

Central East **LHIN**

2012/2013 Annual Business Plan

Implementing the 2010-2013 Integrated Health Service Plan



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January 31, 2012

Alex Bezzina, 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. Bezzina,

The Central East Local Health Integration Network (LHIN) is pleased to share its 2012/2013 Annual Business Plan with staff at the Ministry of Health and Long-Term Care.

This document outlines the operational details in support of achieving the aims of the Central East LHIN's 2010/2013 Integrated Health Service Plan (IHSP). Building on previous year's successes we have specifically captured changes planned for the upcoming fiscal year and how success of these changes will be measured. In this upcoming year we will relentlessly continue to achieve the performance targets set out in the Ministry-LHIN Performance Agreement (MLPA) and pursue our two IHSP Strategic Aims to (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. In addition, as a key component of health system change and performance management, this document outlines other activities as they pertain to:

- Health System Design and Integration
- Community Engagement
- Quality and Performance Improvement
- Access to Care

The activities outlined in this Annual Business Plan were anticipated in the 2011/2013 Integrated Health Service Plan (IHSP). Two new initiatives that were not explicitly planned but very consistent with the direction of the IHSP are Behavioural Supports Ontario and the Central East LHIN Regional Specialized Geriatric Services entity. These new exciting initiatives will support the achievement of our strategic aims and improve care for our targeted populations of at-risk seniors and persons with mental illness and addictions. Further details of both initiatives are included in this submission.

This document was approved by the Central East LHIN Board of Directors at their January 25, 2011 meeting. If you have questions or comments, please contact my office at your earliest convenience.

Sincerely,



Wayne Gladstone, Board Chair
Central East LHIN

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

Context

Central East Local Health Integration Network Mandate and Strategic Directions

Being a critical part of the evolution of health care in Ontario, Local Health Integration Networks (LHINs) are striving to make it a system that is patient focused, results-driven, integrated and sustainable. Local Health Integration Networks are mandated to lead the integration of health care services, thus making it easier for people to get the best care when they need it, in the most appropriate setting, while creating greater value-for-money for the public's investment. The Central East LHIN will continue to realize this mandate through community engagement and leadership, local health system design, quality improvement strategies, funding and allocation, and accountability and performance management.

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

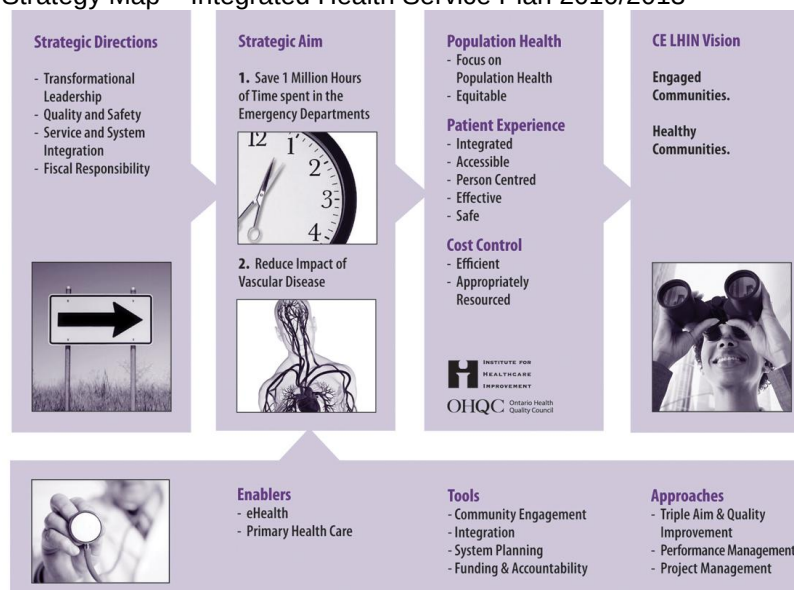
- *Transformational Leadership*: The Central East LHIN Board will lead the transformation of the health care system into a culture of interdependence
- *Quality and Safety*: Health care will be people-centred in safe environments of quality care
- *Health Service and System Integration*: Create an integrated 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 guide 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 LHIN emergency departments by 2013; and
2. Reduce the impact of vascular disease in the Central East LHIN by 10% by 2013.

