Central East **LHIN**

2010-2011 Annual Business Plan

Implementing the 2010-2013 Integrated Health Service Plan

Ontario
Local Health Integration Network

Table of Contents

January 31, 2010

Ken Deane
Assistant Deputy Minister
Health System Accountability and Performance Division
Ministry of Health and Long-Term Care
80 Grosvenor Street, 5th floor, Hepburn Block
Toronto, ON
M7A 1R3

Dear Mr. Deane,

The Central East LHIN is pleased to share its 2010-2011 Annual Business Plan with staff at the Ministry of Health and Long-Term Care.

This document operationalizes the Central East LHIN's 2010-2013 Integrated Health Service Plan. We look forward to implementing this plan in the pursuit of our two system level aims: 1) Save 1,000,000 hours of time spent in Central East LHIN Emergency Departments by 2013; and 2) Reduce the impact of vascular disease by 10% by 2013.

This document was approved by the Central East LHIN Board of Directors at their January 19th meeting.

If you have questions or comments, please contact my office at your earliest convenience.

Sincerely,

Foster Loucks

Board Chair, Central East LHIN

cc Central East LHIN Board of Directors
Deborah Hammons, CEO, CE LHIN
James Meloche, Senior Director, System Design and Implementation, CE LHIN
Paul Barker, Senior Director, System Finance and Performance Management, CE LHIN

Context

Central East LHIN Mandate and Strategic Directions

The mandate of LHINs is to improve access to, and the quality of, health services for residents of Ontario through strengthened integration and coordination of health services. The Central East LHIN will continue to realize this mandate through community engagement, local health system planning, funding and allocation, and accountability and performance monitoring.

The Central East LHIN will improve the health of our communities through an integrated health care delivery system focused on wellness and equitable and timely access to care, that delivers high quality outcomes. Such outcomes can only be achieved through engagement and partnership with patients and their families, the full range of health care service providers, the Ministry of Health and Long-Term Care, other LHINs and other non-health care stakeholders that have a significant impact on the health of individuals and communities. These actions will ultimately advance the Central East LHIN vision of *Engaged Communities. Healthy Communities.*

In support of this mandate, the Central East LHIN has, and will continue to be guided by its own strategic directions:

- *Transformational Leadership*: The Central East LHIN Board will lead the transformation of the health care system into a culture of interdependence
- *Quality and Safety*: Health care will be people-centred in safe environments of quality care
- *Health Service and System Integration*: Create an integrated system of care that is easily accessed, sustainable and achieves good outcomes
- *Fiscal Responsibility*: Resource investments in the Central East LHIN will be fiscally responsible and prudent

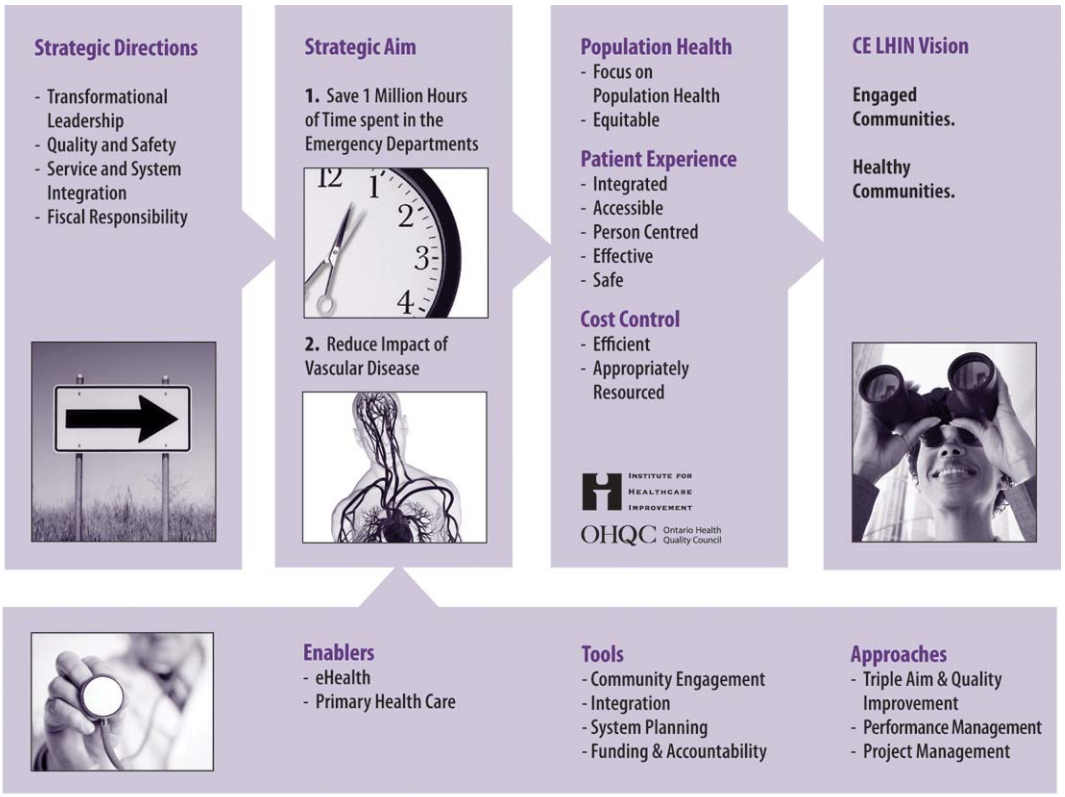
The Central East LHIN vision and strategic directions will be a guide to staff and health service providers in the achievement of the two system-level aims arising from the 2010-2013 Integrated Health Service Plan:

1. Save 1,000,000 hours of time patients spend in Central East emergency departments by 2013, and
2. Reduce the impact of vascular disease in the Central East LHIN by 10% by 2013.

In the Central East LHIN Strategy Map, the strategic directions provide the basis for Central East LHIN decision making that is intended in the short and intermediate term to accomplish elements of a high performing system and which, over the longer term, will achieve the vision of *Engaged Communities. Healthy Communities.*

The accomplishment of the strategic aims will be measured and evaluated using the Institute for Healthcare Improvement's (IHI) Triple Aim Framework and the Ontario Health Quality Council's Attributes of a High Performing Health System. Supporting our accomplishments are key enablers, tools and approaches as shown in the Central East LHIN Strategy Map.

Central East LHIN Strategy Map – Integrated Health Service Plan 2010-2013



Strategies and initiatives implemented in the Central East LHIN will be focused on the Ministry-LHIN Accountability Agreement targets listed below. Second quarter (2009/10) performance is also provided.

MLAA Measure	Target	Actual Performance (Q2 09/10)
90th Percentile Wait Times for Cancer Surgery	48 days	49 days
90th Percentile Wait Times for Cataract Surgery	140 days	125 days
90th Percentile Wait Times for Hip Replacement	182 days	163 days
90th Percentile Wait Times for Knee Replacement	182 days	170 days
90th Percentile Wait Times for Diagnostic MRI Scan	65 days	105 days
90th Percentile Wait Times for Diagnostic CT Scan	28 days	42 days
Median Wait Time to Long-Term Care Home Placement -All Placements	75 days	88 days
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution	9.46%	15.5%

Resources

To achieve our strategic aims, the Central East LHIN will use funding resources currently made available by the government of Ontario. These resources are tied to specific strategies of the LHIN and the Ministry of Health and Long-Term Care including:

- Current health service provider base budgets as specified in the Ministry LHIN Accountability Agreement
- The Aging at Home Strategy
- Emergency Department Pay for Results Program
- Central East LHIN Urgent Priority Funding
- eHealth Funding
- Other revenue provided by the Ministry of Health and Long-Term Care

Community Engagement

The strategic aims can only be realized through collaborative partnerships with the Ministry of Health and Long-Term Care, our Central East LHIN Stakeholders, and other LHINs in the province.

As a result of lessons learned from the first three years of the Central East LHIN and the enhanced strategic focus outlined in the 2010-13 Integrated Health Service Plan, some revision to the *Framework for Community Engagement and Local Health Planning* will be required. Working in partnership with local Collaboratives, LHIN-wide Networks and Task Groups, we will pursue options to strengthen community engagement, collaboration and coalition building that will result in measurable outcomes for individuals and families of identified priority populations.

