



Central East Local Health Integration Network
2008/2009 Annual Service Plan

Engaged Communities.
Healthy Communities.



MEMORANDUM

To: Carrie Hayward, Director, Health System Accountability and Performance Division

From: Foster Loucks, Chair, Central East Local Health Integration Network

CC: John Babos, Manager (Acting), GTA Unit, LHIN Liaison Branch

Date: June 6, 2008

Re: **Transmittal Letter for the Central East LHIN Annual Service Plan, 2008-2009**

I am pleased to present to the Ministry of Health and Long-Term Care our Annual Service Plan (ASP) for 2008-2009, in fulfilment of the requirements outlined in Schedules 5 and 8 of the Ministry-LHIN Accountability Agreement.

This Plan was presented to the full Board at our open Board meeting on August 10, 2007, in accordance with the *Local Health Systems Integration Act 2006* provisions to demonstrate to our stakeholders that LHIN decision-making is transparent, evidence-based and grounded in the priorities of our Integrated Health Service Plan. Following discussion and review, the Board is proud to approve and endorse the Plan as an articulation of:

- our plans for the implementation of the Integrated Health Service Plan with a focus on improving access, quality and integration of local health services; and
- identified health service needs and pressures within the CE LHIN region related to the strategic priorities of the government and the LHIN, including wait times.

This Plan represents the LHIN's blueprint to achieve our vision of "*Engaged Communities, Healthy Communities*." Throughout our community engagement process, we heard that Seamless Care for Seniors, Chronic Disease Prevention and Management, and Mental Health and Addictions were priorities for transformation in the health care system. Along with Wait Times and Critical Care, these four elements became the "priorities for change" in the LHIN, and form the basis of the ASP and the work plan for the implementation of the Integrated Health Service Plan.

Our ASP initiatives have been checked against the risk framework submitted as part of the attached Plan, as well as the outcome measures adopted by the LHIN from the Ontario Health Quality Council of: accessibility, efficiency, effectiveness, safety, integration, person-centred care, appropriate resources, equity, and a population health focus.

Key initiatives described in the Plan to meet the needs of residents and health service providers in the Central East LHIN include:

- Developing a Stroke System for the Central East to improve equity and parity of access to timely care for Central East residents. The Durham Region lacks a District Stroke Centre resulting in inequitable and/or inconsistent access to services along the stroke continuum;
- Improving the Basket of Services for Seniors and People with Mental Health and Addictions needs to support Aging in Place and remove barriers to accessing the right care at the right time by the right provider in the right setting;
- Clinical Services Planning to ensure equity of access to hospital services balanced with the elimination of wasteful and time consuming duplication within the macro-level vision of "one hospital system for the Central East LHIN";
- Ensuring that the LHIN is appropriately resourced to meet residents' needs by transitioning 1% of the overall acute care budget from the acute care to the community sector by 2010/11;
- Innovative Supportive Housing partnerships to increase the number of individuals and families who have secure, affordable, and supportive living arrangements;

- Creating a Disordered Eating Initiative for youth/young adults and their families based on a balanced systems approach for a coordinated continuum of cross-sector supports;
- Improving patient self-management of their chronic diseases; and
- Establishing a CE LHIN virtual Project Management Office that would increase capacity of providers to work collaboratively on integration opportunities.

The ASP also identifies known areas of health service sector growth due to demographic pressures, clinical practice and inflation. They are included in this plan for the purposes of notifying the Ministry of pending growth. Inclusion in the ASP is not an approval or commitment of the Central East LHIN to provide funding within its current allocation. It follows that spending in these areas will need to follow a process consistent with LHIN and MOHLTC policies and procedures.

Our 17 Planning Partners, including nine local geographic Collaboratives, three priority Steering Committees, and five project-based Task Groups, will be applying their tremendous capacity, knowledge, and experience to bring these initiatives to fruition. Their active partnership ensures that the proposed initiatives detailed in the ASP are responsive and reflective of all of our unique communities from Scarborough to Haliburton.

The Board is confident that the following Annual Service Plan represents the necessary steps to establish a truly transformative and appropriately resourced health system.

Yours truly,



Foster Loucks, Board Chair
Central East Local Health Integration Network

Enclosure: 2008/2009 Annual Service Plan

Central East Local Health Integration Network
Annual Service Plan

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B. Introduction

The 2008/09 Annual Service Plan provides an overview of the implementation of the Central East LHIN Integrated Health Service Plan (IHSP). The IHSP is a multi-year plan that details the goals and objectives for health care system change in the Central East LHIN. Through the commitment of local health service providers and other interested stakeholders, the implementation of the IHSP has already begun. The ASP provides the basis of support for any regional transformation objectives and associated funding realignments. This local health system plan will assist the public to understand how the LHIN is planning to address the needs of their community. Community engagement was the cornerstone of developing our priorities for change, and it is also the foundation of delivering on that vision.

The Annual Service Plan (ASP) presents the Central East LHIN with a transparent means to document and communicate some of the known pressures and risks related to the local health system to the Ministry of Health and Long-Term Care and other government ministries. The Central East LHIN ASP, along with the plans of other LHINs, are an important input to the preparation of the Ministry of Health and Long-Term Care financial forecasts for the Ministry of Finance.

The Central East LHIN Annual Service Plan is guided not only by the goals and objectives of the IHSP, it is also consistent with the vision and strategic directions of the CE LHIN. Both provide the Central East LHIN board and management, as well as local health service providers, a guide to priority setting and decision making.

Our Vision:	Engaged Communities. Healthy Communities
Our Strategic Directions:	Transformational Leadership Quality and Safety Health Service and System Integration Fiscal Responsibility
Desired Outcomes for the Health System:	Accessible Effective Efficient Quality People Centred Integrated Appropriately Resourced Equitable Focus on Population Health

The Central East LHIN vision, strategic directions and goals inform the **priorities for change** identified in the IHSP and re-iterated in this Annual Service Plan. These priorities are based on the direction received from our health care community, and the sound application of health care policy directions and local evidence.

Priorities for change: Access and Wait Times

Seamless Care for Seniors
Chronic Disease Prevention and Management
Mental Health and Addictions

Establishing and implementing the CE IHSP – not to mention the importance of instilling a new culture of cooperation – has required an extensive, predictable and sustainable plan for community engagement. The **Framework for Community Engagement and Local Health Planning** is a cornerstone document that outlines how the Central East LHIN organization will engage its community in order to achieve health system change. To date, we have thrived under this plan!

In this Annual Service Plan, we have identified the involved stakeholders in each one of our proposed initiatives. While we will continue to work in partnership with the Ministry of Health and Long-Term Care, other LHINs and health service providers, we will also turn to the expertise and commitment of our planning partners.

The Central East LHIN planning partners can be summarized as follows:

Planning and Engagement Collaboratives (9 based on geography)

These collaboratives, or local advisory teams, represent the individual communities of the LHIN and consist of 9 to 15 people who provide and/or receive health care services in a specific community. Collectively, these teams approximate the continuum of the health care system with members from primary care, hospitals, community services, mental health and addiction services, long-term care, physicians and pharmacists. Local residents interested in the public health system are also participating.

LHIN-wide Health Interest Networks

Like Collaboratives, Network membership represents the continuum of health care services. *Unlike the Collaboratives however, Networks bring together a single team from across the LHIN on a specific priority area identified in the IHSP.* Networks are guided by a steering committee of 12 to 15 individuals with specific interests and skills related to that priority. For the most part, Networks are generative bodies for new strategic directions that will improve service integration and quality of care for their priority communities. They also serve as an umbrella for sub-committees dedicated to specific services within the portfolio. The existing networks are:

- o **Seamless Care for Seniors Network** – Steering Committee of 13, with a full Network Membership of 180 individuals and/or organizations
- o **Chronic Disease Prevention and Management Network** – Steering Committee of 14, with Network Membership of over 60 individuals and/or organizations and growing
- o **Mental Health and Addictions Network** – Steering Committee of 15, with Network Membership of over 90 individuals and/or organizations and growing

Task Groups

Task Groups have been created around the common themes identified in the Integrated Health Service Plan. They work with and support other planning partners to turn priority area actions into reality. Each Task Group has defined actions to achieve over a set time frame. Current task groups include:

- Primary Care Working Group
- Alternate Level of Care (ALC) Task Group
- Emergency Department Task Group
- E-health Steering Committee
- Rehabilitation Task Group

Mobilizing the community for system change requires a vision and a commitment to achieving results. It also requires common business solutions that teams utilize to work intelligently and efficiently across organizational boundaries. To this end, the Central East LHIN has adopted a **project management methodology** to operationalize our priorities and guide our activities. Using such a methodology allows Central East LHIN planning partners and health service providers to own and manage system change for themselves in a way that is transparent and inclusive.

To this end, the project teams related to our IHSP and ASP activities are being established through the sponsorship of our planning partners. These teams will be preparing project charters for Central East LHIN Board review and approval prior to the implementation or maturation of their specific projects. As the ASP outlines, however, additional resources are required to establish a Central East LHIN project management office. Without such a systemic approach to planning and implementation, Central East LHIN staff resources will be under constant stress. Not only does this risk the achievement of our goals and objectives, but threatens the continued development of a Central East LHIN culture of shared responsibility.

To help understand the connections between the above – from our vision to common business solutions – two diagrams may be instructive.

The figure on the right illustrates how our vision informs our strategic directions and, in turn, the IHSP. Supporting this is our community engagement structure and common business solutions.



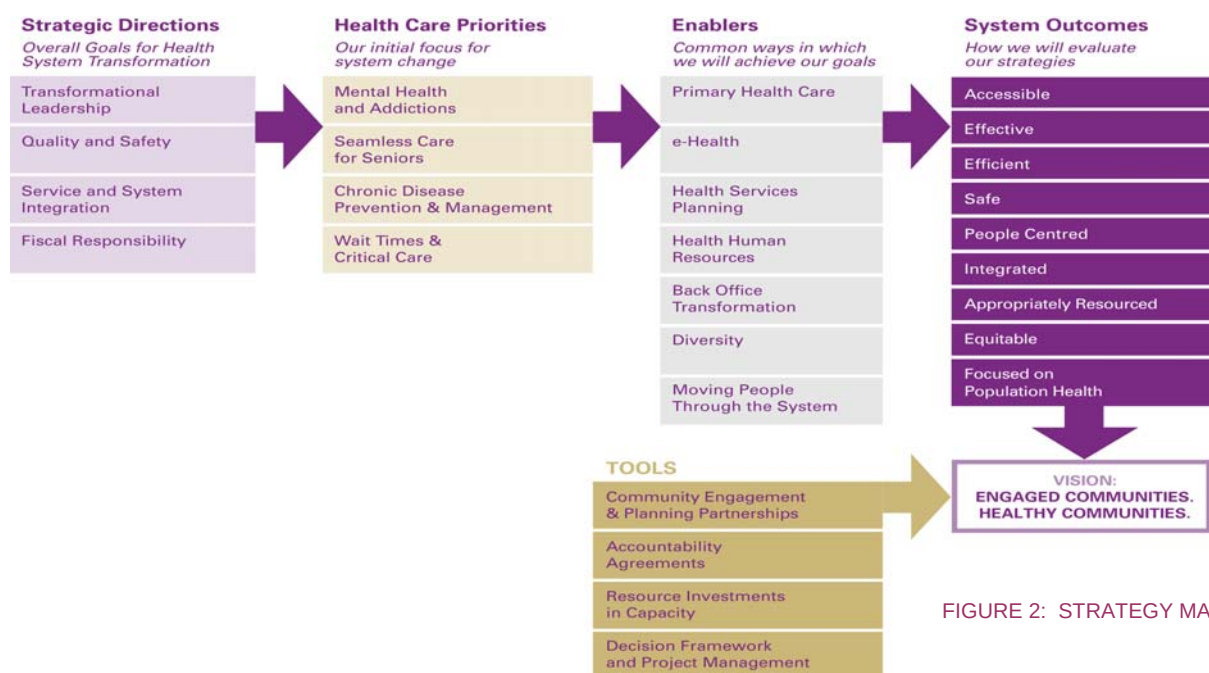


FIGURE 2: STRATEGY MAP

The Central East LHIN Strategy Map (figure 2) outlines our IHSP priorities for change and how, through common enablers and activities, they promote our desired outcomes for the local health system.