As depicted in the **Central East LHIN Strategy Map**, these strategic directions and aims provide the basis for Central East LHIN decision making. The accomplishment of the strategic aims will be measured and evaluated using the Institute for Healthcare Improvement's Triple Aim Framework and Health Quality Ontario'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 Performance Agreement (MLPA) targets listed below.

MLPA Measure	Target
90th Percentile Wait Times for Cancer Surgery	49 days
90th Percentile Wait Times for Cataract Surgery	140 days
90th Percentile Wait Times for Hip Replacement	179 days
90th Percentile Wait Times for Knee Replacement	179 days
90 th Percentile Wait Times for Diagnostic Magnetic Resonance Imaging Scan	63 days
90 th Percentile Wait Times for Diagnostic Computed Tomography Scan	28 days
Percentage of Alternate Level of Care Days - by LHIN of Institution	14.80%
90 th Percentile Emergency Room Length of Stay for Admitted Patients	39 hours
90 th Percentile ER Length of Stay for Non-Admitted Complex Patients	7 hours
90 th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated Patients	4 hours
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions	16.60%
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions	19.00%
90 th Percentile Wait Time for Community Care Access Centres (CCAC) In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)	39.9 days
Readmission within 30 Days for Selected Case Mixed Groups	14.50%

Resources

To achieve our strategic aims, the Central East Local Health Integration Network (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 (MOHLTC or the Ministry) including:

- Current health service provider funding as specified in the Ministry-LHIN Performance Agreement;
- Alternate Level of Care Community Investment Funding;
- Emergency Department Pay for Results Program;
- Central East LHIN Urgent Priority Funding;
- eHealth Funding; and
- Other revenue provided by the MOHLTC.

Community Engagement

The Central East Local Health Integration Network (LHIN) is improving the health of our communities through an integrated health care delivery system that delivers high quality outcomes. Such outcomes can only be achieved through engagement and partnership with patients and their families, health care service providers, the Ministry of Health and Long-Term Care (MOHLTC or the Ministry), other LHINs and other 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.*

As a result of lessons learned since the Central East LHINs 2006 inception and the enhanced strategic focus outlined in the 2010/2013 Integrated Health Service Plan, a new Community Engagement Framework has been adopted by the Central East LHIN that is consistent among all 14 of Ontario's LHINs. Details on specific community engagement activities are outlined in the Central East LHIN **Annual Communications and Community Engagement Plan** that is included within this Annual Business Plan (Page 82).

Central East Local Health Integration Network – Operations Overview

Since the 2010/2011 restructuring of the Central East LHIN organization, the **Performance Management Program** was re-designed to ensure new responsibilities were evaluated and monitored to fulfill the organization's expectations. A survey of the 2010/2011 restructuring outcomes was conducted with staff and the results focused on the need to strategically position our roles and responsibilities to implement the 2010/2013 Integrated Health Service Plan and to become more efficient in our internal workflows. The staff then completed a value stream analysis on two workflows that were recently implemented as revised business processes.

The Agency Establishment and Accountability Directive requires all Ministries and Agencies that report to the Provincial government to perform regular risk assessments. The **Detailed Agency Risk Assessment Tool (DARAT)** was introduced as a new process in 2010/2011 as a risk-based reporting mechanism to assess agency risks, identify mitigating options and provide context for a risk management plan.

Local Health Integration Networks (LHINs) are classified as "operational service agencies" and report to the Ministry of Health and Long-Term Care (MOHLTC or the Ministry). In 2010/2011, LHINs were required to individually complete DARAT submissions for fiscal years 2010/2011 and 2011/2012. The final version of the 2011/2012 Central East LHIN DARAT report was brought forward to the Board of Directors in November 2011 for approval and then submitted to the MOHLTC.

Information reported in the submission for fiscal year 2012/2013 will assist the Ministry to provide appropriate oversight, identify and inventory all relative risks faced by the organization, as well as ensure that there are appropriate action plans in place to mitigate these risks and safeguard both the LHIN and the Ministry by correctly naming ownership for all identified risks.

The Central East LHIN continues to identify and mitigate risk by ensuring compliance with directives, business processes, governance practices, the application of legislative and policy levers, robust issues management strategies and, finally, through active engagement of Ministry clients.