At a minimum, the *Framework* will need to be revised to incorporate new developments in the Central East LHIN engagement strategy, such as the French Language Health Services Planning Collaborative, and the Central East LHIN Aboriginal Advisory Circle. A new *Framework* is expected to be completed by April 1, 2010.

LHIN Effectiveness Review

The Effectiveness Review published in September 2008 recommended that the LHINs should develop processes and/or structures to facilitate more effective points of integration within the organizations and to re-evaluate how they accomplish their work in order to appropriately manage and deliver on their objectives. In response to these recommendations, the Central East LHIN is in the process of redesigning the internal organizational structure to ensure strategic alignment and allow the LHIN to meet current and future priorities, facilitate integration and be adaptable to the changing demands in the environment. The realignment will result in enhanced internal collaboration and communication between the Central East LHIN teams allowing for more effective use of human resources, and a shared approach to delivery of services based on common processes, tools, frameworks and templates that will deliver value to stakeholders. The new internal organizational structure is expected to be implemented by May 1, 2010.

Overview of Central East LHIN Current and Forthcoming Programs and Services

The 2010-2013 Integrated Health Service Plan (IHSP) is focused on two system-level initiatives or "strategic aims" that will propel the achievement of the vision and strategic directions of the Ministry of Health and Long-Term Care and the Central East LHIN.

- ### Strategic Aim #1 : Save 1,000,000 hours of time patients spend in Central East LHIN emergency departments by 2013.

Saving 1,000,000 hours will be accomplished by reducing the number of visits to the emergency departments (reducing emergency department demand), improving the flow within the emergency department (improving emergency department capacity and performance), and providing more appropriate levels of care in the community for patients who no longer require acute care services within the hospital, reducing ALC and improving bed utilization.

- ### Strategic Aim #2: Reduce the impact of vascular disease in the Central East LHIN by 10% by 2013.

Reducing the risk of people developing *and* effectively and efficiently managing vascular disease will reduce the impact of vascular disease on individuals and the health care system. While success will be measured in terms of hospital patient days, success will require the collective effort of patients, health care clinicians, community-based agencies and hospitals.

Along with our two strategic aims, the IHSP identified segments of the population where it will prioritize its efforts:

- Seniors
- People with a Mental Illness and/or Addictions
- People with Chronic Disease
- Francophone community and our Aboriginal partners

With successful implementation of the strategic aims, the health system will see:

- A reduction in emergency department demand,
- An improvement in patient flow within the emergency department,
- More appropriate levels of care provided in the community for patients who on longer require acute care services within the hospital, reducing ALC and improving bed utilization,
- A reduction in the impact of vascular disease on individuals and the health care system,
- A reduction in the number of hospital days associated with vascular diseases,
- A decrease in the prevalence of co-morbidity for those patients with an existing primary chronic condition.

Assessment of Issues Facing the Central East LHIN

Key issues facing the Central East LHIN environment and key drivers for health transformation include:

- Population growth - Durham has had a 22.4% increase in population over the past 10 years. Although the greatest proportion of the population is in the younger age cohorts, the population of seniors over age 65 is facing the greatest increase in growth (from 6.9% to 11.9% by 2030) and will use the most resources. Age is a risk factor for chronic diseases and for certain mental health disorders like dementia. High growth funding has been provided from 2007-08 through 2009-10 and provincially only $10M in high growth funding remains for 2010-11.

- Population diversity – 45% of the western (GTA) portion of the Central East LHIN do not have English or French as their mother tongue (third highest percentage in the province).
- Social characteristics – the Central East LHIN has the second highest percentage of families with children who are headed by a single parent.
- Long term care home capacity – aging population projections have reduced the bed availability in past years and this trend is anticipated to continue. Long term care beds per 1,000 population aged over 75 will decrease from 118 in 2001 to 90 in 2009 and an estimated 80 by 2016.
- Health human resources – due to a lack of primary care providers there are approximately 86,000 unattached patients in the Central East LHIN who may be using the emergency departments as an alternate care resource.
- Economic slow-down had significant impact on unemployment rate – the Central East LHIN has the third highest unemployment rate in the province (compounded by the reduction of General Motors employees), resulting in related increases in mental health services for our community agencies, as well as decreases in non-LHIN revenues for our hospitals.

Core Content

Integrated Health Service Plan Strategic Aim #1: Save 1,000,000 Hours of Time Patients Spend in Central East LHIN Emergency Departments by 2013

IHSP Priority Description:

Saving 1,000,000 hours of time spent in Central East LHIN Emergency Departments aligns with the Ministry of Health and Long-Term Care (MOHLTC) priority of decreasing time patients spend in the emergency department. Saving 1,000,000 hours will be accomplished by reducing the number of visits people make to the emergency department (reducing emergency department demand), improving the flow within the emergency department (improving emergency department capacity and performance), and providing more appropriate levels of care in the community for patients who no longer require acute care services within the hospital (reducing ALC and improving bed utilization). Saving time spent by patients in Central East LHIN emergency departments will result in increased access to services, decreased health burden to the individual, decreased cost to the health care system, improved efficiency and effectiveness, and increased patient satisfaction.

The Central East LHIN will pursue improvements to health system quality through application of the Institute for Healthcare Improvement (IHI) Triple Aim Framework. Through the Triple Aim, the Central East LHIN will pursue simultaneous improvements to population health, patient experience and value for money by controlling or reducing the health care cost per capita.

Success will be measured according to the government's emergency department wait time targets. In an effort to summarize these specific targets, the Central East LHIN has established the aim of saving 1,000,000 hours of time patients spend in emergency departments. This aim was selected for several reasons:

- The aim motivates the entire health care system to mobilize its energy and participate in the strategy. While time spent in an emergency department is experienced in the hospital, many other parts of the health care system can contribute directly and indirectly to ED utilization and length of stay.
- The aim provides a clear and understandable commitment to all health care stakeholders.
- The aim is expressed in real terms, and encourages front-line staff to make a direct contribution in number of hours saved.

To measure our aim of saving one million hours of time patients spend in Central East LHIN emergency departments by 2013, we projected the number of hours that are expected to be spent in emergency departments between April 1, 2009 and March 31, 2013 if current trends continue. Using the baseline number of hours from the 2008-09 fiscal year, and accounting for demographic projections for the LHIN over a four year time period, we project that there will be approximately 10.2 million hours spent in Central East LHIN emergency departments. We then subtracted 1,000,000 from this number and arrived at 9.2 million, our target number of hours. We will re-evaluate the projected number each year as actual information becomes available on population changes and other external factors. Any substantial changes to the information that informed the initial calculation of the target number will be incorporated, and required strategies may shift over the four-year measurement period. While the actual number of total hours spent in the ED may change by 2013, the overall aim of reducing this total by one million hours will not, nor will our commitment to achieve Ministry performance standards for ED wait times.

Current Status

The Central East LHIN is responsible for funding more than 170 health care programs/services approximately 1.9 billion dollars. Priority programs are delivered with a focus on reducing ED demand, improving ED capacity and performance and improving hospital bed utilization.

To reduce ED demand, the Central East LHIN has focused on decreasing the number of visits to the ED by patients with non-urgent or less urgent needs (CTAS IV-V), sometimes referred to as "avoidable visits". The type and level of care required by these patients could have been delayed or even referred to other areas of the health care system, including the CCAC. The Nurse Practitioner Outreach to Long-Term Care project is an initiative that has been implemented across the three geographical clusters of the LHIN (Scarborough, Durham and North East) with the intention of decreasing the number of ED visits and transfers to the ED from long-term care homes.

The total number of ED visits in the Central East LHIN between April 1, 2008 and March 31, 2009 was 460,083. The number of ED unscheduled visits per 1000 population for Central East LHIN increased from 87 in Q1 to 89 in Q2 (2008/09), and then dropped to 82 for both Q3 and Q4 (2008/09). These numbers are consistently lower than the provincial numbers, but follow the same trend (provincial visits per 1000 population were 100, 102, and 96 for the same periods).

To improve ED capacity and performance the Central East LHIN has focused on helping move patients efficiently through the hospital. Initiatives designed to decrease ED length of stay have been targeted mostly at hospitals participating in the Pay-for-Results program, although some initiatives will have a LHIN-wide impact. Lean, the Flo Collaborative, the spread of the Flo Collaborative, and the ED Process Improvement Program have been implemented at different sites across the Central East LHIN.

