



Creating Caring Communities, Healthier People... *Together!*

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**An Integrated Health Service Plan
2010-2013 Launch Series
June 23, 2010**

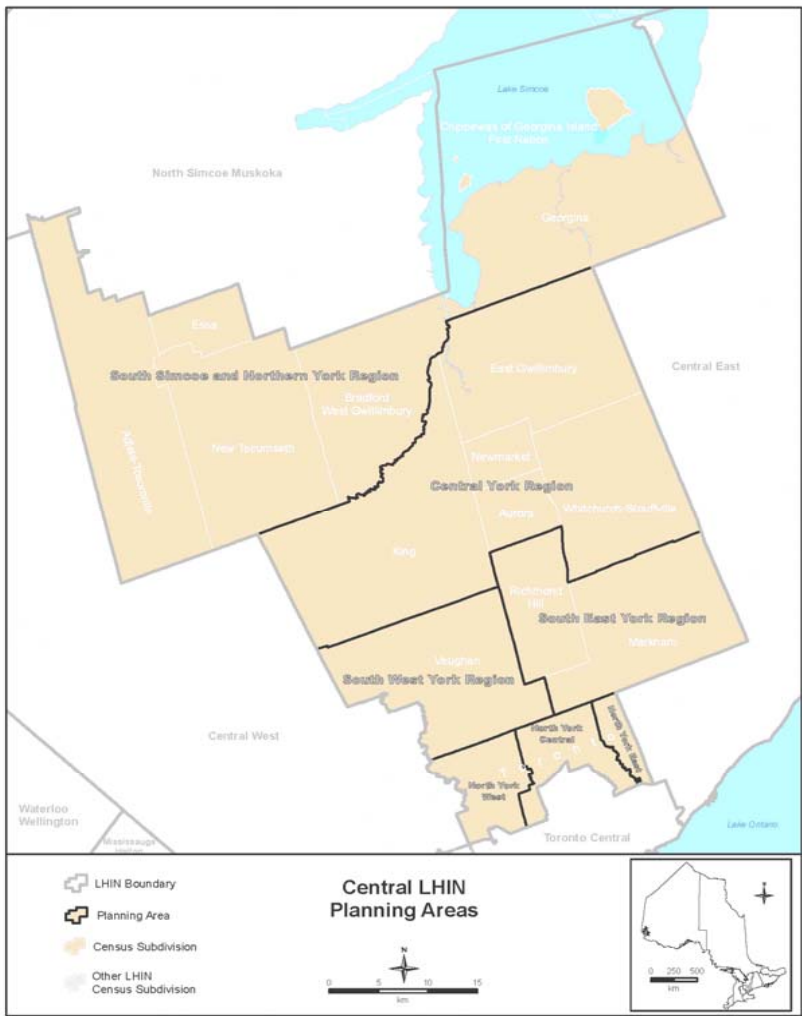
Current Context - The Fiscal Environment

- Healthcare spending currently accounts for \$0.46 cents of every \$1.00
- Provincial Health Care Budget of \$46.1 billion, a 57% increase since 2003/04
- Health Care Budget projected to increase by a further \$6 billion (2009/10 to 2012/13)
- Provincial deficit of \$20 billion with a plan to eliminate it in 8 years

The Challenges are large but not insurmountable.....



Central LHIN



Population Trends and Highlights:

- 1.7 million residents
- 7 planning areas
- Projected 19.2% growth rate over the next 10 years (vs. 12.6% ON)
- 42.1% of the population is a visible minority
- 76.2 family physicians per 100,000 population (vs.80.4 ON)

North York West:

- highest rate of diabetes associated hospitalizations
- lack of healthcare providers to provide diabetes care
- highest prevalence and relative risk of diabetes

South Simcoe/Northern York Region:

- limited access to primary care due to fewer general practitioners and limited specialist support
- limited access to services on Georgina Island

Health Service Needs Assessment and Gap Analysis (SNAGA)

Identified and aligned the health service needs and gaps within the Central LHIN

- To better understand existing gaps
 - Inform planning and funding activities
 - Provide an epidemiologically based framework of need for health services
 - Provides a sound basis to guide planning for health service delivery - contributing to the annual service planning process
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- Identified integration priorities and strategies for implementation
 - Guided planning of the healthcare system (locally)

Central LHIN's IHSP 2010-2013 Planning Priorities

We identified four planning priorities where our investment of resources was likely to have the greatest impact...