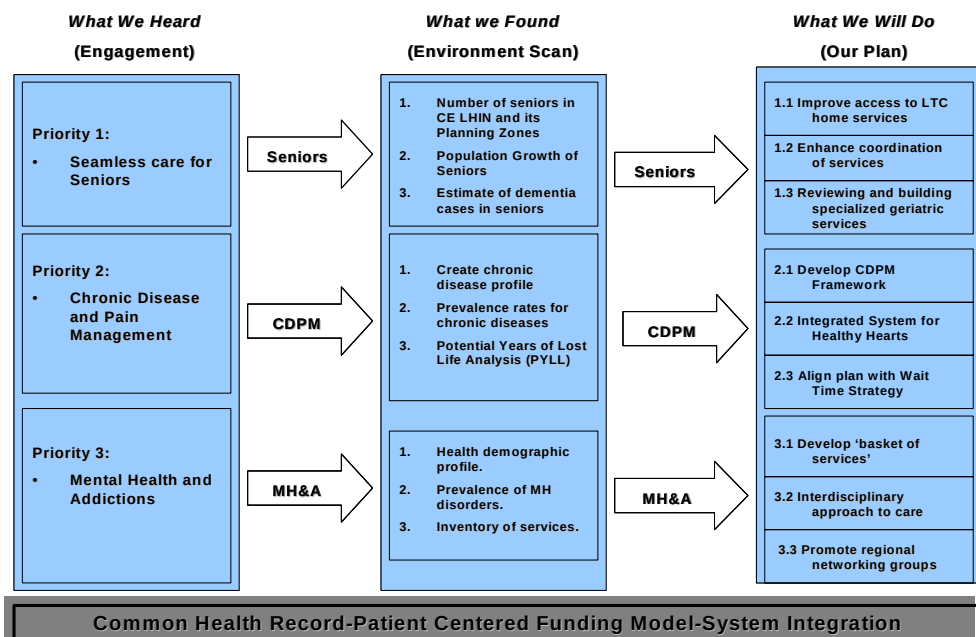
The structure and processes of the ASP are also consistent with the Ministry-LHIN Accountability Agreement (MLAA) and Ministry strategic directions. Specific references to MLAA performance outcomes are referenced to particular initiatives within this ASP. Finally, all reporting between the Ministry and the LHIN is grounded by legal requirements included in the Local Health System Integration Act, 2006 (LHSIA), and their Memorandum of Understanding.

C. Environmental Scan of Opportunities and Risks

Description: The environmental scan sets the context for the detailed plans to implement the IHSP priorities by providing evidence for the plans set forth, based on the LHIN's own research, through local planning, community engagement and other activities, and risk analysis of its local health system, its needs and future priorities.

Having a clear and concise understanding of the environment in which we plan and deliver our health services is essential to the success of our Integrated Health Service Plan moving forward.

Through ongoing community engagement and consultation processes with residents, consumers and health care providers, four LHIN-wide priorities for change were identified. They are Seamless Care for Senior's, Chronic Disease Prevention & Management, Mental Health & Addictions and Wait Times & Critical Care. While the latter priority resulted from alignment of efforts with broader Provincial guidelines and initiatives, identifying the other three strategic 'priority for change' areas resulted from a firm commitment to the underlying philosophy of 'heard, found, do'.

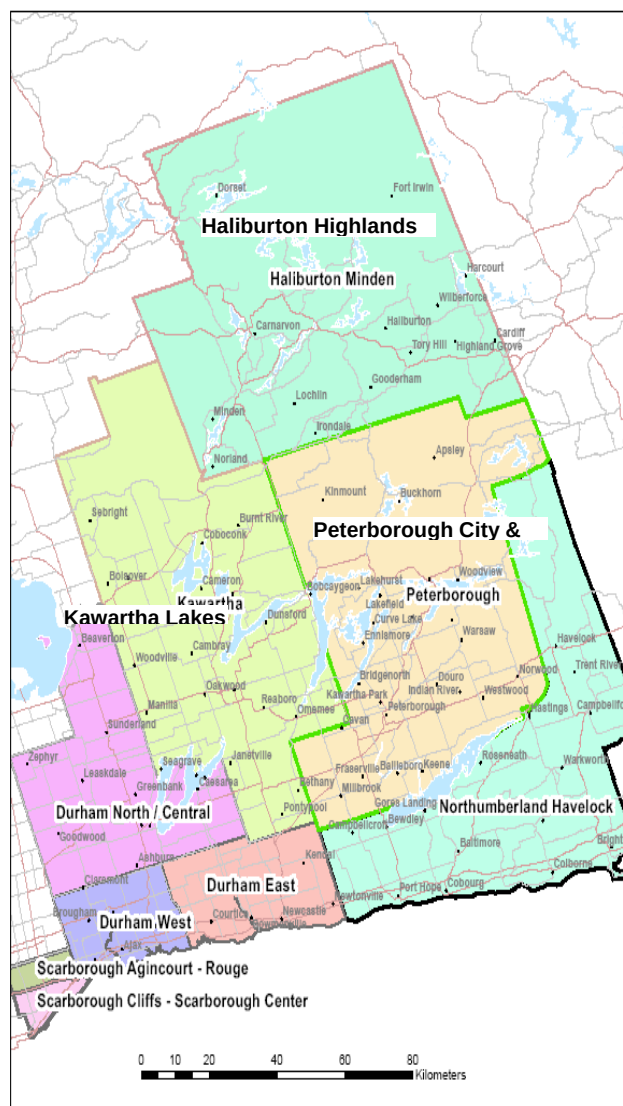


Accordingly, through various Health Interest Networks, Task Groups and Collaboratives, work has since begun on initiatives aimed towards improving care across these priority areas.

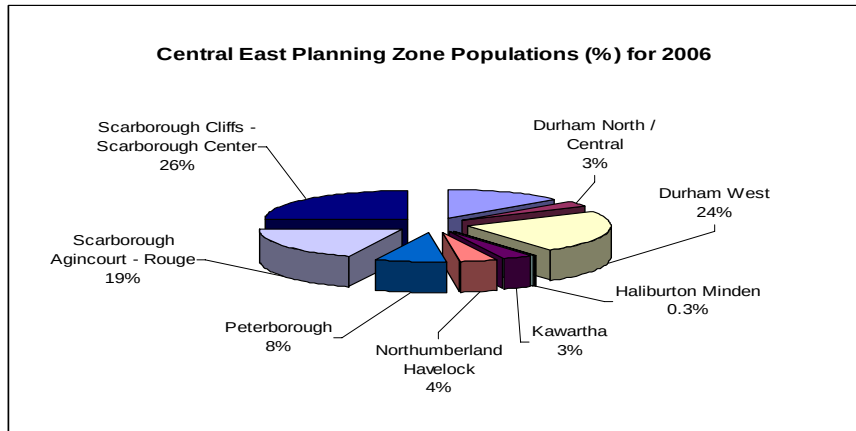
Population Characteristics of the Central East LHIN

The Central East LHIN region stretches from the culturally diverse and densely populated Scarborough planning zones to the rural and less populated areas of Haliburton Highlands, and northern sections of the City of Kawartha Lakes and Peterborough City and County.

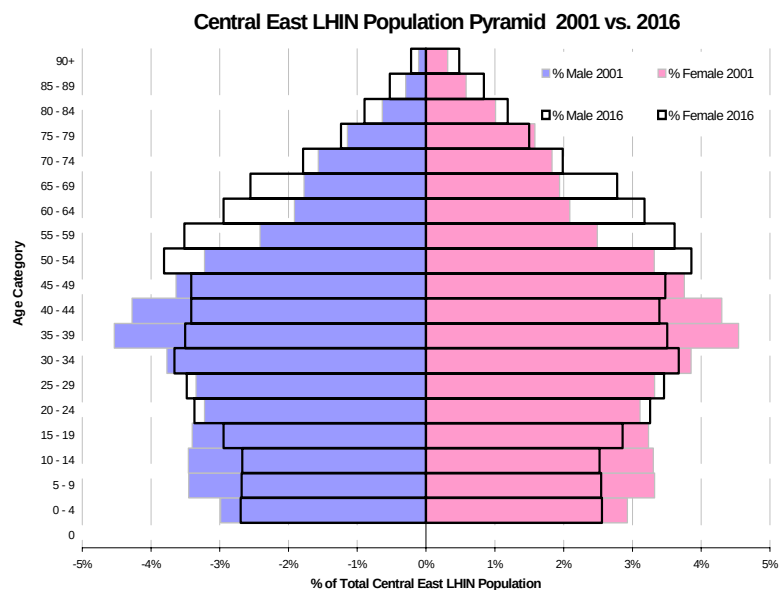
Central East LHIN



The population of the LHIN is mainly concentrated in the South West portion of the region, with the population of Scarborough accounting for nearly 50% of the whole.

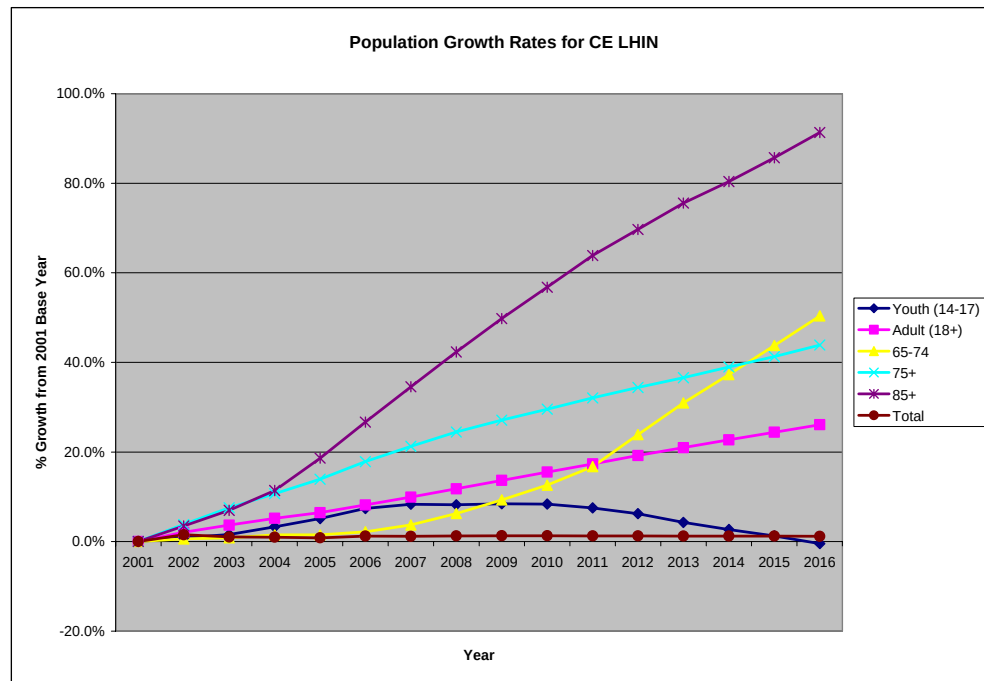


Generally speaking, the population of the Central East LHIN is aging. At the same time, the portion of youth is dwindling. As time passes, the population pyramid of the LHIN will therefore grow increasingly 'top heavy'.



In fact, the Central East LHIN already has the second highest percent of those over age 65 of any LHIN in the province. Further to this, trends indicate that the 85+ age group will also increase by over 91% between 2001 and 2016. Meanwhile, the 14-17 years-of -age cohort will decrease by 0.5% over the same time period.

This continued trend will result in the portion of the 85+ segment of the population growing from 1.3% of our total population to 2.1% by 2016.