In 2009/10, the Pay-for-Results program was expanded from 2 to 6 sites in the Central East LHIN. Pay-for-Results sites have seen more improvement in length of stay than non Pay-for-Results sites. Pay-for-Results hospitals are required to increase the proportion of patients meeting ED length of stay guidelines by 10% for admitted patients, non-admitted high acuity patients (CTAS I-III), and non-admitted low acuity patients (CTAS IV-V). The expectation is that hospital sites which are not designated to receive Pay-for-Results funding will have no change in their performance levels from fiscal year 2008 to fiscal year 2009. The provincial goal is that all measures will achieve the provincial length of stay targets at the 90th percentile.
Data describing actual performance is shown in the tables below.

Pay-for-Results Hospital Length of Stay Targets, Baseline measures and Q1 09/10 Performance

Pay-for-Results Hospital	Percentile Meeting Target								
	Admitted			Non-Admitted CTAS I-III			Non-Admitted CTAS IV-V		
	2008/09 Baseline	Target	2009/10 Q1	2008/09 Baseline	Target	2009/10 Q1	2008/09 Baseline	Target	2009/10 Q1
Lakeridge Health – Bowmanville site	53	63	52	95	98	93	93	98	92
Lakeridge Health – Oshawa site	28	38	29	90	98	91	87	97	88
Ross Memorial Hospital	26	36	27	82	92	82	82	92	81
Rouge Valley – Ajax site	23	38	21	88	98	88	83	93	79
Rouge Valley – Centenary site	31	41	29	75	85	79	67	77	69
The Scarborough Hospital – General site	30	40	30	66	76	66	76	86	74

Non Pay-for-Results Hospital Length of Stay Targets, Baseline measures and Q1 09/10 Performance

Non-Pay-for-Results Hospital	Percentile Meeting Target								
	Admitted			Non-Admitted CTAS I-III			Non-Admitted CTAS IV-V		
	2008/09 Baseline	Target	2009/10 Q1	2008/09 Baseline	Target	2009/10 Q1	2008/09 Baseline	Target	2009/10 Q1
The Scarborough Hospital – Birchmount site	30	30	27	74	74	73	70	70	69
Peterborough Regional Health Centre	30	30	31	82	82	80	75	75	70
Campbellford Memorial Hospital	61	61	56	89	89	88	83	83	83
Northumberland Hills Hospital	58	58	62	88	88	88	86	86	90
Lakeridge Health – Port Perry site	44	44	31	92	92	92	94	94	92

Note: Information is not provided for HHHS-Haliburton and HHHS-Minden because these sites have fewer than 30,000 ED visits per year and are therefore not reported in EDRS. Information is not provided for MSH-Uxbridge because this site, although physically located within the Central East LHIN, is under the management of Markham Stouffville Hospital, which falls under the governance of the Central LHIN.

Time spent in the ED for high acuity patients in Q1 2009/10 (14 hours) was lower than Q4 2008/09 (15.6 hours), but not very different compared to the previous two quarters (13.2 and 15.2 hours, respectively). Time spent in the ED for low acuity patients was 5.2 hours in Q1 2009/10 with no substantial change from any of the previous three quarters (5.1, 5.1, and 5.3 hours, respectively). All measures for time spent in the ED in the Central East LHIN are higher than the provincial averages, both for previous periods and for Q1 2009/10.

To improve hospital bed utilization, the Central East LHIN has focused on moving patients through the hospital to the most appropriate setting which includes the community. A transitional/restorative care program was established in the community through collaborative partnerships between Long-term Care/Retirement Home and Hospital. The Central East LHIN has decreased its ALC rate from 15.97% in Q4 08/09 to 15.5% in Q1 09/10, but is still not yet at the LHIN target of 9.46%. During the same period, the provincial average decreased from 17.14% to 15.17%.

GOALS and ACTION PLANS : **Reduce ED Demand**

Goals:

- Provide care alternatives outside of the hospital setting
- Enhance access to integrated primary health care
- Prevent, identify, assess, treat and manage health conditions in other settings
- Increase awareness and use of health care services available in the community
- Increase the capacity of community agencies and support services
- Enable patients to manage their own chronic conditions

Each initiative designed to decrease ED visits will be evaluated monthly according to the actual number of visits avoided or diverted by that initiative. At the end of each month, the Central East LHIN will be able to determine the total number of ED visits prevented by our initiatives.

Consistency with Government Priorities:

Reducing ED Demand in the Central East LHIN will contribute to the achievement of the Ministry of Health and Long-term Care's priorities of:

- Reducing emergency department wait-times
- Enhancing mental health services
- Enhancing access to primary care for citizens

Action Plans/Interventions

Action Plans/ Interventions:	% completion anticipated in each of the next three years		
	2010-11	2011-12	2012-13
Implement Community Crisis Supports for Mental Health Clients	33%	33%	34%
Provide Supportive Housing Services for at-risk individuals	20%	10%	10%
Support Ministry expansion of primary care models and urgent care	25%	25%	10%
Provide Nurse Practitioner Outreach to Long-Term Care	50%	25%	25%
Implement Community-based Comprehensive Geriatric Assessment	50%	50%	
Deploy Self-Management Resources	100%		
Provide resource-matching and education to help clients locate alternatives to care	25%	25%	25%

Expected Impacts of Key Action Items

Aligned with the IHI Triple Aim's focus on population health, patient experience and cost per capita, the interventions designed to decrease ED Demand will:

- Decrease the rate of ED visits per 1,000 population

- Decrease the number of hospital admissions and in-patient hospital days
- Decrease the rate of ED visits that could be managed elsewhere
- Decrease ED length of stay
- Increase the % of the population with a primary care provider
- Decrease the number of ambulatory care sensitive conditions presenting in the ED
- Decrease the percentage of ALC days
- Decrease the number of transfers to the ED from long-term care homes
- Improve patient satisfaction

What are the risks/barriers to successful implementation?

- Funding availability/sustainability for programs
- Other factors affecting ED volume (such as pandemics)
- Limited human resources
- Stakeholder resistance to change
- Perverse funding incentives for volume based procedures
- Continuation/expansion of Pay-for-Results funding
- Continued funding for ED/ALC Performance Lead
- Central East Community Care Access Centre Deficit Recovery Plan and potential impact on services influencing ED utilization

GOALS and ACTION PLANS: **Improve ED Capacity and Performance**

Goals:

Emergency department capacity and performance initiatives are hospital based and tend to address administrative and clinical practices such as:

- Improve patient flow and improve efficiency of care practices
- Testing of innovations such as both virtual and physically distinct clinical decision units in the ED
- Add equipment that will impact flow within the ED
- Improve access to diagnostics
- Use of additional ancillary support/personnel
- Use (or introduction of new) eHealth initiatives to improve patient flow and referral

Each initiative designed to reduce time spent in the ED will be evaluated monthly according to the actual number of hours saved by that initiative. At the end of each month, we will be able to determine the total number of ED hours saved by our initiatives.

Consistency with Government Priorities:

Improving ED capacity and performance in Central East LHIN emergency departments will contribute to the achievement of the Ministry of Health and Long-term Care's priorities of:

- Reducing emergency department wait-times
- Reducing the number of days that patients spent waiting in hospital for an alternate, more appropriate

care setting (ALC days)
- Enhancing mental health services

Action Plans/Interventions

Action Plans/ Interventions:	% completion anticipated in each of the next three years.		
	2010-11	2011-12	2012-13
Provide Geriatric Emergency Management Nurses (GEM) in the emergency departments	100%		
Implement process improvement programs such as Lean methodology, PIP, and the Flo Collaborative	50%	25%	25%
Implement Rapid Assessment Units, Admission Units and Clinical Decision Units	50%	25%	25%
Provide additional health human resources through Pay-for-Results program	33%	33%	34%
Provide triage, assessment and crisis support to mental health clients in the emergency department	33%	67%	
Deploy eHealth projects such as ED Patient Self-Registration Kiosk, ED/CCAC Client Notification and Drug Profile View	33%	33%	34%

Expected Impacts of Key Action Items

Aligned with the IHI Triple Aim's focus on population health, patient experience and cost per capita, the interventions designed to improve ED capacity and performance will:

- Decrease ED length of stay
- Increase the proportion of admitted patients treated within the LOS target of <= 8 hours [MLAA]
- Increase the proportion of non-admitted high acuity (CTAS I-III) patients treated within their respective targets of <= 8 hours for CTAS I-II and <= 6 hours for CTAS III [MLAA]
- Increase the proportion of non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of <= 4 hours [MLAA]
- Decrease the number of hospital admissions and in-patient hospital days
- Decrease the rate of ED visits that could be managed elsewhere
- Decrease the number of ambulatory care sensitive conditions
- Decrease the percentage of ALC days
- Improve patient satisfaction

What are the risks/barriers to successful implementation?