Emergency Department
and Alternate Level
of Care

1

Chronic Disease
Management and
Prevention

2

Mental Health
and Addictions

3

Health Equity

4

The enablers that are key to our success

We've also identified four enablers that play a key role in achieving our IHSP 2010-2013 goals ...

Health Human
Resources

1

Primary Care

2

Decision
Support

3

eHealth

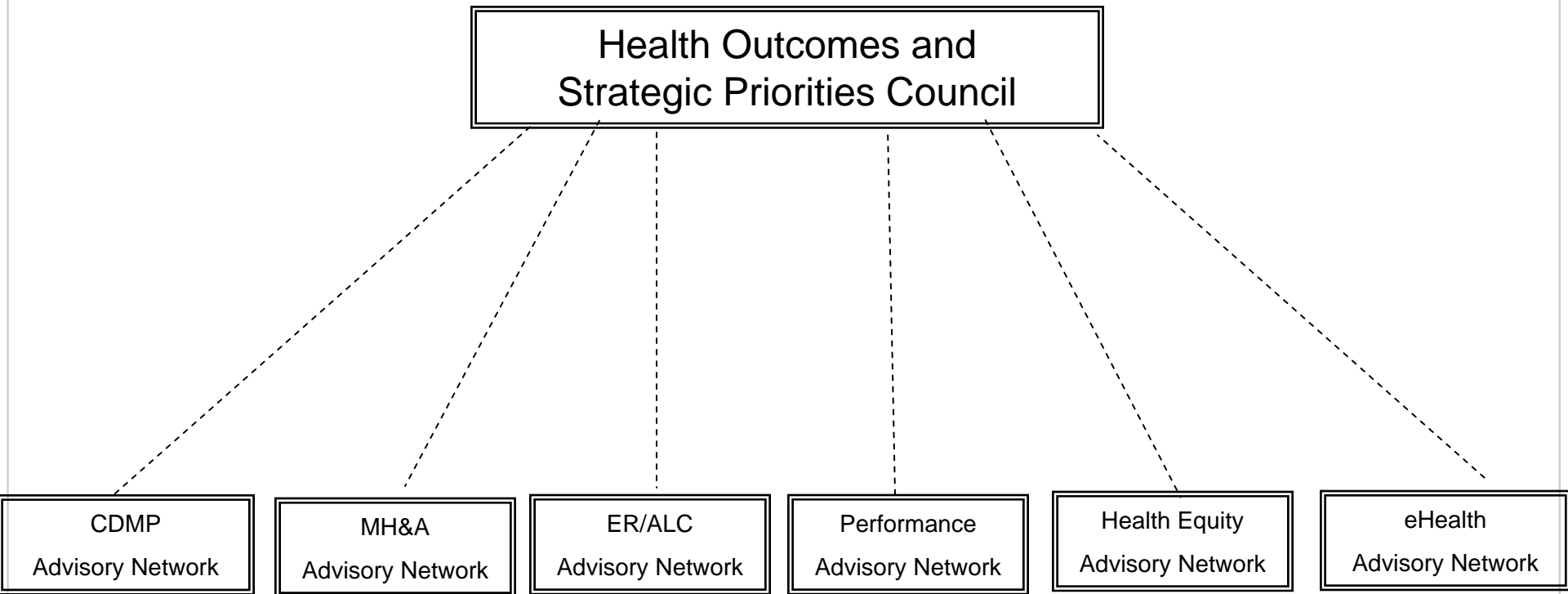
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Central LHIN IHSP 2010-2013 Planning Priorities

Current and Future State

Priority	Where we are (current state)	Where we want to go (future state)
Emergency Department and Alternate Level of Care	<ul style="list-style-type: none"> • Long wait times for patients • Ministry of Health and Long-Term Care priority for improvement 	<ul style="list-style-type: none"> • Reduced numbers of non urgent cases presenting in emergency departments • Improved triage and admission processes • Improved access to hospital services • Improved access, coordination and integration of services
Chronic Disease Management and Prevention	<ul style="list-style-type: none"> • Health system designed for acute care • Chronic disease associated with high costs • Aging population leading to higher demand 	<ul style="list-style-type: none"> • Improved partnerships leading to increased access to services • Enhanced continuity of care and improved system processes • Prevention strategies to delay onset and reduce progression of disease • Skills and supports focused on self management for patients and families
Mental Health and Addictions	<ul style="list-style-type: none"> • Long wait times for patients • People in need not receiving mental health and addictions services • Gaps in services 	<ul style="list-style-type: none"> • Improved linkages among health service providers • Reduced non urgent emergency department visits • Programs to address service gaps
Health Equity	<ul style="list-style-type: none"> • Variations in health status and access to care • Certain communities in Central LHIN are at greater risk of chronic disease 	<ul style="list-style-type: none"> • More equitable access to health care in all Central LHIN communities • Increased outreach and community engagement to target populations