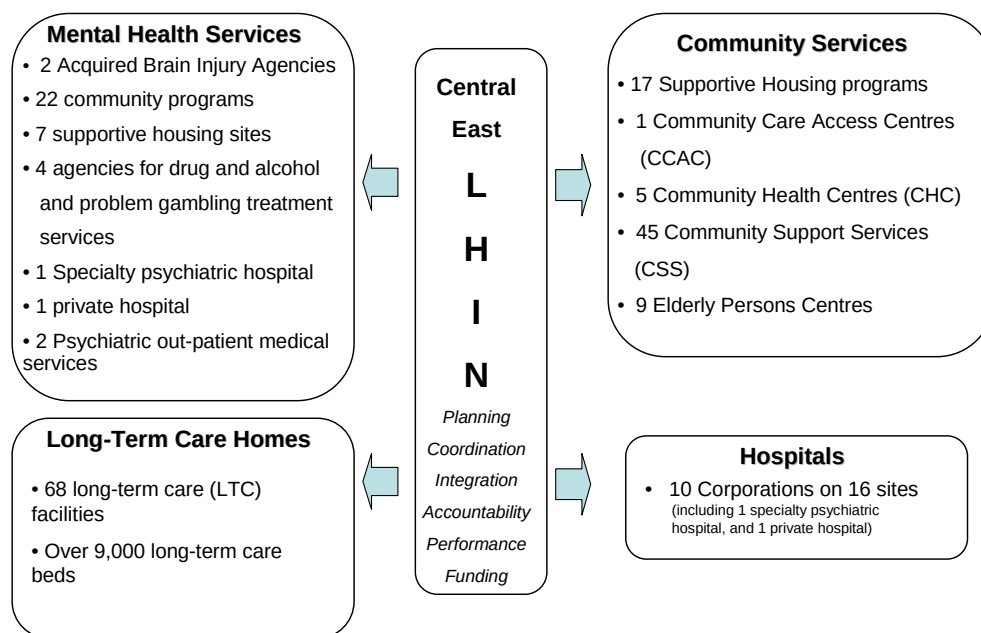


	Base Year (2001)		2006			2016		
	Population	% of Population	Population	% of Population	Percent Increase from Base Year	Population	% of Population	Percent Increase from Base Year
Total Population	1,402,899	100.0%	1,483,126	100.0%	5.7%	1,677,507	100.0%	19.6%
0-64	1,223,404	87.2%	1,287,215	86.8%	5.2%	1,412,764	84.2%	15.5%
65+	179,495	12.8%	195,911	13.2%	9.1%	264,743	15.8%	47.5%
65-74	99,786	7.1%	101,985	6.9%	2.2%	150,064	8.9%	50.4%
75-84	61,405	4.4%	70,744	4.8%	15.2%	79,657	4.7%	29.7%
85+	18,304	1.3%	23,182	1.6%	26.6%	35,022	2.1%	91.3%

Present Health Care Services

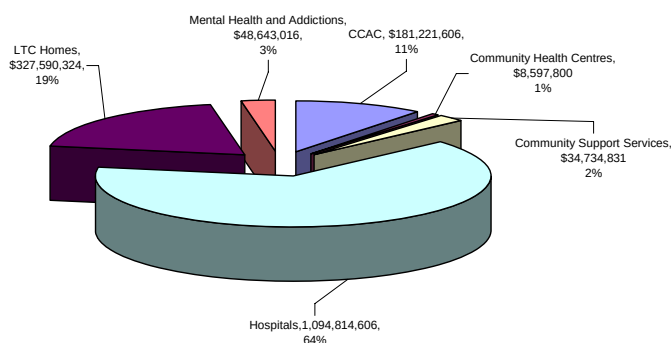
The Central East LHIN encompasses more than 180 health service organizations in total. These organizations include hospitals, long-term care homes, nursing homes, community health programs, home care, social programs, and mental health and addictions programs.

Size and Complexity of the System



By far, the bulk of allocated funding received (almost two-thirds or 66%) goes toward the acute care hospitals of the Central East LHIN. On the other hand, Long-Term Care Homes account for approximately one-fifth (or 20%) of LHIN funding with the remaining 14% divided amongst the Central East CCAC and various other smaller community based programs that have traditionally rounded out the local health care environment.

Total Program Funding, CE LHIN, 2007-08



Background Context for the Four Priority Areas for Change of the Central East LHIN:

Access & Wait Times

In many respects, the Central East LHIN is very similar to the Province across a broad range of measures and indicators. Averages can however mask some of the unique characteristics of the various planning zones that negatively affect access to health care. For example, areas like Scarborough and Haliburton are distinct in terms of their population characteristics. Factors such as cultural diversity, age composition and rural character also vary greatly and often create barriers to accessing care across the continuum. Additionally, since the LHIN is aligned with the Provincial Wait Times priority initiatives under the terms of the Ministry-LHIN Accountability Agreement, certain key wait times for so-called priority service areas must achieve negotiated target reductions moving forward. Moreover, reducing the Percentage of Total ALC Days is becoming increasingly important in terms of improving overall access to care.

Seamless Care for Seniors

Like many places in Ontario, the population of the Central East LHIN is aging higher than the Provincial average rate. There are many reasons for this pattern: an overall aging 'baby boomer' population, the desirability of the Central East LHIN as a retirement destination, and the abundance of mature communities located in rural areas. However, since health care use generally tends to increase with age, planning care for this segment of the LHIN's population will undoubtedly remain a top priority well into the future.

Chronic Disease Prevention & Management

Planning and developing appropriate services for people suffering with a chronic disease remains a crucial component of our LHIN's IHSP. Health care providers face an ever aging population with a growing number of newly diagnosed cases, particularly with those whose needs are intensifying as a result of having more than one chronic condition. The effective management (and ideally the prevention) of these cases will therefore assist in greatly reducing the need to access urgent/emergency care and reduce demand along the entire continuum of care. Interestingly, our LHIN's historical analyses suggest that more than 10% of total ED visits across the LHIN result directly from a chronic disease or illness. Also of note, 6 out of every 10 of these ED visits sought treatment for a cardiovascular or respiratory illness. These facts represent both an enormous challenge and an opportunity in terms of addressing this crucial priority going forward.

Mental Health & Addictions

Historical analyses of prevalence rates throughout the LHIN revealed that approximately 3% of the population suffers serious mental illness and addictions. In fact, nearly one out of every five people (20%) over the age of 15 years annually consulted a physician for treatment in the Central East LHIN. These telling facts ensure that Mental Health & Addictions will remain a priority area for change going forward.

Conclusions

The ongoing community engagement process, combined with the evidence collected in the environmental scan of the region, strongly suggests that the LHIN's overall health care strategy can be framed and viewed within the context of our four identified IHSP priority for change areas. Therefore, focusing long-term plans and efforts on these key priorities represents the most likely areas in which significant gains can be achieved in terms of overall system integration, access, quality and performance going forward.

D. Detailed Plans to Implement Central East LHIN IHSP Priorities for the Local Health System

Description: This section provides detailed description and analysis of how the LHIN will meet the commitments of the IHSP. Any changes to existing programs, cost adjustments, etc. as well as new inter-LHIN initiatives or reallocations, and integration activities will be discussed in the context of meeting the commitments and addressing the priorities outlined in the IHSP.

Please see the table below for details on Central East LHIN activities, current service pressures, risks and opportunities.

GENERAL – HOSPITAL Services						
Objectives	Involved Stakeholders (including CE LHIN Planning Partnerships)	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators / Targets (incl. MLAA)
1% Challenge: Bending the Hospital Cost Curve and Strengthening Community Capacity						
Under the Board Strategic Direction for Financial Accountability is the following objective: 1% of the Central East LHIN's expenditure in 2007-08 for acute care services will be re-allocated to community programs by FY 2010.	CE LHIN Hospitals Community Health Service Providers Community Stakeholders	The Board endorsed this objective on Aug 10, 2007. A detailed Project Charter is being brought forward to the CE LHIN Board on June 6, 2008 For Approval. To complete the transfer, the CE LHIN will issue an "Integration Decision"	Better alignment of health services between hospital and community Sustainability of health services in both hospital and community Use generated revenue to expand community service capacity and fund system delivery transformation.	Project charter complete. Implement in 08-10	See Project Charter	1% = \$10,003,024 or rounded to \$10 million.
One Acute Care Network: Central East LHIN Clinical Services Plan						
Improved and equitable patient access to an integrated hospital	CE LHIN Hospitals Physician Leaders	For targeted surgical/medical services, phases of planning to include: 1. Review of	Identification of Integration Opportunities with a focus on: • Thoracic • Vascular	See Detailed Project Charter \$602,000	Less than optimal access and quality of patient care Lack of	TBD: Indicators will reflect changes in: • Quality & Safety

GENERAL – HOSPITAL Services						
Objectives	Involved Stakeholders (including CE LHIN Planning Partnerships)	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators / Targets (incl. MLAA)
system that provides the highest quality of care across the Central East LHIN See detailed Priority Project Charter	CE LHIN planning Networks and Task Groups Community Groups	current patterns of service delivery 2. Projection of future demand 3. Projection of demand (status quo) 4. Scenario modeling Subsequent stages in the development of the Clinical Services Plan will include: • developing a workforce plan; • developing an ambulatory care plan; • developing a demand management plan to reduce bed demand; • developing an infrastructure plan; • identifying appropriate models of care	• Cardiac Care • In-Patient Mental Health • Paediatrics / Child, Youth and Family Services		balance between urban and rural hospitals Lack of specialized clinical services capacity within the CE LHIN requiring residents to travel greater distances. On-going yearly financial deficits of hospitals that will result in financial strain for all services, including those provided in the community.	• Access (wait times) • Sustainability • Efficiency (Change in Hospital Productivity) • HHR: Physician specialist recruitment and retention

GENERAL – HOSPITAL Services						
Objectives	Involved Stakeholders (including CE LHIN Planning Partnerships)	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators / Targets (incl. MLAA)
		for key clinical areas; • integrating with planning undertaken neighbouring LHINs • undertaking a costing exercise to financially cost the Clinical Services Plan • seeking approvals from hospital Boards, the CE LHIN Board and related Ministry approvals for necessary capital plans or impact on provincial programs			Absence of a preparations for growth and changes in hospital services as a result of population growth and technological advancements (including both ambulatory care and in-patient care) Increased risk that the CE LHIN will not meet performance expectations regarding wait times to specific services	

IHSP Priority ACCESS AND WAIT TIMES (Including Critical Care, ED Performance, and Alternate Levels of Care)						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
Wait Times Working Group						
Access & Wait Time efforts are guided by the commitments set forth in the present Ministry-LHIN Accountability Agreement, as well as by the other main priorities of the Integrated Health Services Plan which was derived from a comprehensive framework for community engagement and local health planning. Efforts are also mindful of the balanced dimensions and	Presently the Wait Times Work Group is restructuring towards becoming a steering committee for several very focused sub-groups that will be accountable for their respective 'bite sized' areas (e.g, A Diagnostic Imaging Focus Team, Joint Replacement Focus Team, etc.). The following are the predominant stakeholders: CE LHIN health	Initiatives aimed specifically at improving system access and reducing wait times will take many forms going forward and much overlap exists between various other LHIN projects and initiatives. All efforts will however be channelled towards solutions based initiatives that are community driven and respectful of both the accountability framework and the community engagement and integration processes of the LHIN. Projects and initiatives are likely to: consider the implementation of one queue theory	- Improved overall health system access and wait-time reductions across the continuum of care. - Achievement of specific wait time performance targets negotiated between the Ministry and the LHIN.	Use existing WT volumes with additional investments (see below) Cataracts \$2,593,400 Hip/Knee \$10,298,000 CT \$949,700 MRI \$2,714,200 TOTAL: \$16,555,300	The following are many of the more predominant risks associated with planning improved Access & Wait Times in the LHIN; - Aging population 'Rurality' and size of certain regions - Prevalence of mental illness and addictions - Prevalence of chronic disease - ALC Pressures - Rapidly increasing demand for	90th Percentile Wait Times - MRI/CT - Cancer Surgery - Hip and Knee Replacement - Cataract surgery - Cardiac surgery

IHSP Priority						
ACCESS AND WAIT TIMES						
<i>(Including Critical Care, ED Performance, and Alternate Levels of Care)</i>						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
outcomes approach of The Ontario Health Quality Council's vision of a high performing health care system. Just for example, these include accessibility, efficiency, integration and equitability. The LHIN will support interdisciplinary team approaches to care and push for more coordinated access to care. The <u>Wait Times Work Group</u> will provide directional leadership in planning and implementing specific initiatives	service providers MOHLTC (e.g., Wait Time Information Office, Performance Improvement & Compliance Branch, Ontario's Wait Time Strategy, Health System Accountability and Performance Division) Other priority Work Groups and Task Forces (including ED, Senior's, Orthopaedic Assessment Centre, DI Work Group, ALC Taskforce).	models for reducing wait times and improving access to care • increase throughput and capacity through improved efficiencies and 'tweaked' service delivery • empower providers of care to identify and tackle the true barriers to the provision of care in a timely manner with support, information and a solid mandate for uniformly changing practice across hospital corporations • focus on understanding and resolving unique (often individual) issues affecting those patients forced to wait beyond the targeted wait times, thereby			Diagnostic Imaging • Diverse populations having disproportionate number of recent immigrants • Implementation of Orthopaedic Assessment Centre. • Shortage of LTC, supportive housing and community supports	

IHSP Priority ACCESS AND WAIT TIMES <i>(Including Critical Care, ED Performance, and Alternate Levels of Care)</i>						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
aimed at improving priority area wait times across the Central East LHIN, while easing patient flow and maintaining quality along the broader continuum of care. Also, in parallel, members will utilize their role to identify opportunities for the integration and coordination of more streamlined and efficient health care services.		reducing backlog - improve access to care through diversity training - promote initiatives that alter practice to minimize barriers and improve system access without shifting the backlog elsewhere - leverage standardized methods of practice (data collection, process, standards of care, etc.) as much as possible in order to eliminate duplication of effort and streamline care - develop/adopt a funding allocation process that rewards positive practice in terms of improving access and wait time reduction.				