- Funding availability/sustainability for programs
- Limited human resources and lack of appropriately trained staff
- IT infrastructure deficiencies at hospitals
- Perverse funding incentives for volume based procedures
- Stakeholder resistance to change

GOALS and ACTION PLANS: **Improve Hospital Bed Utilization**

Goals:

- Optimize the length of time patients spend in acute care and rehabilitative beds based on standard of care practices for their condition
- Appropriate distribution of bed types and services within and between hospital providers based on the needs of the patient population to ensure the right care in the right place at the right time
- Reduce ALC by providing community supports and placement alternatives based on population need
- Use eHealth to improve patient flow and referral

Each initiative designed to improve hospital bed utilization will be evaluated monthly according to the actual number of ALC days prevented by that initiative. At the end of each month, we will be able to determine the total number of ALC days prevented by our initiatives.

Consistency with Government Priorities:

Improving hospital bed utilization in Central East LHIN Hospitals will contribute to the achievement of the Ministry of Health and Long-term Care's priorities of:

- Reducing the number of days that patients spent waiting in hospital for an alternate, more appropriate care setting (ALC days)
- Enhancing mental health services

Action Plans/Interventions

Action Plans/ Interventions:	% completion anticipated in each of the next three years		
	2010-11	2011-12	2012-13
Implement the "One Acute Care Network" plan to improve access to specialty services between hospitals (notably in mental health and paediatrics)	25%	20%	20%

Undertake programmatic review of complex continuing care and restorative care programs (both hospital and community based) in order to improve patient access, system navigation and resource management	100%		
Provide supportive housing services as alternatives to Long-Term Care	20%	5%	5%
Provide restorative care options outside of the hospital	33%	33%	34%
Promote and support senior friendly hospital initiatives such as patient activation	25%	50%	25%
Improve discharge planning coordination between hospitals and community services, such as “Home First”	50%	25%	25%
Implement transportation initiatives to support movement to home and to other care providers	25%	40%	20%
Provide CCAC Case Management in the Emergency Department	75%	25%	
Use eHealth solutions to improve patient discharge, notification of patient primary care team, resource matching and referral to expedite movement of clients to the next destination of care	33%	33%	34%

Expected Impacts of Key Action Items

Aligned with the IHI Triple Aim’s focus on population health, patient experience and cost per capita, the interventions designed to improve hospital bed utilization will:

- Decrease the rate of ED visits per 1,000 population
- Decrease the number of hospital admissions and in-patient hospital days
- Decrease the rate of ED visits that could be managed elsewhere
- Decrease ED length of stay
- Decrease the number of ambulatory care sensitive conditions
- Decrease the percentage of ALC days
- Improve patient satisfaction

What are the risks/barriers to successful implementation?

- Stakeholder resistance to change
- Funding availability/sustainability for programs
- IT infrastructure deficiencies at hospitals
- Lack of human resources

Integrated Health Service Plan Strategic Aim #2: Reduce the Impact of Vascular Disease by 10% by 2013

IHSP Priority Description:

Vascular disease is characterized by a thickening or narrowing of the arteries that move blood through our bodies. Vascular disease includes cardiovascular (heart), cerebrovascular (brain) including vascular dementia and stroke, and peripheral vascular disease which presents in other areas of the body such as kidneys, arms and legs. Reducing the risk of people developing *and* effectively and efficiently managing vascular disease will reduce the impact of vascular disease on individuals and the health care system. While success will be measured in terms of reducing hospital patient days, success will require the collective effort of patients, health care clinicians, community-based agencies and hospitals across the health care continuum. Vascular disease is prevalent in the Central East LHIN, results in high numbers of hospital admissions and emergency department visits and is costly to individuals and the health care system.

The Central East LHIN will pursue improvements to health system quality through application of the IHI Triple Aim Framework. Through the Triple Aim, the Central East LHIN will pursue simultaneous improvements to population health, patient experience and value for money by controlling or reducing the health care cost per capita.

Central East LHIN programs targeting vascular disease are planned and delivered with a desire to advance and invest along the continuum of health and social services namely:

- Prevention and Primary Health Care,
- Acute Care treatment,
- Secondary Prevention of Disease Progression & Adverse Events, and
- Policy and System Design.

Various indicators can be considered to assess the impact of vascular disease on individuals and the health care system. To serve as a proxy measure of the success of our collective strategies, we aim to monitor and reduce hospital utilization as measured by in-patient days (including ALC and acute days) by 10% by the end of 2013.

In 2008/09 Central East LHIN residents spent a total of 98,456 days in Central East LHIN hospitals as a result of their vascular condition. Based on population projections, the anticipated total number of patient days related to vascular conditions will be:

- in 2009/10: 100,936 patient days
- in 2010/11: 103,357 patient days
- in 2011/12: 105,856 patient days
- in 2012/13: 108,538 patient days

Using the 2008/09 as the benchmark year in which the 10% reduction is calculated, it is our collective target to save an accumulative 10,000 hospital in-patient days related to vascular conditions by 2012/13. Saving these patient days will be a system-level indicator of our strategic aim to reduce the burden of vascular disease by 10% by the year 2013.

Current Status

The Central East LHIN is responsible for funding more than 170 health care programs/services approximately 1.9 billion dollars. Based on Ministry and LHIN priorities, all programs and services enhancements or reductions will be assessed based on the desire to achieve our two strategic aims.

Prevention and Primary Health Care in the Central East LHIN includes early identification and screening programs for asymptomatic vascular and related diseases including chronic kidney disease (CKD), diabetes, hypertension and dyslipidemia. More than 3000 Central East LHIN residents in the Scarborough community have been screened for renal disease. CKD screening for people residing in First Nations communities is also underway. A Renal Chronic Disease Prevention and Management Promising Practices Report/Toolkit has been jointly developed across Central East LHIN renal programs. In partnership with Baxter Canada, the Lakeridge Health Corporation renal program has redesigned patient supports, clinical processes and care protocols to focus on prevention of renal disease progression. These learnings will form the bases for LHIN-wide improvements.

The Central East LHIN has also focused on improving access to primary care for people without a primary care provider. Access to general health assessment and referral for people without a primary care provider has been provided through implementation of the unattached patient assessment, triage and referral project (UPA). The UPA team provides general health assessment and connection with disease specific and/or self-management supports for people who are currently without a primary care provider. The team refers to and accepts referrals from the MOHLTC Health Care Connect program. The UPA team is able to complete a minimum of 360 assessments per month or 4320 clients per year at current staffing levels.

Acute Care Treatment in the Central East LHIN has included the development of the District Stroke Centre at Lakeridge Health Corporation in partnership with the MOHLTC. This Centre provides equitable access to the clot-busting drug tPA within the recommended time guidelines to Central East LHIN residents living in Durham and surrounding areas.

Per recommendations from the Central East LHIN Clinical Services Plan, cardiac services, specifically Primary Percutaneous Coronary Intervention (PCI) is currently being offered at Rouge Valley Health System where the service is provided within the recommended guideline of 90 minutes. The LHIN is working with the MOHLTC to provide equitable access to all Central East LHIN residents for PCI by providing this service to the Northeast cluster of the LHIN in a timely way through Peterborough Regional Health Centre.

The Clinical Services Plan recommends that vascular services across the Central East LHIN be organized to reflect the North East/Durham clusters and Scarborough/Durham clusters with surgical delivery being sited at two LHIN-wide centres. Efforts will be made to move this recommendation to reality in 2010-11.

