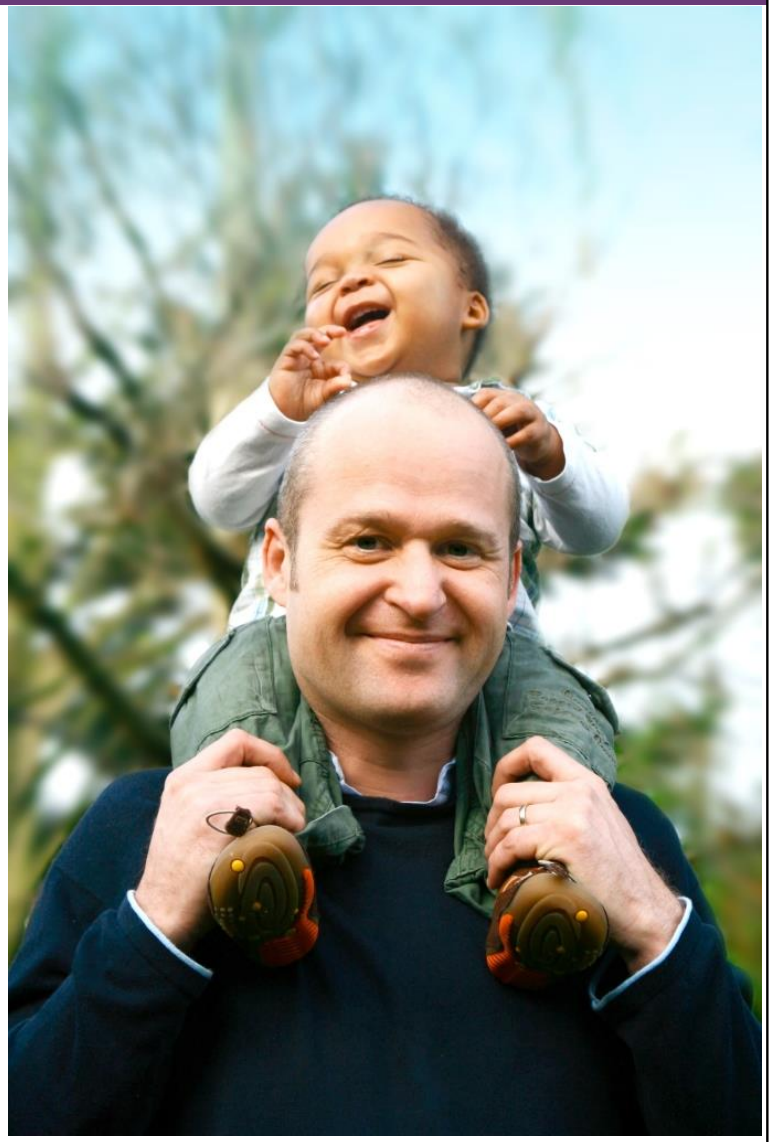

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