North East **LHIN**
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MEMORANDUM

To: NE LHIN Hospital CEOs and Hospital Clinicians

From: Martha Auchinleck, Senior Director, Health System Transformation and Implementation, NE LHIN

Date: October 16, 2013

Subject: **UPDATE ON NORTH EAST LHIN CLINICAL SERVICES REVIEW**
QBP Focus – Stroke

Further to feedback received during our ongoing Clinical Services Review (CSR) engagements, I am sending this memo to keep you apprised of progress being made with the CSR (see backgrounder on page 3). I have also highlighted the *stroke QBP* as there has been relevant work done by the Northeastern Ontario Stroke Network (NEOSN) which feeds in directly to our CSR.

The CSR is helping the NE LHIN develop a future vision for the delivery of QBPs across our region. It is anticipated that a recommended model for restructuring QBPs will go to our Board of Directors early in 2014.

Following the hospital CEO engagement on the evening of Wednesday September 11, we had good participation in the second round of clinician engagements held in Nipissing and Sudbury, September 23; Cochrane, September 25; Algoma, October 1.

Mark Hundert of the Hay Group is now going through all comments received at the engagements however, in general, a few of the main themes heard include:

- Data quality.
- Process – opportunity for input along the way.
- Safeguarding role of small hospitals.
- Need for "standards of care"
- Caution around moving care out of small hospitals and into community locations.
- Consider rurality and remoteness in any model.
- Different community solutions are needed given that not all communities have FHTs.

On November 19, the NE LHIN's HSFR Local Partnership will hold a full-day meeting to review the CSR process and its findings. We will provide further information and seek your input once again following that date, possibly through a webinar which will examine the results and possible models for restructuring QBPs.

Regional Stroke Care Review

The Northeastern Ontario Stroke Network (NEOSN) and the NE LHIN embarked this year on a regional review to determine the impact of moving to a fully integrated model of stroke care that would incorporate:

- The consolidation of post-emergency department inpatient stroke care (acute + rehabilitation phases) to the LHIN's four designated stroke centre hospitals (HSN, SAH, TDH, NBRHC).

- The development of a regional approach to providing outpatient post-stroke interdisciplinary follow-up and community navigation services.
- The development of a regional anticoagulation program, as part of a regional vascular health strategy.
- The review was done in collaboration with hospital and community stroke care stakeholders on the recommendations of NEOSN.

This review will determine the impact of moving to an integrated regional model of stroke care, rather than the current model of centralized and decentralized services.

The review has been done in collaboration with hospital and community stroke care stakeholders on the recommendations of NEOSN:

- Impact of consolidation on stroke survivors, families, caregivers and EMS
- Impact on community hospitals and designated stroke center hospitals
- Impact of regional post-stroke community reintegration program on stroke survivors, families, caregivers, designated stroke centres and community hospitals.

Review drivers included:

- 1,100 – 1,200 inpatient admissions annually for stroke across the NE LHIN's four designated stroke centres and 20 community hospitals
- The NE LHIN 2011 and 2012 Stroke Report Card Findings (published by Ontario Stroke Network) that demonstrated sub-optimal performance in stroke care across areas including acute care, rehabilitation and stroke prevention care
- Canadian Stroke Best Practice Recommendations
- Critical Mass and Stroke Expertise (current research indicates that a critical mass of 160-200 stroke patients per year is required at a single site to develop and provide best practice stroke care)
- Move to Patient Based Funding (HBAM + Quality Based Funding) with a model that incorporates the delivery of stroke best practice care.

Anticipated outcomes from an Integrated Regional Model of Stroke Care include:

- Patient benefits: fewer post-stroke complications, decreased mortality and disability rates; improved secondary prevention leading to a decreased risk of second stroke
- Improved system efficiency including improvements in: length of stay, readmission rates, wait period to access rehab and overall decrease in costs to the health care system.

Recommendations/Timing:

- Report expected by the end of 2013 with recommendations related to consolidation, community navigation services and a regional anticoagulation program.
- Implementation Period: January 2014 – Sept. 2015

In summary, I commit to continuing to provide you with updates on both reviews. Please do not hesitate to contact me to seek clarification or to provide your further input.

Regards,

Martha Auchinleck

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Attached: HSFR Memorandum, October 9, 2013

Clinical Services Review Background

Ontario's health care system is moving away from a global funding system to a model that organizes the system around patient needs.

Since 2011, the Ministry has provided educational sessions and established clinical expert panels to develop handbooks for each of the QBPs. The handbooks are based on clinical evidence for best practices and can be found here on our NE LHIN website.

Health System Funding Reform (HSFR) began in 2012/13 and uses two funding models: health-based allocation model (HBAM) and the QBP model. Together, these ensure that funding is allocated based on the number of patients and the most efficient procedures to deliver high-quality care.

When HSFR is fully implemented in 2014/15, 30% of hospital funding will be based on QBPs. (See web page.)

In year 1 (2012/13), four QBPs were implemented: primary hip replacements, primary knee replacements, cataract surgery and chronic kidney disease. In year 2 (2013/14), six additional QBPs were added: colonoscopy, chronic obstructive pulmonary disease, congestive heart failure, stroke, chemotherapy-systemic treatment and non-cardiac vascular. We have now learned of the 2014/15 QBPs (see attached HSFR memo of October 9, 2013).

In 2012, a NE LHIN Small Hospital Working Group was established to look at implications of QBPs on small hospitals (a hospital with less than 2700 acute weighted cases). The group came up with two recommendations to phase in QBPs for small hospitals: (1) small hospitals should adopt the clinical pathways in 2012/13; (2) the “carve-out” and funding for small hospitals should be delayed until 2014/15 to give small hospitals time to adjust, plan and realign their services as needed given the impending QBPs.

Early in 2013, the NE LHIN retained the Hay Group to do a review of QBPs that are completed at all 25 hospitals and develop potential future models and an action plan to help implement the vision for the NE LHIN.

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