Required by the DARAT report, the quarterly **Declaration of Compliance** involves a very stringent review of the Central East LHIN's compliance with its obligations under the Ministry LHIN Performance Accountability Agreement, the Memorandum of Understanding with MOHLTC and all government directives applicable to the LHINs. The process involves the completion of a comprehensive checklist which demonstrates compliance to the policies, agreements and legislation in all LHIN activities.

The Declaration of Compliance is authorized by the Chief Executive Officer and Board Chair. Any corrective actions are documented, recommended and completed before the Declaration of Compliance report is submitted to the Central East LHIN Audit Committee for review.

Overview of Central East Local Health Integration Network 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 and the Central East Local Health Integration Network (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 (ED), improving the flow within the ED to home or other hospital units, providing more

appropriate levels of care in the community for patients who are ready to be discharged from the hospital, and finally, preventing avoidable hospital readmissions.

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 if already acquired, improve the management of – vascular disease that will reduce the impact of vascular disease on individuals and the health care system.

Success will be achieved through the strategies identified in the **Comprehensive Vascular Disease Prevention and Management Initiative**. Those strategies include: namely prevention, secondary prevention, improved access to specialized services, self-management program, and education.

Along with our two strategic aims, the IHSP identified target **populations** for whom the LHIN is prioritizing its efforts:

- At risk seniors;
- People with a mental illness and/or addictions;
- People with chronic disease; and
- Francophone, First Nations, and Aboriginal communities and residents.

With successful realization of the strategic aims, the health system is starting to see:

- Engaged, pro-active and prepared patients and their formal and informal care providers;
- A reduction in ED demand and hospital readmissions;
- An improvement of wait times within the ED; and
- More appropriate levels of care provided in the community for patients who no longer require acute care services within the hospital.
- Improved hospital utilization and efficiency
- 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
- Improved wait times for diagnostic and surgical procedures
- Better access to home care services

Assessment of Issues Facing the Central East Local Health Integration Network

Key issues facing the Central East Local Health Integration Network (LHIN) environment and key drivers for health transformation continue to include:

POPULATION HEALTH

The Central East LHIN has the **second highest** population within the Province. Since 2006, Central East LHIN has experienced an increase in population growth, slightly higher than the provincial population growth. Population projections from 2008/2013 (five year projection) indicate that there will be a six percent growth with year-to-year incremental increases of one percent to 1.3%. As a result, the LHIN is preparing to manage future resource demands arising from inflation, aging, population growth and patient expectations regarding access to service.

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.

AVAILABLE FISCAL AND HEALTH SERVICE RESOURCES

Central East LHIN Funding Summary: 2011/2012	
	Per Central East LHIN (\$)
Operation of Hospitals	1,235,001,984
Grants – Municipal Taxation – Public Hospitals	283,200
Grants – Municipal Taxation – Specialty Psychiatric Hospitals	24,600
Long-Term Care Homes	410,380,986
Community Care Access Centre	224,228,749
Community Support Services	32,183,028
Acquired Brain Injury	1,450,060
Assisted Living Services in Supportive Housing	13,899,005
Community Health Centres	23,030,006
Community Mental Health	48,415,334
Addictions Programs	10,689,536
Specialty Psychiatric Hospital	114,698,047
Initiatives remaining unallocated – Aging at Home	0
Initiatives remaining unallocated – Urgent Priorities Funding	157
TOTAL HSPs	2,114,284,692
LHIN Operations	4,772,730
eHealth	0
Behavioural Supports Ontario – Unallocated (Additional Health Care Providers)	556,600
Alternate Level of Care Resource Matching and Referral – Unallocated	138,800
LHIN Initiatives	1,319,750
TOTAL Central East LHIN Allocations	2,121,072,572

Mitigation

A number of key issues and risks associated with resources are being managed by the Central East LHIN and its health service providers (HSPs). This includes responding to fiscal issues through strategic integration initiatives such as:

