Top Priorities for Sub-Regions

Identified for action at November 1, 2017 meeting

November 1, 2017 provided an opportunity for many members of South East LHIN Sub-Regions to come together and review key data elements from a regional perspective, as well as through a specific sub-region lens. While the information presented was not exhaustive, the discussion offered the first opportunity to provide direction to our conversations, and exploration of solutions as a region.

The following provides a synopsis of the top priorities identified and shared:

- **Access to physician services** – primary care, specialists (better linkages/connections); after hours and 24/7 care, especially in rural settings (increased capacity could fall within this or separately); and recruitment and retention issues.
- **Better transitions** – between needed services and that also include better communication among providers, and with patients about their treatment and follow-up.
- **Increased and more reflective supports for seniors, Indigenous, immigrants, and Francophone communities -** Increase capacity to support these specific populations.
- **Caregiver burnout –** including overall patient, family and caregiver supports.
- **Transportation** – seen as an issue predominantly for rural populations and for seniors
- **Technology** – themes within this varied widely but include: utilization, sharing info/stronger and easier communications with providers and patients; uptake of eReferral; and better records management, etc.

One overarching observation was provided from multiple sub-regions: The positives of the Health Links model and its shared purpose could be set as a foundation to work from, while addressing some of the current issues noted above.

Lanark, Leeds and Grenville

- **Primary Care**
  - Many people unattached/without access to a primary care provider.
  - Developing a primary care attachment model that works for the community.
  - Linkage/integration of services with primary care - particularly AMH, but including all sectors.

- **Aligning Strategies and how to implement**
  - Using the Sub-Region Integration Table to inform how strategies should be rolled out.
  - SHIIP, opioid services.
  - Other technologies such as e-referral.

- **Patient Experience**
  - Develop a common way to measure patient experience across the continuum and to help inform priorities.

- **Health Equity**
  - Our current focus is health care data we need to broaden the view of population needs and partners to help inform priorities and actions that will help from a health equity approach.

- **Integrating Care**
  - Identify areas of duplication and gaps in care/transition.

<u>Other notes:</u>

- Suggestion to rename sub-region to *Lanark, Leeds and Grenville Community of Care.*
- Suggest the need for a clear hook/focus to bring everyone together in order to work together.
- Regarding the data distributed on November 1 – Concerns about accuracy, what is included and do not feel it can drive decisions as it is now.

Kingston

- Population increase is higher than any other area:
    - High levels of immigrants; and
    - Fluctuation throughout the year due to students/tourism (not likely captured in data to accurately reflect local demand).

- Health prevention/promotion:
    - Needs forward thinking – focus is often on addressing health-related issues once they happen; and
    - Greater impact could occur through planning to address issues earlier for prevention.

- Unattached patients, especially the homeless.
- AMH with two distinct populations – youth (16-24 years old) and older adults (65 years and older).
- Patient flow:
    - Transition from hospital to home; and
    - Access to specialists.

- Hospital readmissions for specific issues – address this issue.
- Stronger communication between organizations:
    - Patient record is not shared across agencies; and
    - Utilize various electronic solutions.

- Affordable housing and basic life needs i.e. food security.

Follow-up questions:

- Data
    - Impact of students/tourism on data – is it included?
- Cannabis/vaping – smoking statistics include these or will the question “do you smoke” need to be adjusted to include all kinds of smoking?

Rural Frontenac, Lennox and Addington

- **Physician and other health care professionals' recruitment/retention**
  - ○ Problem recruiting more health care professionals (hard to recruit even if stats say otherwise)
  - ○ hard to retain them in a rural setting
  - ○ PSWs have piecemeal jobs and patients need consistency.

- **Social Determinants of Health**
  - ○ Housing options - require novel approaches for affordable housingL
    - Lower demand for long-term care, perhaps look at retirement home options; and
    - Assign PSW to an existing building as an idea.
  - ○ Consider caregiver burnout and respite options.
  - ○ Transportation, low income, and food security in particular are challenges.