Secondary Prevention of Disease Progression & Adverse Events has focused on the implementation of the comprehensive Chronic Disease Self Management Program (CDSM) across the LHIN. This was the first comprehensive deployment of CDSM in Ontario which has been provided to more than 1100 Central East LHIN residents through more than 100 workshops.

To advance the Central East LHIN Clinical Services Plan recommendation for an integrated community-based approach to delivering cardiac rehabilitation services similar to a hub-and-spoke model, preliminary service design and business models have been developed.

Policy and System Design activity includes the design and initiation of a Comprehensive Vascular Disease Prevention and Management Initiative (CVDPMI) implementing a common patient-centred approach to screening and treatment protocols across primary care, and community and hospital based specialty care

(cardiology). The initiative will begin with coordinated screening, prevention, diagnosis, treatment, medical management, follow up and patient self management for 2500 Central East LHIN residents including 1000 unattached patients.

Support for the integrated diabetes care system design has included development of a Central East LHIN Diabetes Network and design of a community integration and outreach deployment strategy to guide the MOHLTC Ontario Diabetes Strategy service team expansion. A diabetes indicator initiative has introduced standardized collection of a core set of biophysical and behavioural indicators for diabetics receiving care through Diabetes Education Centres and Ontario Shores Weight and Metabolic Clinic.

GOALS and ACTION PLANS: **Prevention and Primary Health Care**

Goals:

- Prevention, early identification and screening for vascular disease
- Support expansion of Primary Care with the Ministry of Health and Long-Term Care
- Reduce the number of unattached patients and/or provide screening, assessment and referral
- Partner with other ministries and industry partners to promote healthy lifestyles
- Implement metabolic disease screening for people entering Community Mental Health and Addictions Programs or an Acute or Tertiary In-Patient Unit to identify those with or at risk of developing diabetes
- Work in partnership with Aboriginal communities to develop and implement a comprehensive vascular disease screening, assessment and management strategy that includes chronic kidney (renal) disease, metabolic syndrome and diabetes

Consistency with Government Priorities:

Focusing on prevention and primary health care as it relates to reducing the impact of vascular disease in the Central East LHIN will contribute to the achievement of the Ministry of Health and Long-term Care's priorities of:

- Reducing emergency department wait-times
- Improving access to integrated diabetes care
- Enhancing mental health services
- Enhancing access to primary care for citizens

Action Plans/Interventions

Action Plans/ Interventions:	% completion anticipated in each of the next three years		
	2010-11	2011-12	2012-13
Expand best/promising practices for Renal Chronic Disease Prevention and Management (Renal CDPM) through early identification, screening and effective disease management for people with chronic kidney disease	50%	25%	25%
Assessment, triage and referral of Unattached Patients to identify asymptomatic disease and provide referral to community and/or specialist resources	100%		
Leverage the Ontario Shores Metabolic Screening Program to provide outreach support and increasing the capacity of Diabetes Education Centres/programs to support people with mental health and addictions	50%	25%	25%

Expected Impacts of Key Action Items

Aligned with the Triple Aim's focus on population health, patient experience and cost per capita, the interventions focused on prevention and primary health care will:

- Decrease the rate of ED visits per 1,000 population
- Decrease the number of hospital admissions and in-patient hospital days
- Decrease the rate of ED visits that could be managed elsewhere
- Decrease ED length of stay
- Increase the % of the population with a primary care provider
- Decrease the number of ambulatory care sensitive conditions
- Improve patient satisfaction

What are the risks/barriers to successful implementation?

- Funding availability/sustainability for programs
- Limited human resources
- Stakeholder resistance to change
- Alignment of pace of change and, strategies (new and existing) within the LHIN to Ontario Diabetes Strategy

- The Ontario Government has established a new Ontario Renal Network (ORN) through the sponsorship of Cancer Care Ontario. In 2010 the ORN will hire a medical director and administrative lead for Renal Coordination in each LHIN. This development is an opportunity to advance renal coordination and standardization in the province. It will be important to ensure that the development does not stagnate the significant advances in chronic kidney disease prevention and management in the Central East LHIN.
- Limited collaboration with Health Care Connects (Central East CCAC) to improve patient flow/transfer.
- Ontario Shores Weight and Metabolic Clinic's ability to successfully build capacity in diverse partner agencies to ensure uptake and sustainability of program. High demand for support from various communities/partners.

GOALS and ACTION PLANS: **Acute Care Treatment**

Goals:

Continue with the implementation of the One Acute Care Network to improve equitable and timely patient access to an integrated hospital system that provides the highest quality of care across the Central East LHIN.

Consistency with Government Priorities:

Focusing on acute care treatment as it relates to reducing the impact of vascular disease in the Central East LHIN will contribute to the achievement of the Ministry of Health and Long-term Care's priorities of:

- Reducing emergency department wait-times
- Reducing the number of days that patients spent waiting in hospital for an alternate, more appropriate care setting (ALC days)
- Enhancing Mental Health services

Action Plans/Interventions

Action Plans/ Interventions:	% completion anticipated in each of the next three years		
	2010-11	2011-12	2012-13
Enhance and integrate regional Cardiac and Vascular Programs in the Central East LHIN including Cardiac Percutaneous Coronary Intervention (PCI) and STEMI (ST-segment Elevation Myocardial Infarctions)	40%	30%	30%

Continued implementation of the Central East Unified Stroke System which will have improved access to Telestroke on-call support for area hospitals and an improved ability to access Enhanced District Stroke Centre and Regional/Tertiary Stroke Centre supports for LHIN residents	33%	33%	34%	
Continued implementation of the Central East LHIN Renal Network to promote best practices, common reporting standards and organ transplant care	50%	25%	25%	

Expected Impacts of Key Action Items

Aligned with the IHI Triple Aim's focus on population health, patient experience and cost per capita, the interventions focused on acute care treatment will:

- Decrease the rate of ED visits per 1,000 population
- Decrease the number of hospital admissions and in-patient hospital days
- Decrease ED length of stay
- Decrease the percentage of ALC days
- Improve patient satisfaction

What are the risks/barriers to successful implementation?

- Lack of stakeholder commitment/confidence
- Funding availability/sustainability for programs
- Limited human resources
- Stakeholder resistance to change
- Variability in physician funding models
- Resistance to clinical integrations across clusters by physicians, communities. Capital Resource investments required. Human resource transitions. Leadership and change management support from senior hospital administration.
- Telestroke: Provincially equitable access to on-call neurology/physician resources. Access to sufficient neurologists to support 24/7/365 on a provincial basis.
- Unified Stroke System in Central East LHIN: Challenges of clinical realignment for Regional clinical/acute supports to St. Michael's Hospital. Resources to developed Enhanced District Stroke Centre capacity within Central East LHIN.
- Loss of Central East LHIN Renal Network momentum for quality improvement and LHIN wide consistency with development of new Ontario Renal Network.

GOALS and ACTION PLANS: **Secondary Prevention and Disease Progression & Adverse Events**

Goals:

- Enable consumers and caregivers to effectively manage their chronic conditions in partnership with their health care team
- Improve access and coordination of care by building interdisciplinary care delivery teams and partnerships/coalitions between community agencies, hospitals, pharmacy, primary and specialty care providers, allied health professionals and non-health funded community providers such as education, social services and business
- Improve supports in community and primary care settings to reduce avoidable or non urgent/less urgent Emergency Department visits for vascular diseases, including ED visits related to completion of routine lab-work
- Reduce hospital in-patient admissions and re-admissions for complications of vascular disease that could have been managed effectively elsewhere in a community or primary care setting

Consistency with Government Priorities:

Focusing on secondary prevention and disease progression & adverse events as it relates to reducing the impact of vascular disease in the Central East LHIN will contribute to the achievement of the Ministry of Health and Long-term Care's priorities of:

- Reducing emergency department wait-times
- Reducing the number of days that patients spent waiting in hospital for an alternate, more appropriate care setting (ALC days)
- Improving access to integrated diabetes care

Action Plans/Interventions

Action Plans/ Interventions:	% completion anticipated in each of the next three years		
	2010-11	2011-12	2012-13
Create an integrated community-based Cardiopulmonary Rehabilitation program across the LHIN	40%	40%	20%
Address relevant recommendations of the Central East LHIN Rehabilitation Services Report and pursue integration opportunities and enhancements	30%	40%	30%

Continue implementation of Self Management training opportunities for consumers and caregivers and expanded capacity for follow-up	100%		
Develop Self Management Support tools/toolkit to better enable health care providers/clinicians to support their clients to self-manage their chronic conditions	50%	25%	25%
Monitor, test and spread the Peterborough Comprehensive Vascular Disease Prevention and Management Initiative (CDVPMI)	30%	20%	50%

Expected Impacts of Key Action Items

Aligned with the IHI Triple Aim's focus on Population Health, Patient Experience and Cost per Capita, the interventions focused on secondary prevention and disease progression & adverse events will:

- Decrease the rate of ED visits per 1,000 population
- Decrease the number of hospital admissions and in-patient hospital days
- Decrease the rate of ED visits that could be managed elsewhere
- Decrease ED length of stay
- Decrease the number of ambulatory care sensitive conditions
- Improve patient satisfaction

What are the risks/barriers to successful implementation?