IHSP Priority ACCESS AND WAIT TIMES <i>(Including Critical Care, ED Performance, and Alternate Levels of Care)</i>						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
Critical Care						
- The CE LHIN is a high growth region. The need to invest and build additional capacity for the region in the long term is self evident. - Quality care and centre of excellence development is patient volume dependent. - The LHIN supports local development of high quality ICUs with adequate volumes needed to	CE LHIN Critical Care Leader CE LHIN Critical Care Providers Critical Care Secretariat	On-going. Current foci: - Inventory and Capacity of CE LHIN resources (including examination of potential new ICU bed investments; Critical Care Response Teams; and solutions to address chronic ventilation burden on system and clients - Continued uptake of ICU Intensivist-led Management Model - Use of Criticall and the development of a regional "always open" bed policy - Attached to any bed funding are defined accountabilities including an "always open" bed policy to Criticall with a set target reduction for Criticall transfers (i.e. 25%).	Recognition exists at the corporate and front line that the CE LHIN is not currently functioning as a self sufficient network. Acceptance that this is our goal (i.e., retain LHIN market share and provide care as close to home as possible) with the maintenance of the highest quality of care.	Accountability to quality of care, performance improvement, and efficiency are tied to any future investment.	- The need to invest and build additional capacity for the region in the long term is self evident. - ICES data suggests that CE LHIN is predicted to need another 21 beds based on the data for 2016. Prov planning targets are not even approaching 50% of that need, and continue to operate on the assumption that some	All CE LHIN hospitals will be submitting data to the Critical Care Information System by 2008-09, providing local LHIN and hospital management a better understanding of current utilization and opportunities for improvements.

IHSP Priority ACCESS AND WAIT TIMES <i>(Including Critical Care, ED Performance, and Alternate Levels of Care)</i>						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
develop these centres of excellence.		Rollout of the Critical Care Information System			clinical services will continue to be transferred to other LHINs. Quality care and centre of excellence development is patient volume dependent.	
Alternate Level of Care						
Conduct a scan of Central East LHIN ALC pressures and existing practices that includes: Liaising with other provincial and regional ALC stakeholders in determining areas of leverage, incl. standardized	An ALC Task Group has been formed to address growing pressures in CE LHIN related to alternate level of care (ALC) patients. The Task Group has joint reporting responsibility to the CE LHIN Board and the CE Executive Council – CEOs of LHIN,	Prepare a Central East LHIN ALC Action Plan that includes - Common set of definitions - Suggested performance goals - Standardization of tools, best practices and innovations - Recommendations regarding new or alignment of existing resources - Risk management strategies	Task group will deliver an environmental scan of the ALC issue across the LHIN and develop a common understanding of issues, definitions and solutions among partners. An action plan to resolve short and long-term ALC pressures will be	Task Group 08/09: \$20,000 Recommendations may have financial implications	Managing expectations Maintaining momentum Active engagement of stakeholders across the continuum including providers from across the patient flow continuum of	Number and percent of ALC days. Medium Wait Time for LTC placement Patient satisfaction. Appropriateness of level of care.

IHSP Priority ACCESS AND WAIT TIMES <i>(Including Critical Care, ED Performance, and Alternate Levels of Care)</i>						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
definitions for levels of care, and evidenced-based best practices - Analyze/evaluate current incentives/disincentives and risks impacting ALC and patient-centred care - Review of relevant literature, provincial policy and regulations, and recent local investments and innovations and their impact	9 hospitals and the CCAC Working in close partnership with the Central East LHIN, Central East LHIN providers, the Central East LHIN Seamless Care for Seniors Network, the Rehabilitation Task Group, and other planning partners	An analysis and recommendation directly related to long-term care, supporting housing, and home care capacity/needs assessment is out of scope for this working group. These issues will be examined jointly with other projects related to Seniors (Supportive Housing, Community Services, LTC capacity – see below)	presented to the CE LHIN board for approval prior to year end. Reduction in ALC bed days across the LHIN to meet provincial targets.	such as: - Design and implementation of improved and standardized information systems that can provide data in real time. - Development of a CE LHIN electronic, web-based bed map and utilization inventory.	care.	

IHSP Priority						
ACCESS AND WAIT TIMES						
<i>(Including Critical Care, ED Performance, and Alternate Levels of Care)</i>						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
Flo Collaborative						
To participate in the Ontario Health Performance Initiative (OHPI) (a joint initiative of the Health System Strategy and Health System Accountability and Performance Divisions of the Ministry of Health and Long-Term Care). To address the issue of Alternate Level of Care days by focusing on processes of care delivery, while recognizing the critical importance of	Partnership between Peterborough Regional Health Centre (PRHC) and the Central East Community Care Access Centre (CE CCAC) Steering Committee comprised of membership from PRHC, CE CCAC, Lakeridge Health Centre and Rouge Valley Health System ALC Task Group -comprised of membership from all CE LHIN hospitals and a variety of community agencies - for	Application has been submitted for the August 1, 2007 deadline. Successful proposals will begin implementation according to an established 18 month schedule beginning in August/September 2007.	Improvements in patient flow; improved accreditation status through integrated and coordinated health services within the LHIN; Interaction with and learn from world leaders in quality improvement; Improvement Advisor Certification for an individual within the LHIN partnership; action-based learning opportunities for front-line and management staff who participate in the Improvement Teams;	• \$60,000 - \$65,000 per partnership funded by OHPI. • Possibility of renewal. Cost of knowledge transfer and training to other LHIN hospitals and patient care providers: 08/09: \$10,000 09/10: \$30,000	Funding may not cover full cost of staff coverage during program participation – risk would fall to partnership to cover.	Number and percent of ALC days Efficiency of patient flow measures

IHSP Priority ACCESS AND WAIT TIMES <i>(Including Critical Care, ED Performance, and Alternate Levels of Care)</i>						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
complementary longer-term strategies needed to address policy and capacity issues in the system. To adopting better practices for timely discharge, streamlining of referrals, and case management in the community creating a “pull” through the system. To improve patient flow within and across provider organizations. To communicate learning and share ‘best practices’ across the CE LHIN	advice and support in communication and distribution of information.		Enhanced leadership capability for quality improvement through participation in the Leadership Series; \$60-\$65k MOHLTC financial support, with the possibility of a secondary allotment contingent on achieving measurable aims; and Support from OHPI, including project coordination, exploratory work to gather and synthesize potentially better practices to help teams redesign care processes, and coaching of Improvement			

IHSP Priority						
ACCESS AND WAIT TIMES						
<i>(Including Critical Care, ED Performance, and Alternate Levels of Care)</i>						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
hospitals and all appropriate patient care providers.			Advisors (IAs) using a train-the trainer model.			
Emergency Care Improvement						
ED Task Group will examine internal hospital practices and strategies that will improve ED efficiency and reduce wait times. This includes patient flow practices, physician resources, team approaches to patient care, access to diagnostic services, ambulance off-load times and on-call coverage.	An Emergency Department Task Group has been formed to create profound and sustainable improvements in ED performance across the CE LHIN. The Task Group has joint reporting responsibility to the CE LHIN Board and the CE Executive Council – CEOs of LHIN, 9 hospitals and the CCAC.	Work in collaboration with related CE LHIN initiatives such as - Central East Critical Care LHIN Leader - ALC Task Group - Steering Committees of CE LHIN priority areas as needed - Liaise with provincial initiatives and resources (e.g., ED coaching teams, ED flow toolkits) in order to facilitate regional uptake of best practices. The ED Task Group will also serve as the Steering Committee to the Geriatric Expertise in the Emergency Department Project Team. This team will be	Conduct an environmental scan of Central East LHIN ED pressures and existing patient flow practices Prepare a Central East LHIN ED Action Plan that includes: Common set of definitions and patient flow practices Suggested performance goals Standardization of tools, best practices and	Task Group 08/09: \$30,000 09/10: \$15,000 Recommendations may have financial implications such as: Design and implementation of improved and	Requires ‘buy-in’ of entire hospital system with respect to patient flow continuum. Next steps will require coordination with enhanced community services to avoid ED visits. Costs of improving access to diagnostic services and required IT systems may be inhibitive.	Rate of ED visits that could be Managed Elsewhere ED Wait Times EMS Off-Load times

IHSP Priority

ACCESS AND WAIT TIMES

(Including Critical Care, ED Performance, and Alternate Levels of Care)

Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
		tasked with implementing the use of geriatric emergency management nurses in five Central East LHIN hospitals through the support of the previously announced \$1.35M provincial ED support fund.	innovations Recommendations regarding new or alignment of existing resources Risk management strategies Areas of future study Work in collaboration with the CE LHIN ED LHIN Lead Provide ongoing oversight and advice to the CE LHIN on ED-related issues	standardized information systems that can provide data in real time. • Development of a CE LHIN electronic, web-based bed map and utilization inventory.	ED closures if physician HR issues have not been resolved.	
Orthopaedic Assessment Centre						
The OAC will: • Act as the centralized intake of patients being refer-red by	A cross representational Steering committee with shared	By 2008 the OAC program is expected to be fully operational, involving approximately 20+ Orthopaedic	The program supports Ontario's Wait Time Strategy	On Going Operational Funding of \$893,249.00	Delay in renovation completion Delay in	<i>Access:</i> Referral date to assessment centre visit date

IHSP Priority

ACCESS AND WAIT TIMES

(Including Critical Care, ED Performance, and Alternate Levels of Care)

Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
primary care providers who are potential candidates for joint replacement or require greater comprehensive care that can be provided by family physicians • Provide initial triage assessment to determine a client's treatment needs • Make referrals to Orthopaedic surgeons and allied health professionals through processes established • Reduce avoidable deterioration of health and reduce variations in care • Provide	governance has been established between the Rouge Valley Health System (RVHS) and The Scarborough Hospital (TSH) Orthopaedic Surgeons from each of the RVHS and TSH Resource Membership (Ad Hoc) Family Practice MD Emergency MD Rheumatology MD Physiatry	surgeons Next phase: Conduct a feasibility study for a comprehensive MSK centre of excellence in the CE LHIN. Additional Action: Where possible, duplicate OAC model in other parts of the CE LHIN, notably Durham, Haliburton, Kawartha Lakes, Peterborough and Northumberland.	Improve access, patient flow, quality and efficiency of services throughout the continuum, from primary to acute care to recovery Reduce time to surgery: by expanding the availability of Orthopaedic surgeons to perform more cases, leaving assessment and case management to more appropriate health human resources Link effective chronic disease prevention and management initiatives around arthritis and Orthopaedic care	MSK Feasibility study a joint undertaking of CE LHIN, RVHS and TSH. (Aligns to clinical service planning, below) OAC expansion: Requires additional resources	obtaining buy-in to OAC Care Delivery Model Ensuring adequate OR time and maximizing utilization Delay in WTIS Support Recruitment and retention of providers Opening OAC before adequate orientation, team building and processes in place	Assessment centre visit date to surgical consult date Decision to treat date to surgery date (using Ontario Access Targets) • Priority II: 6 weeks • Priority III: 12 weeks • Priority IV: 26 weeks Number of referrals received by Centre versus surgeons directly