- **Health Behaviours and Attitudes**
  - ○ Prevention - Keeping people of all ages healthy, both young and older.
  - ○ Leverage community to participate in addressing local issues.
  - ○ Include mental health promotion.
  - ○ By changing attitudes and habits, reduce unnecessary care to increase provider capacity.
  - ○ Chronic pain and opioid strategy alignment.
  - ○ Need more metrics around attitudes, promotion and behaviours to monitor improvements.

- **Health Care System Utilization**
  - ○ High numbers of avoidable emergency visits - usage stats need to be looked at on deeper level
  - ○ Technology for providers to communicate with one another, as well as for patients, to connect with the system efficiently
  - ○ Nearly half of patients in this sub-region go elsewhere for primary care
    - Challenging when looking at performance metrics –truly reflect care provided in the rural area?

Quinte

- **Improving Access**
  - After-hours access to primary care (e.g., pool resources to expand access),
  - Primary care for Addiction and Mental Health patients,
  - Primary Care for military families.
  - Primary care for the unattached population (includes children and those with complex needs).
  - Access to acute episodic care.
  - Availability of hospice and palliative care services – improve palliative care services for patients with Congestive Heart Failure and Chronic Obstructive Pulmonary Disease; enhance end-of-life support and education.
  - Access to care for seniors and their caregivers, including preventative and rehabilitation services; continuing care; complex care; personal support workers and nursing services in the home setting; dementia care services; and availability of more long-term care beds
  - Availability of bereavement support (grief and loss).
  - Opioid trauma support and access to support for trauma (effects of trauma on health).

- **Social Determinants of Health**
  - Improve transportation access for seniors (cost, availability).
  - Ensure affordable and safe housing options (e.g., income-based housing for seniors).

- **Indigenous Population**
  - Address challenges faced by Indigenous people accessing services.
  - Provide culturally appropriate services in culturally safe spaces.

- **Address Needs of Vulnerable Populations**
  - Identify and address the needs of immigrants/refugees.
  - There is growing awareness of human trafficking in the region.

- **Prevention**
  - Cancer screening (cervical) rates and opportunities to improve process efficiency.
  - Coordination of preventative screening.
  - Standardization of group sessions/patient education for prevention.
  - Health promotion to include broad public health education.

- **Capacity: Health Human Resources**
  - Utilization of Nurse Practitioners to improve service delivery access.
  - Plan for primary care capacity by taking into account allied health providers, management/ administration, and family physician recruitment.
  - Define team-based primary care models

Rural Hastings

- **Data Quality and Utilization**
  - What is used – data did not accurately reflect what was occurring in the region.
  - Questions regarding where the data comes from, what dates/timelines was it collected?
  - Collectively utilizing quality and timely data to identify priorities for the region.

- **Caregiver Support and Burnout Avoidance**
  - Increasing support is critical while looking at how to support caregivers in new and different ways.
  - Importance for sustainability within region - how to best support clients within an aging and rural population.
  - How do we "think outside the box" and find solutions for clients and caregivers living in rural and remote areas (e.g. transportation, maintain homes in winter, etc.)

- **Social deprivation/socio-economic factors greatly influence health outcomes in Rural Hastings**
  - Clients and caregivers living in small towns or in very large rural area.
  - High poverty and social deprivation.
  - Ensuring linkages with socio-economic factors are understood and how they link with health outcomes.
  - Designing health care services and access that factor in social deprivation, poverty and rural isolation.
- **Access**
  - Large portion of the population living in remote/rural locations without traditional access to health care in urban centers – need to design supports to meet needs differently for this population.
  - Access for clients in Rural Hastings needs to be improved (e.g. transportation, location, increased provision etc.).
  - Leverage Health Links care coordination model is a key objective to ensuring that clients have comprehensive care plans and coordination of service.

- **Health Work Force**
  - Recruitment and retention - how to attract people to stay and plan for the future.
  - Looking at service provision at every level and the critical mass needed to sustain services.
  - Acknowledging the retiring work force and how replacement and retention plans can be rapidly put in place.