- Lack of stakeholder commitment/confidence
- Funding availability/sustainability for programs
- Limited human resources
- Stakeholder resistance to change
- Shift in focus from hospital-based Cardiopulmonary Rehabilitation to community-based, multi-partner service delivery model
- Transition of Self Management program from LHIN priority project to program of CECCAC – maintenance of priority status within CCAC environment.
- Agreement on consistent tools for disease specific self management supports for clinicians
- Uptake of screening and treatment protocols by family physicians and specialists beyond initial pilot groups. Integration of screening and treatment protocols into physician's own Client Management Systems.

GOALS and ACTION PLANS: **Policy and System Design**

Goals:

- Support local implementation of the Ministry of Health and Long-Term Care's Diabetes Strategy, specifically through the regional coordination of diabetes programs
- Pursue service enhancements to increase to 100% the proportion of people with diabetes supported by primary care and specialty resources such as Diabetes Education Centres
- Implement eHealth strategies that will support integration of clinical care, self-management and performance monitoring of chronic disease management
- Increase consumer, caregiver and clinician capacity to follow best practice care guidelines and achieve recommended health outcome targets
- Integrate/coordinate and improve consistency of service delivery across the Central East LHIN

Consistency with Government Priorities:

Focusing on policy and system design as it relates to reducing the impact of vascular disease in the Central East LHIN will contribute to the achievement of the Ministry of Health and Long-term Care's priorities of:

- Reducing emergency department wait-times
- Reducing the number of days that patients spent waiting in hospital for an alternate, more appropriate care setting (ALC days)
- Improving access to integrated diabetes care

Action Plans/Interventions

Action Plans/ Interventions:	% completion anticipated in each of the next three years		
	2010-11	2011-12	2012-13
Continue to distribute the Living Well with Diabetes – Resource Guide and develop complementary tools to continue to support the uptake of best practice and self care	75%	25%	
Improve coordination and consistency of the service delivery system that supports people with diabetes across Central East LHIN	30%	40%	30%
Integrate eHealth projects that provide: a complete picture of the patient record (e.g., Hospital Info System Consolidation);	20%	20%	40%

Prevention support (e.g., e-learning, healthy living web portal; Disease management (e.g, Diabetes indicator project pilot) and Measurement support (e.g., Clinical Documentation standardization)				

Expected Impacts of Key Action Items

Aligned with the IHI Triple Aim's focus on population health, patient experience and cost per capita, the interventions focused on policy and system design will:

- Decrease the rate of ED visits per 1,000 population
- Decrease the number of hospital admissions and in-patient hospital days
- Decrease the rate of ED visits that could be managed elsewhere
- Decrease ED length of stay
- Improve patient satisfaction

What are the risks/barriers to successful implementation?

- Lack of stakeholder commitment/confidence
- Funding availability/sustainability for programs
- Limited human resources
- Stakeholder resistance to change
- Lack of information around MOHLTC Diabetes Strategy and potential alignment
- Resourcing for third print of Living Well with Diabetes Resource Guide. Alignment with Provincial Patient Toolkit.
- Implementation of Regional Coordinating Centres: Development and effective alignment between provincial diabetes service integration strategy (including Regional Coordinating Centres) and LHIN integration objectives in absence of accountability or requirement for data sharing and collaboration between LHINs, RCCs and their DECs.
- Ability to implement local/LHIN eHealth strategies in absence (or during development of) provincial ehealth strategies – i.e. diabetes portal.

Central East LHIN Staffing and Operations

Central East LHIN Staffing

Based on an internal review and analysis of peer organization's human resource capacity, Central East LHIN Management recommends that additional staff are required to meet the legislative mandate of LHINs and strategic directions of the Ministry of Health and Long-Term Care. The depth and scope of strategic, financial and performance responsibilities has increased for the LHINs since their inception in 2006. This includes assuming new roles on behalf of the Ministry of Health and Long-Term Care, including capital planning, human resources planning, financial oversight, and - where necessary - corrective action of health service provider performance. The lack of additional resources is a risk to the overall health of the Central East LHIN organization (e.g., staff retention and recruitment) and its ability to meet our strategic and operational responsibilities. This request is made with thoughtful consideration of the economic challenges faced by the province and its health service providers. Our commitment to providing effective and efficient oversight of the local health system will not be compromised.

LHIN Staffing Plan Full-Time Equivalents

Position Title	2008/09 Actual as of Mar. 31 FTEs	2009/10 Forecast FTEs	2010/11 Forecast FTEs	2011/12 Forecast FTEs	2012/13 Forecast FTEs
CEO	1	1	1	1	1
Executive Assistant	1	1	1	1	1
PICE/PCA Senior Directors	2	2	2	2	2
Communications/PICE/PCA Leads	6	6	6	6	6
Corporate Business Support Manager	1	1	1	1	1
PICE/PCA Senior Consultants	2	4	5	5	5
Corporate/PCA Analysts	3	5	5	5	5
Corporate Public Affairs	1	1	1	1	1
Health Planners	2	2	2	2	2
Corporate/PICE/PCA Coordinators/Administrators	2	4	4	4	4
Administrative/Program Assistants	6	4	5	5	5
TOTAL FTE	27	31	33	33	33

Central East LHIN Operations

LHIN Operations Sub-Category ($)	2008/09 Actuals	2009/10 Allocation	2010/11 Planned Expenses	2011/12 Planned Expenses	2012/13 Planned Expenses
Salaries and Wages	2,227,923	2,664,544	2,753,500	2,808,570	2,864,741
Employee Benefits					
HOOPP	202,595	266,454	275,350	280,857	286,474
Other Benefits	241,786	319,745	413,025	421,286	429,712
Total Employee Benefits	***444,381***	***586,199***	***688,375***	***702,143***	***716,186***
Transportation and Communication					
Staff Travel	51,429	60,000	60,000	61,200	62,424
Governance Travel	38,194	40,000	40,000	40,800	41,616
Communications	5,007	40,000	60,000	61,200	62,424
Other			2,000	2,040	2,081
Total Transportation and Communication	***94,630***	***140,000***	***162,000***	***165,240***	***168,545***
Services					
Accommodation	312,792	344,255	450,000	300,000	300,000
Community Engagement	128,329	120,000	180,000	183,600	187,272
Consulting Fees	320,734	75,000	50,000	51,000	52,020
Governance Per Diems	166,366	150,000	150,000	153,000	156,060
LSSO Shared Costs	300,000	300,000	350,000	357,000	364,140
Other Meeting Expenses	82,354	38,414	40,000	40,800	41,616
Other Governance Costs	45,024	40,000	40,000	40,800	41,616
Staff Development	27,424	59,000	80,000	81,600	83,232
Other Services	27,228	42,617	45,000	45,900	46,818
Total Services	***1,410,251***	***1,169,286***	***1,385,000***	***1,253,700***	***1,272,774***
Supplies and Equipment					
IT Equipment		20,000	30,000	30,600	31,212
Office Supplies & Purchased Equipment	137,970	30,000	40,000	40,800	41,616
Total Supplies and Equipment	***137,970***	***50,000***	***70,000***	***71,400***	***72,828***
LHIN Operations: Total Planned Expense	4,315,155	4,610,029	5,058,875	5,001,053	5,095,074
Annual Funding Target	[redacted]	[redacted]	5,058,875	5,001,053	5,095,074
Variance	[redacted]	[redacted]	-	-	-

The proposed capital expenditures for the fiscal year 2010-2011 are due to the Central East LHIN staffing plan forecast to increase up to 2 FTEs for capital planning consultant and administrative support. In the past 3 years the LHINS have completed the HSAAs and MSAAs, and in 2010-11 the LHINs are implementing the LSAAs for the Long-Term Care agencies. The Central East LHIN is forecasting staffing requirements to support this increase of responsibilities.