IHSP Priority ACCESS AND WAIT TIMES <i>(Including Critical Care, ED Performance, and Alternate Levels of Care)</i>						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
care path-ways based on specific conditions						

IHSP Priority						
AGING AT HOME -- SEAMLESS CARE FOR SENIORS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
Seamless Care for Seniors (SCFS) Network <i>Improving the system of care for seniors, across the continuum and throughout the LHIN.</i>						
Seniors' issues were identified as a LHIN priority very early on and further substantiated through extensive community engagement.	A CE LHIN SCFS Network has been established. Membership is open to anyone interested in improving the system of care for seniors in Central East including: - Consumers - Caregivers - Families - Providers - Physicians - CCAC - Specialists - Others as identified in the projects listed below	Established a LHIN-wide SCFS Network that is 130 organizations strong to help with planning, advising and informing the LHIN and other planning partners on senior's issues. Established a 13 member Network Steering Committee that is the LHIN's first point of contact with the Network. The Steering Committee is chaired by a local geriatrician.	Developing a seamless system of care for seniors including improving the coordination, access, integration, quality and sustainability of a continuum of care.	Multi-year implementation. First 18 months will be foundational activities spanning a number of continuum areas as outlined below. Financial resources for projects are indicated below. Financial resources for the Network include costs associated with communications, forums, Steering Committee work, etc.	Managing expectations Maintaining momentum Active engagement of stakeholders across the continuum including consumers	See below

IHSP Priority						
AGING AT HOME -- SEAMLESS CARE FOR SENIORS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
				08/09 = \$30,000 09/10 = \$35,000 10/11 = \$40,000		
Seamless Care for Seniors Planning Framework						
<i>To develop a framework within which planning for senior's can be anchored.</i>						
To provide a guideline document and tool that providers and LHIN Board and staff can reference as we move forward with system transformation in Central East. To sponsor 2 IHSP action items including basket of services and specialized geriatric services (see in table below)	Developed by SCFS Network Steering Committee in draft.	Planning framework drafted spring - summer 07. Document presented to LHIN Board August 07. Further consultation with SCFS Network and other planning partners Fall 07 Completion by Dec. 07. Final document to LHIN Board early 2008. Sharing with other	A guideline or tool to be referenced when planning, funding, expanding or modifying services for seniors in Central East. Will be an important tool for implementing the Aging at Home Strategy in Central East.	No financial implications at this time.	Broader feedback results are unknown at this time There is potential for ethical issues to arise due to principles outlined in document Not having a framework means planning is happening without a compass	

IHSP Priority						
AGING AT HOME -- SEAMLESS CARE FOR SENIORS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
A key input to guide aging in place planning		LHINs and MOHLTC Spring 2008				
Geriatric Emergency Management Initiative (GEM)						
An initiative funded through the provincial ED Support Fund to support the design and implementation of evidence-based system improvements strategically focused on improving access to emergency care. To introduce a standard level of geriatric expertise within five emergency departments across Central East	A GEM Project Team has been struck which includes: Five participating hospitals: - Peterborough Regional Health System - Rouge Valley Health System - Scarborough Hospital - Ross Memorial Hospital - Lakeridge Health Corporation Other partners: - Central East	The GEM initiative is phase one of a multi-year process to address specialized geriatric services (SGS) in Central East Phase 1 will be fully operational by April 2008. Recruitment for the five nurses will be complete September 07 Future phases will consider outreach capacity to LTC Homes and the broader community, specialty clinics, etc. The RGP is providing Project Management expertise, nurse	In addition to the one GEM nurse in place in CE, by Sept. 07, five new GEM nurses will be functional within five EDs across Central East. Standardized tools and processes will be implemented. A foundation for SGS will be initiated. Impacts on quality of care for seniors in ED, use of resources in ED and wait times. e.g., - At risk seniors are identified and assessed in a timely fashion - Inappropriate	See Detailed Project Charter Have received \$1.35M from ED Support Fund as one-time grant Estimate for ongoing 08/09 = \$1.35M 09/10 = \$1.35M 10/11 = \$1.35M 2008/09 plans include exploring expansion of phase 1 to three remaining EDs in Central East as well as outreach to community	As this is a one-time grant. Program sustainability beyond March 08 is a concern. ED wait times, hospital LOS may be impacted if GEM resource is used as a referral service from the community. Availability of resources to refer people to once they have been assessed	Rate of ED visits that could be Managed Elsewhere Hospitalization Rate for Ambulatory Care Sensitive Conditions Others TBD with Regional Geriatric Program

IHSP Priority						
AGING AT HOME -- SEAMLESS CARE FOR SENIORS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
	CCAC • Regional Geriatric Program • SCFS Network • ED Task Group • LHIN Shared Services and Microsoft for technology pilot	training and mentoring services and evaluation assistance. To pilot new communication software using Communicator and LiveMeeting.	admissions are reduced • Appropriate admissions occur • Linkages to appropriate resources are made	sector.		

IHSP Priority						
AGING AT HOME -- SEAMLESS CARE FOR SENIORS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
Supportive Housing						
Identify strategies to improve access to units for seniors, individuals with physical disabilities, individuals with chronic diseases and those with mental health and/or addiction needs To build community capacity by exploring current opportunities related to supportive housing (SH)	Multi-sector SH Networks in Peterborough and Kawartha Lakes.	Currently have two multi-phased proposals that have developed at the community level with impetus coming from the Canada/Ontario Affordable Housing Program. Populations within these proposals include seniors, individuals with physical disabilities and individuals with intellectual impairments. CE LHIN Board has approved in principle to fund assisted living services to 42 new supportive housing units in Peterborough (effective 08/09). Management is currently exploring fiscal and accountability options.	To increase the number of individuals and families who have secured affordable, supportive living arrangements. Decrease ALC burden; avoid unnecessary hospitalization To prevent, avoid or prolong premature institutionalization To improve access to LTC by providing other living options. To increase the community's capacity to respond to the needs and desires of individuals to remain independent for as long as possible.	Peterborough total for St. Peter's and Marycrest projects = \$1,759,617 (BOARD ENDORSED) City of Kawartha Lakes Phase 1 = \$916,500 (BOARD DEFERRED for need of additional information) Securing the funds indicated through new funding or reallocations. See Background CE LHIN Board Briefing Note:  Item 8.4 BN-FINAL.doc	Aware of new build in Peterborough County that will be seeking funds for 26 senior's units in 08/09	Improved quality of life for those who access SH In-house supports provide means by which to monitor the health of at-risk individuals and add a preventative measure. Decreased waitlist for SH Percentage of ALC Days

IHSP Priority AGING AT HOME -- SEAMLESS CARE FOR SENIORS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
To undertake a range of activities to increase the equitable and effective delivery of supportive housing throughout the CE LHIN.	Collaboratives in Peterborough and Kawartha Lakes Supportive Housing Providers CCAC Central East LHIN Supportive Housing Project Team (to be developed fall 2007)	A Supportive Housing Project Charter, sponsored through the Peterborough Collaborative, has been developed and presented to the LHIN Board in Oct. 07. Much of the work links directly to the Aging at Home Strategy.	To increase the number of individuals and families who have secured affordable, supportive living arrangements. Decrease ALC burden; avoid unnecessary hospitalization To prevent, avoid or prolong premature institutionalization To improve access to LTC by providing other living options. To increase the community's capacity to respond to the needs and desires of individuals to remain independent for as long as possible.	Project Charter (planning costs) 08/09 = \$79,000 09/10 = \$131,000 10/11 = TBD See Detailed Project Charter Web	Overall plan for SH has not been developed to date so community may not understand how these proposals came forward. (see below)	Improved quality of life for those who access SH In-house supports provide means by which to monitor the health of at-risk individuals and add a preventative measure. Decreased waitlist for SH Percentage of ALC Days

IHSP Priority						
AGING AT HOME -- SEAMLESS CARE FOR SENIORS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
Community Support Services Review						
Identify strategies to enhance integration of the CSS sector with other parts of the health care system. To work towards an appropriate continuum of care and mix of services based on the needs of various communities and populations: Assessing the CSS infrastructure and resources in terms of its ability to continue to effectively support and maintain individuals in the	Linked strongly to the above work related to LTCH and SH. Kawartha Lakes Collaborative is sponsoring this initiative.	A project charter has been developed and presented to the LHIN Board on Oct. 12, 2007. A project team will be established to move forward with this work. Much of this work will relate and be linked to the Aging at Home Strategy.	To inform the LHIN of pressures within the community based service sector and solutions for same that include opportunities for improved capacity, integration, coordination, quality, etc. To devise a population needs based construct for CSS based on current and future needs as well as reflecting current and future CSS definitions.	See Detailed Project Charter (planning costs) 08/09 = \$100,000 09/10 = \$131,000 10/11 = TBD Financial implications expected once above processes are complete	Potential fear of "taking away" from community Without a full examination of CSS capacity and infrastructure, jeopardize investments for aging at home General concern that volunteer contributions to the sector may be targeted by collective bargaining units.	The completion of an action plan that has been vetted with LHIN planning partners and presented to the LHIN Board by early second quarter 2008.

IHSP Priority						
AGING AT HOME -- SEAMLESS CARE FOR SENIORS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
community.						
Rehabilitation Services						
To develop a philosophy of care To begin a gaps analysis with development of an inventory of rehab services To enhance the use of common definitions across the LHIN r/t rehab To enrich partnerships, collaborations and communication To expand the Total Joint Network Hip/Knee and Fractured Hip projects across CE	Rehab Task Group established with linkages to other planning partners. Total Joint Network	The Rehab Task Group is completing their project charter that sets out the scope, costs and time of the project. This is a phased implementation project in that the Task Group is setting a foundation for future work. The Task Group will identify, once their work is complete, where efforts should be focused in relation to next steps. Discussions with TJN are required to determine the continuation of support. At this time, project support from TJN ceases March	To improve access to appropriate and timely rehab services for Central East - an inventory (tool has been drafted and vetted with Rehab Task Group) - agreement on definitions - philosophy of care - new ways of working together - action plan for next steps Availability of the same quality of care throughout CE related to	Costs relate to: Inventory, philosophy of care and communications 08/09 = \$43,000 09/10 = \$20,000 Estimate for coordination costs for TJN projects 08/09 = \$110,000 See On-Line Information including Terms of Reference	Willingness to wrestle with tough questions Ability of smaller hospitals to implement TJN processes Will highlight gaps and strengths in rehab services. Is expected to result in tangible integration opportunities for service delivery. Current timeframe is tight. Ability to find funds and hire a third party for inventory	Wait time reduction for hip and knee replacements with process consistency and standardization across CE Capacity freed up for hip fracture needs. Wait times along the continuum for hip fracture will be best practice. One philosophy One language

IHSP Priority						
AGING AT HOME -- SEAMLESS CARE FOR SENIORS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
		31, 2008.	elective total joint and fractured hip processes.			
Home at Last Program						
To implement a partnership discharge planning for older adults / frail elderly from hospital. This is an innovative responsive program that is already in place in other LHIN's helping to get people home from hospital faster. In 2001, there were 180,000 seniors, representing 12.8% of the total population in the CELHIN; in 2016, this is anticipated to	- Community Care agencies - Central East Community Care Access Centre - CE LHIN hospitals (x9) - Clients	The HAL program may alleviate some of those pressures that hospitals and CECCAC are currently experiencing. HAL is a co-ordinated approach that could assist and help seniors leave the hospital and get settled at home. The HAL program can make the transition from hospital to home easy and comfortable, it will provide a trained and caring personal support worker, who will go home with the patient and stay until they are settled, it will provide reliable and comfortable	ALC impact: It is expected HAL may impact number of ALC days. Currently, the average occupancy by ALC patients in Ontario hospitals is 12%; of these, 82% are 65 and older. Studies have shown that the frail elderly can lose up to 5% of their functioning daily in hospital settings. ED Impact: HAL should improve ED efficiency by providing service to treated patients who are not being admitted and can return to their home setting but require support to do so.	Phased approach includes a demonstration project in 07/08 which will finalize program design: \$40,000 Estimated average cost per patient = \$400 08/09: TSH (2 sites x 2 patients/day = 20 / wk) $20 \times 52 \times 400 = \\$416,000$ RMH and PRHC = \$208,000 09/10: LHO + RVHS (2 sites) = \$624,000 additional funding	Limited adoption because of poor communication among partners. Coordination complications across sites. Insufficient number of clients.	Reduced ED wait times. Reduced hospital LOS. Number of ALC days. Decreased return visits to ED.