- **Canadian Mental Health Association (CMHA) Northeast Cluster:** In April 2011, representatives from the CMHA branches in the City of Kawartha Lakes and Peterborough began meeting to develop a shared vision for community-based mental health services in the Northeast Cluster of the Central East LHIN - specifically Northumberland County, Peterborough City and County, the City of Kawartha Lakes and Haliburton County.
- **Consumer Survivor Initiative Durham:** In January 2012, the Central East LHIN Board issued a decision to support the facilitated integration of Peer Support services in Durham Region. With this decision, Peer Support services, which were being provided by United Survivors Support Centre, a Consumer Survivor Initiative in Oshawa, will now be provided by Durham Mental Health Services (DMHS) as the lead agency, with CMHA – Durham branch as a service delivery partner. Both DMHS and CMHA-Durham have offices and satellite locations across Durham Region which will ensure that mental health consumers/survivors and their families will have access to local peer supports, as close to home as possible.
- **Regional Cardiovascular Rehabilitation Services:** Patients in Durham Region and Scarborough will now have greater access to co-ordinate cardiovascular rehabilitation services

after the Board of the Central East LHIN approved \$1 million in funding to support the integration of the cardiovascular rehabilitation programs at Rouge Valley Health System and Lakeridge Health. The two hospitals will work together to deliver a groundbreaking regional cardiovascular rehabilitation and secondary prevention program, which will provide services annually to an additional 680 patients per year, or a total of 1,980 residents in their communities.

These initiatives ensure limited resources are being used effectively and continue to provide quality services to the community.

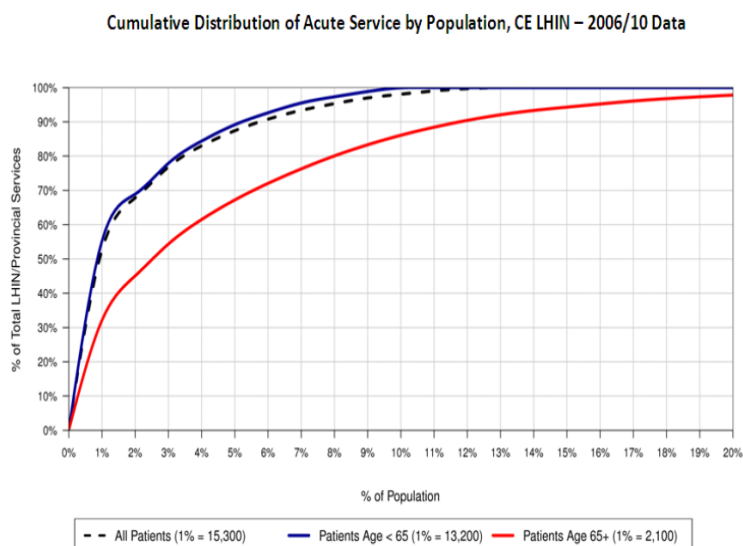
SYSTEM SUSTAINABILITY

To have a better understanding of the mix of resources required to optimally serve the current and future Central East LHIN population, the LHIN commissioned the 2011 Building a Model of Sustainable Access to Community Health Care Services (Sustainable Access Study). In this study, the LHIN assessed current and future needs based on a balanced care approach: examining both the total system resources and the mix of community and institutional resources that best serve the requirements of the Central East LHIN's aging population. To support these objectives, the report included:

- An assessment of the LHIN's existing complement of health services against the requirements of its elderly population. This assessment identified gaps between the current level and mix of services and the future service requirements of the LHIN's elderly population.
- Forecasts of future health service requirements to determine the anticipated future requirements for health services across the continuum of care in the Central East LHIN.
- A set of feasible recommendations that integrate the findings of the assessment and forecasting exercises to address required system reconfigurations, investment and resource distribution strategies, and health human resources planning required to ensure that the Central East LHIN can provide the optimal level and mix of institutional and community health services to its frail elderly population.

The key highlights of the Sustainability Access Study are informing the Central East LHIN of important risks and opportunities that help form the basis of this Annual Business Plan. Highlights include:

- One percent (or 15,300 persons) within the Central East LHIN account for 53% of acute services – approximately \$636 Million in funding. Further, that only 2,100 seniors in the Central East LHIN account for roughly one third of total acute spending. The conclusion is that the Central East LHIN should undertake focused, customized person level care to substantially impact the overall use of acute services in the LHIN. The LHIN's response to this focused approach is outlined in this plan.