Central LHIN's Advisory Networks

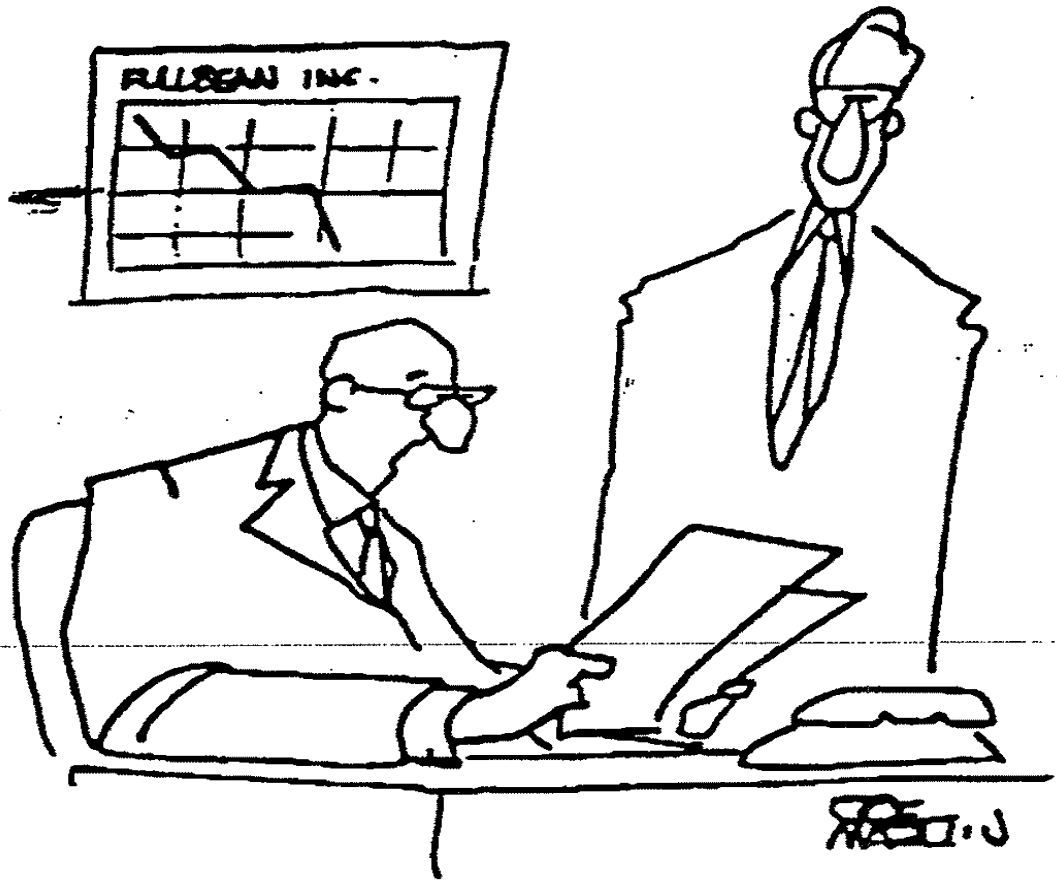


Integration and Collaboration Examples

- St John Rehabilitation Hospital and North York General Hospital (transfer inpatient rehab program/resources)
- COTA Health and Homeward Mental Health Projects of Metro Toronto (transfer all operating funds/services)
- Medication Management Support Services with Central CCAC and partners York Central, Southlake Regional, VHA Rehab Solutions, SRT Med Staff, Saint Elizabeth Health Centre (coordination of services across a multi-disciplinary team)
- LHIN Wide Consolidation of Surgical Ophthalmology Services
- Palliative Care Network for York Region (Pal Care) and Southlake Regional Health Centre (transfer pain and symptom management consulting services)
- York Durham Aphasia Centre and Ontario March of Dimes (merge organization/services)

Linking the Pieces for the Future.....(Plan A)

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- System Priorities
 - Population Demographics (Demand/Needs)
 - Engagement of Health Service Providers/Public
 - Alignment of Partners
 - Building successes and learnings
 - Planning an Integrated System (LHSIA, 2006)
 - Performance/Utilization (Supply/Available Resources)
 - Being responsive to changes



6-8-89

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This Plan B — “running and screaming in all directions.” How’s it working out?

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THANK YOU