IHSP Priority						
AGING AT HOME -- SEAMLESS CARE FOR SENIORS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
increase to 265,000 seniors, representing an increase of 47.5% The HAL program can improve linkages between community support services, hospitals, access centre, etc.		transportation, will pick up groceries and prescriptions and equipment if necessary and prepare a small meal or snack on the day the discharged patient returns home, it will help the patients feel safe, secure, and cared for in their own home. The following day, a HAL community care coordinator will call and also see that the patient get any other services they may need to keep them safe and healthy at home.	Quality and Coordinated Care: It is expected clients will receive a more coordinated linkage of community supports and improve quality of care by providing a link to available resources that may otherwise not be known or accessed. Also, moving people out of hospital faster improves availability of resources for those being cared for in the hospital. Enhanced discharged planning: Standardized and improved efficiency and coordination of discharge planning process across CE LHIN hospitals.	10/11: 5 remaining sites = \$208,000 additional funding		

IHSP Priority						
AGING AT HOME -- SEAMLESS CARE FOR SENIORS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
Transportation						
To consider models that would effectively and efficiently serve rural areas by facilitating transportation to services or mitigating the need for transportation e.g. uptake of technology	Haliburton Highlands Collaborative is sponsoring this initiative. Initial discussions just taking place to determine approach.	A project charter and project team will be implemented. Access to services by individuals living in rural areas will be the general focus.	Identify coordinated cross-provider strategies to improve access to timely, affordable transportation to health services. A model for improving access to services in rural areas that considers past work, current approaches and new ideas.	Financial resources in 08/09 relate to coordination funds for this project. Estimate for planning and coordination of project: \$38,700	Complexity of issue can be overwhelming as transportation cuts across many funders with varying mandates. Capital and operating costs for vehicles and technology is high	To improve access to care, whether by bringing service to individual or bringing individual to service.

IHSP Priority						
CHRONIC DISEASE PREVENTION AND MANAGEMENT						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
CE LHIN Chronic Disease Prevention and Management Network						
Implement the CDPM Model across communities and agencies	A LHIN wide Chronic Disease Prevention and Management Network has been established. Membership includes: consumers, caregivers, healthcare providers and other related community/business agencies.	Established a 15 member CDPM Network Steering Committee that is the LHIN's first point of contact with the Network. The Steering Committee is co-chaired by two physicians: a family physician and a specialist LHIN-wide CDPM Network involves 45 organizations/individual as of August 7, 2007 The Steering Committee will use the CDPM Model and its eight components as the guiding framework to assess and evaluate enhancements to the CDPM system.	To create together a system that enables effective and coordinated planning, delivery and continuous improvement in health promotion, and chronic disease prevention interventions for the residents of the CE LHIN (DRAFT CDPM Network Vision – August 2007)	Multi-year implementation. First 18 months will be foundational activities spanning a number of continuum areas as outlined below. Financial resources for specific projects are indicated below. Financial resources for the Network include costs associated with communications, education forums to develop the Network. Steering Committee work is within LHIN budget.	Alignment/synchronization of provincial and LHIN CDPM projects and priorities for implementation Managing expectations of diverse stakeholders Maintaining momentum	

IHSP Priority						
CHRONIC DISEASE PREVENTION AND MANAGEMENT						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
				08-09: \$20,000 Growing by \$5,000 per year		
Access to Stroke Care in the Central East LHIN						
Access to Stroke Care in the Central East LHIN, specifically Durham Region • Access to t-PA • Regional Coordination The Durham region lacks a District Stroke Centre with a population of 563,000 which requires patients to be redirected to the closest District Stroke Centre in Central East Region (Peterborough RHC, Royal Victoria Barrie) or North East Region (Sunnybrook) in Toronto. In 2004-	• 3 Stroke Networks overlapping CE LHIN boundaries • PRHC • District Stroke Centre • Lakeridge Health • Rouge Valley Health System • Durham EMS MOHLTC Priority Programs	The Central East Regional Stroke Steering Committee supports the advancement of the Ontario Stroke System but must achieve resolution of regional issues regarding access to t-PA for ambulance redirect and to develop the regional communication plan to population of Central East. With approvals to establish a regional or enhanced district stroke centre in the Durham Region, the CE LHIN will assess local provider organizational fit and	Improved regional delivery and access of stroke services, notably for Durham region. Better and timely access to eligible t-PA candidates (10-20% of 644 non-TIA patients) in order to prevent further progression of their stroke symptoms,	See Detailed Project Charter For purposes of equity, CE LHIN must secure new funding from MOHLTC for resources to support stroke centre designation, education, on call and stroke treatments. ALL other stroke centres have received provincial funding to provide these critical services. 2008-09:	Inequitable and/or inconsistent access to services along the stroke continuum leading to poor patient outcomes and cost avoidance of other health care services Analysis has shown that the CE Stroke Region has a number of unfunded HSPs providing essential services within the stroke care continuum (e.g.,	Performance Expectations based on best practice standards of care. Would include: • Median time from stroke symptom onset to mobilization during hospitalization • Stroke

IHSP Priority CHRONIC DISEASE PREVENTION AND MANAGEMENT						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
2005, the Durham region saw 644 separations for Non-TIA, of which 10-20% could have been eligible for t-PA to prevent further progression of their stroke symptoms, including death.		capacity with regard to stroke care and the provision of t-Pa At this time, Lakeridge Health (supported by its MEC, MAC and Board of Trustees) is pursuing District Stroke Centre status.		\$360,000 2009-10: \$1.48m	Secondary Stroke Prevention) Real opportunity to strengthen the Ontario Stroke Strategy by alignment with LHIN activity and boundaries.	clients seen in ED admitted to hospital and receive first Ct or MRI scan within 24 hours of arrival in ED
Self Management Training for Consumers and Caregiver						
A LHIN coordinated and consistent Self Management Training program/template that can be implemented for small and large communities and agencies of various sizes	CE LHIN CDPM Network & Steering Committee with support of other LHIN planning partners <u>Provincial:</u> - MOHLTC - Ministry of Health Promotion	Cross sector and community team is currently developing a Project Charter to present to the CE LHIN Board Implement the Stanford Self-Management Model which develops trained teams of peer and professional	Consistent and coordinated application of the Stanford Self Management model across HSPs and communities in the CE LHIN. Individuals who took the Stanford Self Management Program, when	See Detailed Project Charter 2007-08: \$123,400 2008-09: \$363,800 2009-10: \$527,900 Assumptions include: Program	Physician/HSP buy-in to shifting responsibilities to support client/caregiver self-management	Rate of ED visits that could be Managed Elsewhere Hospitalization Rate for Ambulatory Care Sensitive Conditions

IHSP Priority CHRONIC DISEASE PREVENTION AND MANAGEMENT						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
Stanford model is used in Canada and internationally as best-practice for self management training. A core team of trained leaders/master leaders in CE LHIN Inclusion of a significant follow-up/link back to HSP component including exercise is required.	- Public Health Units <u>CE LHIN Providers:</u> - CE CCAC - Community Support Services - Community Health Centres - Diabetes Education Centres - Hospitals - Primary Care Providers and Specialist Physicians (GP/FP, cardiology, nephrology, etc.) - CDPM Self Management Program	leaders each having a chronic condition. Teams work with consumers/ caregivers to set reasonable goals for health/lifestyle modifications and build consumer capacity/confidence to achieve their goals. Target: 450 consumers/ caregivers receive training per year [15 participants per session]	compared to those who did not, demonstrated significant improvements in: exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations. They also spent fewer days in the hospital, and there was also a trend toward fewer outpatient visits and hospitalizations. These data yield a cost to savings ratio of approximately 1:10.	Initiation/ on-going Coordination Training of Leaders (Licensing for use of Stanford Program Program Delivery Costs Consumers/ caregivers receive training (2700 clients by 09-10) Participant Resource material per participant - HSPs organizations to support participation of HCP leader time, administration resources. Participant Follow-up/ call back and peer		Others TBD

IHSP Priority						
CHRONIC DISEASE PREVENTION AND MANAGEMENT						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
				support initiatives		
Supporting Caregiver Health and Well-being						
Improve access, consistency, coordination and cultural relevance of tools needed by care-givers to enable them to fulfill their care giving role including: Information/education; peer to peer/group support; and supports/resources to enable temporary relief of care giving responsibilities "respite" such as: • consumer care/accompaniment (day/evening/overnight); • access to short-stay LTC beds and • meaningful	CE LHIN CDPM Network & Steering Committee with support of other LHIN planning partners including: • Primary Care Working Group • SCFS Network • Mental Health and Addictions Network CE LHIN Health Services Providers And Primary Care Providers MOHLTC Ministry of Health Promotion Public Health	Cross sector and community team is currently developing a Project Charter to present to the CE LHIN Board	Enable collaborative caregiver support planning amongst health service providers delivering care to consumer and caregiver (i.e., physician, CE CCAC, Community Support Services, Alzheimer Society, Community Mental Health) Enhanced system of supports for family and friend caregivers of seniors, people with chronic conditions and those with mental health and/or addictions.	See Detailed Project Charter Project Coordination and System Plan development across 3 priority populations On-going LHIN/Provincial investment to develop and maintain coordinated, multi-agency LHIN-based system of caregiver supports. Strategic Plan Development and Caregiver Support Resolution Demonstration Project	<u>Opportunity and Threat:</u> Caregiver support is recognized as an area for enhancement by various priority populations/sectors (e.g. Seniors, People with Chronic Conditions, those with Mental Health and Addictions needs) Resource requirements/demand for programming will increase given large number of caregivers who presently	Rate of ED visits that could be Managed Elsewhere

IHSP Priority						
CHRONIC DISEASE PREVENTION AND MANAGEMENT						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
daytime activities for consumers]. Identify and disseminate best/promising practices in maintaining and enhancing the health of caregivers.	Units Seniors Secretariat – Ministry of Citizenship Ministry of Community and Social Services – Special Services at Home (respite program)			2007-08: \$144,500 2008-09: \$234,950 Investment requirements for respite services, tools/resources will be identified as component of strategic plan.	receive no/very limited support	
Chronic Kidney Disease and End Stage Renal Disease Planning						
Develop a comprehensive and collaborative strategy to manage growth in demand for chronic kidney disease and end stage renal disease in CE LHIN including: Dissemination and uptake of best practices; Collaborative cross program planning to address	CE LHIN CDPM Network & Steering Committee MOHLTC Transplant Centres CE CCAC Hospitals – CKD Regional Programs CKD Regional Advisory Committees Independent Health Facilities (IHF)	Regional CE LHIN CKD program and specialist leads have developed a planning group. Regional Group will develop a Strategic Plan for submission to the CE LHIN for its consideration. Appropriate consultation with MOHLTC to follow as per the MLAA	Improved access to Kidney care – CKD prevention clinics Increased access to haemodialysis (HD) stations/units (home and/or centre based care) Meet or exceed provincial target of 30% of ESRD patients using peritoneal dialysis (PD)	Charter complete Requires \$96,000 for future development in 08-09. Resource investments based on Strategic Plan	CE LHIN is projected to have highest growth in chronic kidney disease and end stage renal disease province Increased wait-times for Kidney Care - CKD prevention clinics Capacity of HD units is strained;	Meet or exceed provincial target of 30% of ESRD patients using PD

IHSP Priority CHRONIC DISEASE PREVENTION AND MANAGEMENT						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
capacity problems Development of Transplant follow-up program in CE LHIN	Specialists – Nephrologists PD Implementation Working Group				capital/ equipment and HR investments would be required for expansions <u>Opportunities:</u> Provincial policy challenges and program-level coordination to utilization of excess capacity of HD stations within Independent Health Facilities (IHF's) Expertise amongst LHIN HSPs regarding PD; ability to expand use of PD across LHIN.	