• 1% (15,300) of the CE LHIN's population accounts for 53 percent of total acute services

• 1% of the senior population (2,100) accounted for 32 percent of all acute services received by the LHIN's senior population

- The Central East LHIN hospital bed type mix is different from other LHINs; the Central East mix comprises more acute and mental health beds and less rehabilitation and Complex Continuing Care beds. This difference is not accounted for by differences in population demographics or localization.
 - From 2006/2007 to 2009/2010, the Central East LHIN's acute and home care expenses increased by approximately 20%. Over the same period, mental health, Complex Continuing Care, and inpatient rehabilitation expenses increased by eight percent, similar to the growth in age-weighted population.
- Home care resources in the Central East LHIN are 0.2% less than what is expected based on population characteristics. In 2009/2010, the Central East LHIN's actual provincial share of home care resources was 11.3% while its expected share was 11.5%.
- Community Support Services (CSS) are under supplied in the Central East LHIN. Community Support Services spending in the LHIN was 21% less than expected based on population characteristics.
- Health care spending in the Central East LHIN has increased substantially over the last several years. However, increases were not evenly distributed across sectors.

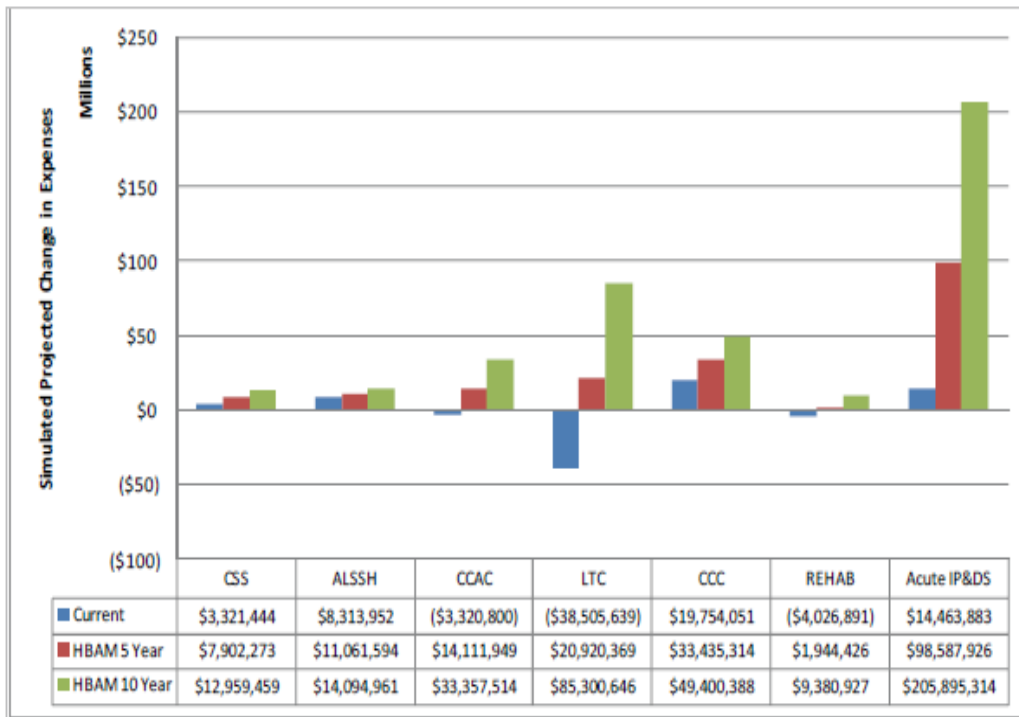
Mitigation

Faced with these risks, the Sustainable Access Study also identified opportunities to mitigate risk and improve the mix of health care resources along the continuum that could substantially reduce the high risk to the community, and the financial risk facing the Central East health care delivery system in light of future population growth, aging, and cost pressures. This includes:

- Improving the mix of seniors' services: Central East LHIN's spending per senior in 2009/2010 was \$5,579, similar to the provincial average, but 12% more than spending by the high performing LHIN.
 - The Central East LHIN Long-Term Care (LTC) spending per senior was 40% more and Complex Continuing Care spending per senior was 30% less than the high performing LHIN.
 - The Central East LHIN spent 65% less in CSS and Assisted Living Services in Supportive Housing than peer comparator LHINs and 79% less than the Province.
- Among all programs, the data suggests that the Central East LHIN should be targeting expansions for:
 - Community Support Services
 - Assisted Living Services in Supportive Housing
 - Complex Continuing Care (Age 65+)
- Relative to the Province, the Central East LHIN has:
 - More services available in LTC
 - Similar services available in:
 - Acute hospitals
 - Community Care Access Centres
 - Specialty Medicine

Using simulation models, comparing the Central East LHIN to provincial resource health service expenditures, the Sustainability Access Study found that Central East LHIN CSS, Assisted Living Services in Supportive Housing, and Complex Continuing Care expenses are forecasted to increase faster at the provincial expense distribution than under Central East LHIN's current distribution by 40%, 108% and 81% over 10 years (See graph below).