The current accommodations consist of two sites one at 6066 sq ft for 29 FTE Central East LHIN staff and the other is 2000 sq ft for Central East LHIN initiative funding staff and a boardroom. The capital cost includes leasehold improvements at $250,000, furniture at $90,000 and computer equipment at $15,000 these cost are reflected in the accommodations sub-category above. The proposed leasehold improvements are to renovate the Board Chair, CEO and Senior Directors offices to accommodate 2 to 4 more cubicles and meeting room.

Communication and Community Engagement Plan

Context:

The Central East LHIN is continuing as mature as one of 14 community-based organizations (LHINs) which have a mandate to plan, co-ordinate, integrate and fund health care services at the local level. As the Central East LHIN continues to mature, it is still vitally important that clear, factual, timely and consistent information be disseminated to all defined audiences in a strategic manner.

The Annual Business Plan (ABP) operationalizes the Integrated Health Service Plan and informs the Ministry's Results-based Planning process. LHINs are required, through their Annual Business Plans, 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 Annual Business Plan will become a public document as an appendix to the ministry-LHIN accountability agreement.

This Plan relates to how Communications and Community Engagement will support the rollout of the Annual Business Plan.

Community Engagement:

As a result of lessons learned from the first three years of the Central East LHIN, and with the enhanced strategic aim focus outlined in this IHSP, revision to the *Framework for Community Engagement and Local Health Planning* will be required. Working in partnership with local Collaboratives, LHIN-wide Networks and Task Groups, we will pursue options to strengthen community engagement, collaboration and coalition building that will result in measurable outcomes for individuals and families of identified priority populations.

"Re-tooling" the *Framework for Community Engagement* will require the support and input from existing stakeholders and the revised Framework will also require endorsement from the Central East LHIN Board. A new *Framework* is expected to be completed by April 1, 2010.

Timelines and Transition

January 2010	Identify Collaborative Transition Team and Coalition Creation Team
March 1, 2010	Refresh of Framework for Community Engagement
March 16, 2010	Framework endorsed by Central East LHIN Board
March - Apr 2010	Expressions of Interest for new Coalitions/Collaboratives
April 1, 2010	IHSP is "Live"

May 1, 2010	Coalitions and Collaboratives in Place
May 5, 2010	Central East LHIN 2010 Symposium

Timing:

This plan is in effect from the posting of the Annual Business Plan on the Central East LHIN website as throughout the implementation of Goals and Action Plans detailed in the Plan.

This plan is a component of an overarching Central East LHIN Communications and Community Engagement Plan. Other supplemental communication plans include Communications and Community Engagement Plans related to the One Acute Care Network – Implementation; Government Relations; HAPS; L-SAA; and any crisis communication plans.

Definitions:

The "Central East LHIN organization" refers to the staff and board that occupy 314 Harwood Avenue S in Ajax. The "Central East LHIN" is the collective of both the Central East LHIN organization and all the Health Service Providers within the geographic boundary of Central East.

Objectives:

Objectives of the Communication and Community Engagement Plan include:

- To demonstrate responsiveness to community needs and to communicate transformation activities and initiatives to stakeholders and the community.
- To reach all audiences throughout the Central East LHIN in order to educate them about the Central East LHIN, the LHIN organization, the collective responsibilities for achieving targets in the MLAA, the refresh of the IHSP and its link to Triple Aim and ongoing community engagement processes.
- To ensure that all audiences are aware of the value of the work being carried out by the Central East LHIN to create a more integrated, safe, accessible, quality health care system
- To be transparent, responsive, timely and appropriate, inclusive and balanced, accessible, accountable, and innovative.
- To deliver key messages on how the Central East LHIN and its stakeholders are working together to learn and educate; promote ownership; share accountability and commit to common goals; and, restore confidence in our public health care system.
- To be proactive and progressive in managing reputation and communications.

Key Messages (Annual Business Plan)

Key messages for the Annual Business Plan:

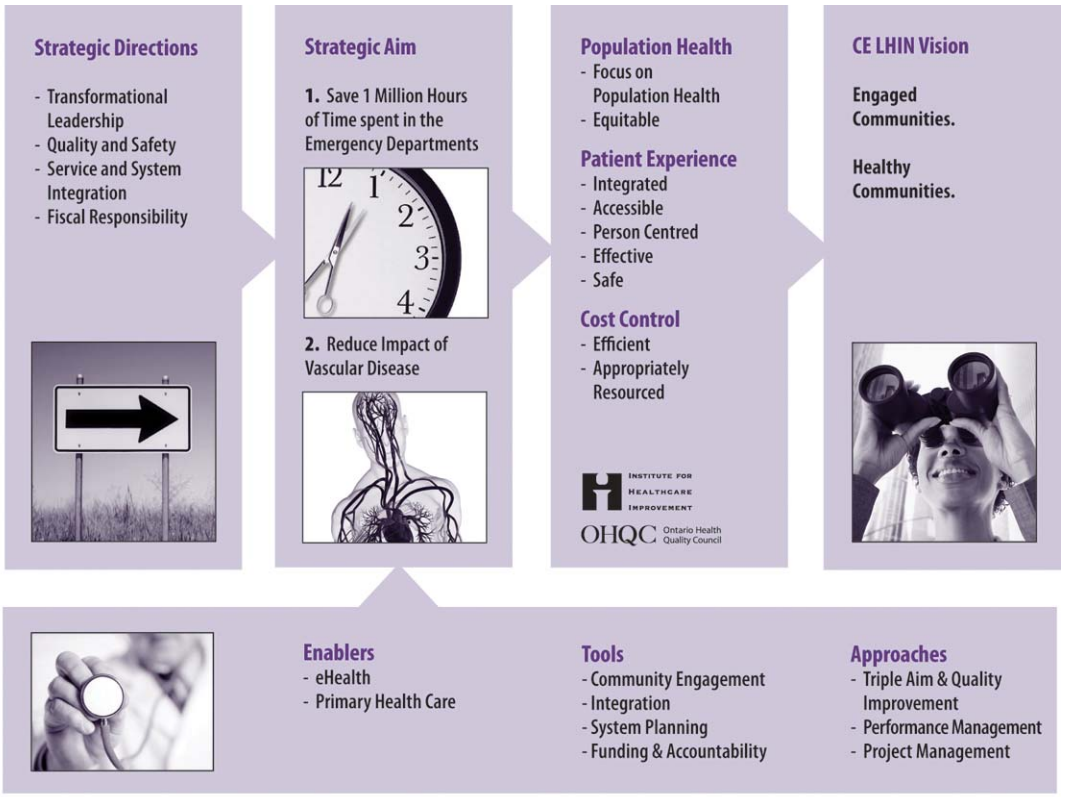
- The Annual Business Plan will assist the public in understanding how the LHIN is planning to address the needs of their community.
- The plans are based on discussions the LHINs have had with thousands of members of the public, providers and stakeholders.

Key Messages (Integration):

Key messages regarding integration:

- The Central East LHIN is working with health service providers to enhance the public health care system through the development of the One Acute Care Network and the ongoing implementation of activities identified in the IHSP.
- The health system should be experienced as a coordinated system: People should get the right treatment at the right time by the right provider
- A seamless flow of information that supports patient care should exist
- A system that begins with primary care providers with an equal focus on prevention and health maintenance
- Create timely access to quality services by aligning people, processes and resources
- Elimination of wasteful and time consuming duplication
- Involvement of patients, residents, family and informal caregivers

Key Messages (IHSP 2010-2013 Strategic Aims):



Key messages regarding the 2010-2013 Integrated Health Service Plan Strategic Aims:

- The Central East LHIN's vision continues to be "Engaged Communities. Healthy Communities."
- The Central East LHIN also has four strategic directions which include transformational leadership, quality and safety, service and system integration and fiscal responsibility.
- The Institute for Healthcare Improvement and the Ontario Health Quality Council have 3 and 8 goals respectively that can be combined to read as Population Health - Focus on Population Health, Equitable; Patient Experience – Integrated, Accessible, Person Centered, Effective, Safe; and Cost Control – Efficient, Appropriately Resourced.