IHSP Priority Family Care / Primary Care						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
Primary Care: Timely Discharge Information System						
Linking Primary Care and Acute Care Services: Require CE LHIN Hospitals to provide 72hr notification of primary care provider when their client has been admitted and/or discharged from hospital	Primary Care Working Group CE LHIN Hospitals CCAC Potential Link to TeleHealth Ontario	Demonstration project for two hospital corporations/communities.	Learnings and technology solutions developed will enable LHIN-wide roll-out	See Detailed Project Charter Demonstration project development and implementation; Phase 2 initiation. 2007-08: \$384,500 2008-09: \$166,250 2009-10: \$180,250		
Provide guidance and approval to new CHCs as they work through developmental stages New CHCs will report to LHIN on progress in developmental milestones.	Community Care City of Kawartha Lakes – new CHC Sponsor <u>Existing CHCs in LHIN</u> Port Hope (developing) Brock Twp (developing) TAIBU-Malvern	LHIN will provide guidance and approval, as required, to developing CHC regarding the following developmental milestones: Needs assessment/ community engagement (CE)	Operation of CHCs; enhanced integration with other primary care providers.	Current HR resources being applied to support this expectation	LHIN internal capacity to support new CHC development will be assessed through CKL start-up.	

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IHSP Priority Family Care / Primary Care						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
Establish relations with existing CHCs for planning, funding and accountability, similar to other HSPs.	(developing) West Hill (existing) Oshawa (existing) Youth Centre [Ajax-Pickering] (existing/expanding) Primary Care Working Group Collaboratives	- process - Governance mechanisms/ infrastructure - Identification of priority populations/catchment area - Key services - Staffing plan - Service plan - Annual budget - Functional plan (space plan)/site location possibilities - Introduction of services				

IHSP Priority						
MENTAL HEALTH AND ADDICTIONS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators (incl. MLAA)
CE LHIN Mental Health and Addictions Network						
Mental Health and Addictions Engagement and Planning Partnerships	A LHIN wide Mental Health and Addictions Network (MHA) has been established. Membership includes: consumers, families, healthcare providers and other related community agencies	Established a 15 member MHA Network Steering Committee that is the LHIN's first point of contact with the Network. The LHIN-wide MHA Network involves organizations/individuals from across the LHIN.		Task Group support: 08/09: \$20,000 09/10: \$25,000 10/11: \$30,000 Multi-year implementation. First 18 months will be foundational activities spanning a number of continuum areas as outlined below. Financial resources for specific projects are indicated below. Financial resources for the		

IHSP Priority						
MENTAL HEALTH AND ADDICTIONS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators (incl. MLAA)
				Network include costs associated with communications, forums, Steering Committee work, etc.		
Early Intervention for Youth Strategy with Mental Health and/or Addictions Service for Children and Youth (under 18)						
Develop a Youth Early Intervention Strategy including prevention education, early intervention and mechanisms/ supports to assist clients move from child to transitional age to adult system.	Lead Partners: Central East LHIN Mental Health and Addiction Network Durham West Collaborative Inputs: CE LHIN Health Service Providers of Children Mental Health and Addiction Services Ministry of Children and Youth Services – Central East	Proposed Project Charter to be developed with the coordination of the Durham West Collaborative and Central East LHIN Mental Health and Addictions Network. Anticipated presentation to Board in early Winter of 2007.	Better understanding of regional resources and stakeholders for children transitioning to the adult mental health and addiction system. Practical solutions (e.g., care maps, public information) that will assist clients in their families understand where appropriate services will be provided.	See Detailed Project Charter 83,429 [2007-2008] 226,950 [2008-2009] However, see related items MH&A Children Inpatient and Outpatient Services Assessment; Peterborough Regional Health Centre Outpatient services	Current funding and staffing pressures throughout the LHIN. Strategy will reveal investments required in order to provide needed services and supports to children and their families.	TBD

IHSP Priority						
MENTAL HEALTH AND ADDICTIONS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators (incl. MLAA)
	Region Central East LHIN Primary Care Working Group					
Program Review and Needs Assessment of Inpatient and Outpatient Child and Family Mental Health Program						
To improve the capacity and organization of child and adolescent mental health programs in CE LHIN hospitals, such as inpatient beds, emergency assessment, intensive ambulatory programs and psychiatric services	Central East LHIN Mental Health and Addictions Network CE LHIN Hospital and related community providers of intensive adolescent psychiatric services	While this Review will be of all services provided in the CE LHIN, immediate attention must be paid to children's inpatient and outpatient programs at Lakeridge Health, Rouge Valley Health System and Peterborough Regional Health Centre. Regarding Lakeridge: The MOHLTC, and now the CE LHIN, is in receipt of a proposal to stabilize, sustain and preferably augment its Child Youth and Family	The outcome of the review is to ensure that existing resources are being max-imized in a manner that is appropriate to the needs of children and their families. Wait times for child and youth mental services are inappropriately long. As an example, Lakeridge Health is reporting the following wait times: - Individual and/or family assessment: 3-4 months - Psychological	TBD: Lakeridge Health has submitted an immediate financial pressure to sustain services while attempting to reduce wait list. To provide inpatient services, intensive ambulatory care, ER crisis and urgent care, Lakeridge has documented a new investment.	Failure to provide adequate inpatient and outpatient mental health services for children, youth and their families will result in: - Increased risk of clients (suicide, homicidal behaviours, physical, and psycho-social health) - Negative impact on the systems of education, justice, child	TBD. Examples: Reduced wait times for: - Individual and/or family assessment - Psychological testing - Psychiatric consultation Reduce hospital length of

IHSP Priority MENTAL HEALTH AND ADDICTIONS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators (incl. MLAA)
		Program. Current global budget approvals (\$1.25M) have been outstripped by costs and demand of services. Lakeridge has provided several options for consideration.	testing: 4 months - Psychiatric consultation: 1 year Other outcomes include: - Reducing length of stay through vibrant out-patient programs - Avoid hospitalization and/or rehospitalization - Meeting growing de-mand in environments that are safe and appropriate		welfare, and health care - Failure to meet growing demand resulting in longer wait times - Negative impact on surrounding services in the GTA and HKPR area	stay Reduce rates of re-hospitalization Client and Family Satisfaction

IHSP Priority						
MENTAL HEALTH AND ADDICTIONS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators (incl. MLAA)
Disordered Eating Initiative						
Using a balanced systems approach to develop a coordinated continuum of supports for youth/young adults with disordered eating and their families Family/caregiver support program to combat disordered eating through prevention/early education and coping strategies for youth/young adults with eating disorders including the development of early intervention, family and transitional	CE LHIN CDPM Network & Steering Committee with support of project team and other CE LHIN planning partners. MOHLTC Provincial hospital based Eating Disorder program network/leads Heart and Stroke Foundation of Ontario Community Mental Health and Addictions Agencies (e.g. CMHA-Durham) CE CCAC Hospitals: Whitby Mental Health Centre; Lakeridge Healthcare Corp – Toronto East	Cross sector and community team including a caregiver champion is currently developing a Project Charter for CE LHIN consideration. Appropriate consultation with MOHLTC to follow as per the MLAA (Schedule 3, sections 33, 34). Develop a residential recovery and transition to home/community re-integration training program for youth/young adults and their families. Establish an on-going support program for family/friend caregivers of youth/young adults with anorexia, bulimia, other disordered eating	Improved ability of youth/young adults with disordered eating to recover in the community within Ontario. Improved support for family/friend caregivers. Increased awareness of the prevalence and risk to youth of developing disordered eating.	See Detailed Project Charter Total Estimate: \$1.0million Residential Recovery and transition to home training program \$700,000 On-going support program for family caregivers \$250,000 Prevention and early education resource material \$50,000 2008-09 \$300,664	<u>Opportunity:</u> Family support and day-to-day coping/community re-integration for people disordered eating is a provincial gap Residential recovery and family unit re-training focused on disordered eating is not available in Canada. Cost savings/recovery for OHIP funded out of country services.	TBD

IHSP Priority						
MENTAL HEALTH AND ADDICTIONS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators (incl. MLAA)
support programs (i.e. transitions from the hospital to community and child to adult system).	General; Toronto Sick Kids Primary Care Providers: and Specialists – Paediatricians	conditions (i.e. toll free-staffed support line; caregiver peer support programs). Introduce/expand prevention and early education on healthy eating and body image.				
Central East LHIN Consumer/Survivor Network						
Lead the design and implementation of a consumer/survivor network for the Central East LHIN Develop a realistic implementation plan to move from the current status to a single network	- United Survivors Support Centre - Survivors Psychiatric Advocacy Network Hong Fook Self-Help Initiative The REACH centre Patients/consumers council of Whitby Mental Health Centre Hospitals with mental health/psychiatry departments	Establish: Vision, Values and Guiding Principles Governance & Operating Structure Membership Criteria Identification of Priorities Strategic Plan Communications & Engagement Plan Work collaboratively with and provide recommendations and plans to Central East LHIN Create working groups and committees of the	A coordinated and integrated approach to consumer/survivor issues	Funding for CS Network in place for current year	NA	TBD

IHSP Priority MENTAL HEALTH AND ADDICTIONS						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators (incl. MLAA)
	Representatives from the mental health sector 2 family members CE LHIN member	Network as needed to produce the key deliverables within an established timeframe Spring 2008 conference to engage appropriate stakeholders across CE LHIN with development of strategic and operational plans				

IHSP Priority E-HEALTH						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
Begin implementation of the LHIN e-Health Plan						
Support the LHIN's <i>Integrated Health Service Plan</i> , and the <i>provincial e-health workplan</i> in order to:	9 Hospitals in the LHIN (8 acute and 1 psychiatric) and the CCAC were directly involved in the oversight and development of the plan. Community consultation with other stakeholders, including Physicians, community agencies, and LTC was done. A broad based e-health steering committee has been established.	The detailed plan is on the website. Key Initiatives this year include:				
1) Ensure clinical information follows the person, with consent		Finalize shared project management office	Implementation of uniform project management process across LHIN	Hospitals, and TEN project paying for software/hardware and a portion of training Staffing from e-health funding	Limited adoption,	
2) Ensure the seamless transfer and referral of people between LHIN partners and others while conforming to Privacy requirements		Extend electronic referral between Hospitals, the CCAC, and begin e-referral between community agencies	Enable faster, more efficient transfer of patients,	Use existing MOHLTC e-referral funds from the Continuing care stream	Failure to fund change management , change in govt policy	
3) Use		Standardise clinical documentation	To develop a common approach to charting and documentation to streamline business	Leverage MOHLTC HOBIC grant, and Hospitals to fund	Inability to get consensus on standards, failure to fund	

IHSP Priority E-HEALTH						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
information technology and information management to support people and families and improve the health and safety of the population in the LHIN and beyond		Consolidate Data Centres in the LHIN(s)	process and information flow	a significant portion (\$1M)		
4) Streamline business processes to facilitate efficiency			The hospitals across 3 LHINS will issue a joint RFI for a common data centre , with	e-health planning money	Process doesn't lead to workable proposal	
5) Support providers in delivering care		Finalize Shared Digital imaging system across the LHIN(s)	appropriate security and redundancy. Hospitals will then consolidate data centers	Funded by participants based on business case	Business case insufficient	
		Implement Robust HIS in 3 remaining Hospital sites		Funded by MOHLTC , Canada Health Infoway and Hospital Participation	Technical capacity to share images, SSHA failure to provide bandwidth in time	
		Finalize e-learning strategy across the LHIN	Electronically shared diagnostic imaging across 23 hospitals on 46 sites in 4 LHINS. Improving efficiencies and		Competing priorities will	
		Regional Decision		Funded by		

IHSP Priority E-HEALTH						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
		support Note: many projects on the e-health plan are being delayed until the 08/09 budget year due to lack of financial resources	reducing transfers Three hospitals will implement robust, compatible HIS that will complement rest of system and enable electronic data exchange. This and the two previous initiatives will enable a consolidated EMR across the LHIN Integrated approach to e-Learning across the LHIN to develop common approaches and efficient use of resources Share resources to improve administrative decision support systems and monitor accountability agreement measures	participating hospitals Participating agencies Participating agencies and e-health budget	absorb funds Failure to achieve consensus on approach The required staff are seconded and may be forced to return to primary job	

IHSP Priority E-HEALTH						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
Project Management Initiative including CE LHIN Virtual Project Management Office						
To oversee and coordinate the design and use of a project management framework by CE LHIN planning partners and health service providers in the planning and implementation of projects. To support the planning and development of Priority Projects in support of the Integrated Health Service Plan.	All CE LHIN Planning Partners and Stakeholders that are engaged in health service planning and projects. Early partnership with the CE CCAC and the EHealth initiative has been established. Project Management Centre of Excellence office in the provincial government as a source of free consultation, advice, tools and materials. Existing PMOs across the LHIN in various HSPs.	Build on the 2-day training workshop conducted for CE LHIN staff, the highly rated introductory presentation delivered to Planning Partners at the CE LHIN "Planning to Action" Symposium and the two August two-day introductory training sessions held for Planning Partners (organized and coordinated by CE LHIN but paid for individually by attendees) Establishment of a CE LHIN Steering Committee to oversee the establishment and growth of the Project Management Initiative and a Project Management Office. PM Steering Committee to support the CE LHIN Project Coordinator and Staff	Standardization of project management processes and tools across CE LHIN. Identification and distribution of standard project management software to support reporting and management of projects. Enhanced capacity of planning partners and health service providers to conduct high quality projects consistent with recognized standards.	Current proposal of \$112,000 to set-up Project Management Office (PMO) with in-kind supports of \$40,000. Request = \$72,000 Ongoing support of PMO to include 2.0 FTE (\$96,000 + \$76,800 = \$172,800) No current budget to support Project Management Initiatives other than 1 FTE staffing as of October 1, 2007 and current funding in support of the CE LHIN web site.	Cost of purchasing software if current licenses do not cover all those identified as requiring access.	Number of project management training attendees. Quality of project submissions for Board approval.

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IHSP Priority E-HEALTH						
Objectives	Involved Stakeholders	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators
		in establishing a 'project management culture' within Central East HSPs and Planning Partners. Establish a 'virtual' Project Management Office to work in conjunction with the CE LHIN web page architecture in supporting project development and learning opportunities.		2008-09 \$186,350		

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LHIN Operations						
Objectives	Involved Stakeholders (including CE LHIN Planning Partnerships)	Implementation	Expected Outcome	Financial Plan	Risks	Performance Indicators (incl. MLAA)
Staff						
See LHIN Wide Business Case				\$320,000 annualized		
French Language Services						
Engagement / Planning Related Costs		Excludes consideration for FLS Planning Entities (TBD)		\$15,000 annualized		
First Nations / Aboriginal Planning and Engagement						
Engagement / Planning Related Costs		Excludes Consideration of Local Aboriginal Health Planning Entities (TBD)		\$20,000 annualized		

E. Financial Summary – by Sector

Table 1: Financial Summary (Attachments A, B1 to B12, F, X, Y *to be provided by Ministry*)

F. Planning for LHIN Operations

Description: This section will outline the LHIN's operational plan for the coming fiscal year and the two subsequent years.

Please refer to **Attachment D** (Operational Plan) and **Attachment E** (Staffing Plan)

G. Management Plan to Deal with Risks

Description: This section requires the development of plans to manage the local health system, in the context of identified risks and opportunities.

All risks will be mitigated by sound project management practices that will balance out the timeline, scope and cost of each initiative. Most importantly, the Central East LHIN continually seeks to identify and manage risks, as well as opportunities, by relying on its community engagement planning partners.

The following are many of the more predominant risks/opportunities outlined in attachment C associated for the Central East LHIN priorities for change:

Access & Wait Times

- Aging population
- 'Rurality' and size of certain regions
- Prevalence of chronic disease
- ALC Pressures
- Rapidly increasing demand for Diagnostic Imaging
 - E.g., a lack of available diagnostic technology may: increase wait times and reduced performance; potential loss of HHR manpower; and continued pressures compromising timely patient access and staff workload.
- Diverse populations having disproportionate number of recent immigrants
- Orthopaedic Assessment Centre: delay in renovation completion and obtaining buy-in to OAC delivery model, ensuring adequate OR time and maximizing utilization, delay in WTIS support, recruitment & retention of providers
- Shortage of LTC, supportive housing and community support alternatives
- Emergency Care: Buy-in of entire hospital system re: patient flow continuum, coordination with enhanced community services, physicians HR issues, and high cost of diagnostic and IT systems (ED closures if physician HR issues are not resolved).

Seamless Care for Seniors:

- Geriatric Emergency Management: One time grant creates problems with program sustainability beyond March 2008.
- Housing: Supportive Housing funding availability for new build in 2008/09, ongoing sustainability issue; Seniors Housing need to have community look at options other than "beds", need for resources for action plan (for St. Peter & Mary Crest project & for City of Kawartha Lakes project). Urgent priorities and Aging at Home funding will assist with these projects but continued program sustainability and increased need for services as population ages will not be able to meet all demands of ALC and senior care requirements.

- Transportation: capital and operating costs for vehicles and technology are high with complex issues.

Chronic Disease Prevention and Management

Sustainability of same level of service by those inequitable and/or inconsistent accesses to services lead to poor patient outcomes and cost avoidance of other health care services; HSPs providing essential services within the stroke care continuum maybe at risk.

- Services Inventory: (Opportunity) Similar baseline population and program information will be needed by all LHINs focused on CDPM. MOHLTC could provide leadership/resource support. CCACs are appropriate single provincial providers for future Information & referral services.
- Coordinated Intake (Opportunity): Increased access to education and self management will lead to reduced pressures/visits to Acute/ED services.
- Disordered Eating initiatives: Family support and day-to-day coping/ community reintegration is a provincial gap. Residential recovery and family unit retraining focused on eating disorders is not available in Canada. Residential recovery program, ongoing support for family caregivers and education estimates.
- Chronic Kidney Disease: Increased wait times and strained capacity of haemodialysis; may require provincial level coordination to utilize excess capacity of haemodialysis stations within independent health facilities.
- Exercise Initiative: coordinated initiative would provide opportunity to consolidate, coordinate and leverage economy of scale; resourcing to expand access to support for other chronic conditions; significant growth projected in cardiac rehab clients in 2 to 4 years at estimated minimum cost.

Mental Health and Addictions

- Peterborough Regional Health Centre – Outpatient Mental Health Services. Operational implications for service delivery as a result of capital funding decision for the new hospital development.
- Mental Health Needs Assessment of Inpatient and outpatient child and family program: Increased client risk, negative system (education, justice, welfare, etc.) impacts, longer wait times, negative impact on surrounding services in GTA and HKPR area; Opportunity for shared integrated business model of Haliburton and Kawartha Lakes may serve as a model for other areas within CE LHIN; at risk is crisis assessment, adult out-patient programs, psycho-geriatric programs, schizophrenia clinic and family & youth programs; at risk are retention, recruitment and training of mental health professionals.
- Assertive Community Treatment Teams: Failure to provide integrated case management and utilization of regional community resources will generate greater burden for inpatient mental health services.

E-Health

- Limited adoption of "TEN" project
- Technical capacity to share images
- SSHA failure to provide bandwidth in time
- Competing priorities may impact consumer resources (financial and human)
- Funding based on business cases which are not complete or sufficient

Other: Central East Community Care Access Centre (CE CCAC)

- The Central East CCAC and its predecessor organizations have been fortunate over many years to receive one-time funding for such things as hip and knee initiatives and emergency department services support. The challenge of one time funding is that the services, once begun, roll over year after year and the absence of base adjustments to meet the needs of these targeted clients is at the expense of home and community based personal support services to the frail elderly, as well as occupational and speech language therapy for children. It is widely known that the frail elderly use proportionately more health care resources than the proportion of the population they represent. Community based nursing, health professional and personal support services help these clients remain independent and health and reduce or avoid costly admissions to hospital, emergency department visits, and the development of ALC challenges. The impact of wait listing children's services such as speech language pathology services and occupational therapy creates long term issues which create health care expenditures far in excess of the cost of services provided today. Annualization of recurrent one-time annual funding, or one-time funding which addresses a long standing need such as emergency department pressures, would provide stabilization and predictability to our base which would allow CE CCAC to meet the needs of clients such as children and the frail elderly.
- During the past 24 months the CE CCAC, along with the other 13 new CCACs, have been involved in a significant reorganization process. The CE CCAC has brought together staff from four predecessor organizations, including the alignment of 8 collective agreements through the Public Services Labour relations Transition Act (PSLRTA) process. There is currently a significant variation in salaries and benefits across the predecessor organizations. It is anticipated that negotiations for the first CE CCAC collective agreements will result in an overall increase in salaries and benefits as salaries move toward harmonization across these organization with the creation of two collective agreements for the CE CCAC. While all are working to negotiate salaries and benefits that are fiscally responsible, it is anticipated that salary changes, coupled with economic pressures, will require additional harmonization funding for the upcoming 2008/09 fiscal year.

Other: Hospital Services

- Clinical Services Plan: Lack of balance between urban and rural hospitals, ongoing hospital financial deficits, absence of preparation for growth & changes in hospital services due to population and technology. Urgent priorities and growth funding have been set aside for start of the planning process.

Other: LHIN Operations

- Ultimately, the success of the Central East LHIN in meeting its accountability and reporting requirements, as well as leading and managing change within the local health system, depends on well-trained, motivated and committed staff. LHIN staff is also required to meet the obligations of LHIN governance, including preparation of briefing materials, community engagement activities, and regular public meetings of the board and its committees.
- Currently, the Central East LHIN has re-purposed some of its resources to meet its business and community engagement needs. Most evident is the establishment of a communications and issues management expertise within the organization. This investment has provided significant returns to both the LHIN and the Ministry of Health and Long-Term Care. While this has paid dividends, it has a negative impact on our planning and financial teams.
- As a maturing organization, the Central East LHIN would like to see a human resources workload analysis study to measure operational resources and effectiveness in meeting LHIN accountabilities. While more capacity may be required, the focus should be on keeping LHINs “smart and small.”

H. Communications Plan for the Annual Service Plan

The Annual Service Plan (ASP) operationalizes the Integrated Health Service Plan and informs the ministry's Results-based Planning process. LHINs are required, through their ASPs, to provide the basis of support for any regional transformation objectives and associated funding realignments (if required). These plans for the local health system will assist the public to understand how the LHIN is planning to address the needs of their community.

The ASP will become a public document as an appendix to the ministry-LHIN accountability agreement.

Timing: to be determined

Objectives: To demonstrate responsiveness to community needs and to communicate transformation activities and initiatives to stakeholders and the community.

Primary Audience: Broader health sector

Secondary Audiences: Local community

Messaging:

- The ASP will assist the public in understanding how the LHIN is planning to address the needs of their community.
- The plans are based on discussions the LHINs have had with thousands of members of the public, providers and stakeholders.

Strategy:

- Highlight the focus of the LHIN plan and any special considerations required in meeting the identified needs of the local health system and community members/stakeholders.

Tactics: Coordinated, same day release for all LHINs (date tbd)

- Morning – LHINs to notify their provider/stakeholder groups
- Afternoon – LHINs post on individual web sites. LHINs could issue local news release (optional) – template to be provided by LHIN Communications Team
 - Discuss at board meetings and meetings with stakeholders
 - Highlight in newsletters
 - Stakeholder events hosted by LHIN

Note: Board Chair/members, staff, planning partner volunteers to be informed in advance of the rollout.