- By setting strategic aims, the Central East LHIN and its stakeholders can focus the Strategic Directions, the Triple Aim Framework and the Ontario Health Quality Council Attributes of a High Performing Health System towards the Vision of Engaged Communities, Healthy Communities.
- These strategic aims are
  - **Save 1,000,000 hours of time spent in Central East LHIN Emergency Departments by 2013;**
  - **Reduce the impact of vascular disease by 10% by 2013.**
- These aims can be met by
    - Reducing emergency department demand
    - Improving emergency department capacity and performance
    - Improving hospital bed utilization
    - Targeting:
      - Prevention and Primary Health Care
      - Acute Care Treatment
      - Secondary Prevention of Disease Progression and Adverse Events
      - Policy and System Design

and

- Supporting the rollout of the Ministry's Diabetes Strategy
- Addressing inequality of access and outcomes between regions / target populations
- Focusing on disease management strategies (e.g., self-management)
- Creating and providing timely, coordinate access to specialty acute care services through the One Acute Care Network (e.g., Metabolic clinics, vascular)
- Engaging Primary Care (e.g., Comprehensive Geriatric Assessment, unattached patients) and Public Health
- Leveraging partnerships with other public and private sectors

Key Messages (Stakeholder Engagement):

Key messages regarding the 2010-2013 Integrated Health Service Plan Strategic Aims:

-
- The Central East LHIN organization is continuing to share new information with the broader community on its IHSP implementation, expectations and accountability of health service providers, integration opportunities, how integration decisions will be handled and the benefits to the residents and health care providers in the Central East LHIN
- Opportunities for involvement continue through the website, attendance at open board meetings and the Annual Symposium, Speakers' Bureau, membership on Planning Partner teams and involvement in engagement carried out by health service providers
- **Many health care service providers in the Central East LHIN are participating in LHIN planning exercises and supporting the activities and objectives of all Planning Partner teams.**
- This type of participation supports shared system design and implementation, with a rigorous emphasis on the patient experience, quality improvement, and value-for-money. It also leads to a system approach to finance and performance management with a rigorous emphasis on achieving greater accountability and efficiency.

Audiences (in order of priority):

Audiences (in order of priority) for the Communication and Community Engagement Plan include:

- MOHLTC
- Other LHINs
- Government stakeholders
    - Municipal

    - Regional
    - Provincial
    - Federal
- Central East LHIN Planning Partner volunteers – to be realigned in early 2010 to support achievement of the Strategic Aims
    - Geographic Collaboratives (9 plus FLHS)
    - Three Networks – SCFS; MHA; CDPM
    - Six Task Groups – Primary Care Working Group; ALC Task Group; Emergency Department Task Group; e-Health Steering Committee;
    - Other Planning Partner /Project groups include –Board to Board Collaboratives (Scarborough, Durham, North East); CE LHIN Communications Network; Central East Diabetes Network; Central East Human Resources Steering Group; Central East Quality, Performance and Effectiveness Group; Hospital and CCAC Financial Leadership Group; Hospice Palliative Care Steering Committee; Regional Decision Support Group; Wait Time Strategy Working Group; Aboriginal Health Advisory Circle
- Central East LHIN Strategic Planning Council/HPAC
- Central East LHIN Provider-based committees
    - Central East Executive Committee (Hospital & CEO)
- Individuals who have indicated an interest in Central East LHIN activities
- Health Service Providers/Stakeholders
    - Health Service Providers Leadership and Front Line staff (including union leadership)
    - Central East Health Service Provider Boards
    - Physicians
    - Patients/Clients/Consumers/Residents
    - Consumer/Patient Support Groups
- General Public
    - Residents
    - Citizens
    - Service Clubs
- Media

Message Matrix:

Audience	**Principle Interests**	**Risks**	**Key Messages**	**Mitigation Strategies**
HSP Leadership – administration/physician	Success of the Annual Business Plan	Failure to participate in collaborative solutions	Collaboration throughout the implementation of items in the ABP	Shared development of CE LHIN communication plans through CE LHIN Communications Network and implementation of strategies
Front Line staff (including union leadership)	Job Security	Public campaigning against ABP implications/ implementation	Health Human Resources vital to the success of ABP implementation	Ensure that front line staff have ongoing access to information through CE LHIN and HSP communication vehicles; targeted

		based on union interests		communication to union leadership at key milestones
Central East Health Service Provider Boards	Protecting the interests of their communities	Failure to participate in collaborative solutions	Collaboration and Integration; Focus on access and quality	Ensure that HSP CEOs/Executive Directors are providing ongoing updates to their boards
Physicians	Ability to practice based on their skills	Public campaigning against ABP implications based on personal interests	ABP derived from community engagement, IHSP development which included their physician peers; moving forward requires ongoing physician involvement	Physicians talking to physicians; Admin talking to physicians; Involvement in Task Groups
Audience	**Principle Interests**	**Risks**	**Key Messages**	**Mitigation Strategies**
Patients/Clients/Consumers/Residents/ Consumer/Patient Support Groups	Access	Public campaigning against ABP goals and actions plans based on perceived loss of access	Quality/Access/ Fiscal responsibility	Transparent disclosure related to projects and timelines; direct involvement of these stakeholders in any HSP consultation/community engagement
Healthcare Associations (OHA, ONA, OMA, etc)	Protecting interests of their membership	Public campaigning	Collaboration by hospitals/memberships throughout the implementation of ABP	Targeted communication to the leadership of these organizations at appropriate milestone
Local Government Stakeholders	Access/protecting the interests of their	Public campaigning against ABP	Quality/Access/ Fiscal	Targeted communication and engagement with

	constituents	implications	responsibility	these stakeholders at appropriate milestones; ensure that message comes from their local HSPs/physicians on the gains to be made by ABP goals and actions
CE LHIN Planning Partner volunteers – Collaboratives, Networks, Task Groups	Involvement in the process and the outcome	Public campaigning re: perceived lack of involvement/consultation in the plan	Involvement throughout; link to other sectors	Ongoing updates at all of their meetings; link to public pages on website and communication vehicles
General Public	Access	Support any organizing and individual campaigning against ABP goals and actions	Quality/Access/ Fiscal responsibility	Informational pages on website; speakers' bureau; enewsletter; news releases; HSP communication vehicles
Audience	**Principle Interests**	**Risks**	**Key Messages**	**Mitigation Strategies**
Media	HSP/Community reaction to the process – implementation and outcome	Will report on any and all public campaigning against project	Quality/Access/ Fiscal responsibility	Informational pages on website; speakers' bureau; enewsletter; news releases; HSP communication vehicles; targeted communication at key milestones
Other LHINs	Seeing if project is applicable to their LHINs	Shared risk on ABP implementation	LHINs to be develop shared messaging to support consistency across the province	Key messages to be included in LHINs' shared communication plan to be used in all LHINs' communication vehicles
MOH	Success of the ABP implementation	Lack of public support for	Collaborative consultation	Ongoing briefings with appropriate

	related to access, financial stability, quality and MOH stewardship	implementation and outcomes	with HSPs and planning partners; communication and community engagement plan with key stakeholders	ministry staff at all key milestones

Communication and Community Engagement Tactics and Vehicles

- Communication Partnership – LHIN Communication Leads
- Communication Partnership – Central East LHIN Communication Network
- Developing strong local Government Relations
- Communicating with Physicians
- Communication between Network Steering Committees and Network Members
- Maintaining strong Media Relations
- Enhancing the Speakers Bureau
- Organizing Knowledge Building/Information Sharing Events
- Maintaining a consistent toolbox of strong communication vehicles
- *2009-10 Annual Report*
- *News Releases*
- *Blast emails*
- *Central East LHIN Website*
  - Public Site
  - Collaboration work spaces
  - Electronic newsletter – as required
  - HSP News button - “Tell a Story”
  - Calendar

Rollout includes:

Coordinated, same day release of ABP document 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)

Inclusion of ABP Goals and Action Plan in all on-going communication and community engagement activities

Ontario
Local Health Integration Network