Simulated Projected Change in Actual and Projected Expenses–Provincial Distribution



INFLATION

Health Human Resource Contracts

Funding levels and the Ministry directive do not use the stabilization funding increase for health human resource compensation increases. Many organizations have assumed a zero percent economic increase to salaries and benefits for all staff. The management and non-union staff for some are past the second year of a zero percent increase. For many, the Ontario Nurses' Association (ONA), Canadian Union of Public Employees (CUPE) and Ontario Public Service Employees Union (OPSEU) collective agreements have already expired. The Provincial Community Care Access Centre (CCAC) sector bargaining for ONA, CUPE and OPSEU have completed their negotiations which include a 1.2% lump sum payment in 2012/2013.

There are some smaller organizations that will continue to have human resource compensation increases. As the community sector has, in general, lower paid staff compared to hospital peers, there is a potential risk that forcing zero compensation increases would result in a loss of experienced staff that would move to other areas of health care.

Some initiatives implemented by the Central East CCAC in 2011/2012 will have significant sustainability issues for fiscal 2012/2013 and will create budgeting challenges to the organization.

Mitigation

- Ontario Nurses' Association, CUPE and OPSEU represented staff have received a 1.2% lump sum payment in 2012/2013 as part of their unions' negotiations (with no impact on their salary grids). It is expected that the Central East CCAC and hospitals are to find any additional funding, if required, from within their MOHLTC/Central East LHIN funding envelope to offset any increase.

- The provincial bargaining strategy is seen to be a risk reduction strategy that helps avoid local changes in one part of the Province having impacts on the whole sector.
- The Central East LHIN continues to pursue integration opportunities that improve quality and efficiency at all levels to reduce operational and financial risks to the health system, its clients and funders.

Service Provider Contracts

Many contracted out services (CCAC specifically) have agencies with increases beyond the funded stabilization increase and can result in reduced service. The risk associated with a low or no increase in stabilization funding would be a potential hardship for some providers operating on slim profit margins. The Central East CCAC risk associated with each full one percent increase would be \$1.2 Million.

Mitigation

- The Central East CCAC has used new protocols introduced in 2011/2012 to offset increased costs by reducing contracted out volumes while improving client care and shortening length of stay. The Central East CCAC is still negotiating the contracted-out rates for all services for the 2012/2013 fiscal year.
- The Central East LHIN and Central East CCAC closely monitor service volumes and waitlists to ensure continued prioritization of the highest risk clients.

Demand for Home Care and Community Support Services

There is an increased demand for CCAC and other community health service providers to support more clients in a home setting. The community waitlists are increasing modestly week over week. Many of these clients have high Resident Assessment Instrument (RAI) composite scores and are at risk for emergency department visits or hospitalization.

There is also increasing pressure to reduce the community wait lists for home support services while continuing to support hospitalized clients upon discharge with enhanced services creating potential sustainability issues in 2012/2013. Approximately 75% of all newly active referrals (i.e., those receiving service) are from hospital referrals. This means that many clients referred from the community are generally waitlisted. The Central East CCAC will see an increase in personal support clients by about 20 to 30 new clients per week. As the Home First success continues to grow, it is expected that service volumes will continue to increase. This additional pressure on base funding can only be mitigated by increasing community wait list and/or referring more clients to community support agencies

Mitigation

- Greater detail on the full range of mitigation strategies of the above resource and health service delivery risks can be found in this document, specifically under the Section dedicated to the Integrated Health Service Plan (IHSP) Strategic Aim #1.
 - The Central East LHIN and CCAC closely monitor service volumes and waitlists to ensure continued prioritization of the highest risk clients.
 - Regular client CCAC re-assessments provide an opportunity to assess the client's home environment, discuss any falls, medication issues and other factors to prevent illness and injury in home settings (thus reducing the need for the emergency department). To assist in mitigation of these risks, the assessing case managers may order occupational therapy visits as required to provide the clients with suggestions for increased safety and to arrange for equipment to reduce issues with the client's home environment and potentially reduce falls. A nurse visit may also be required to discuss medication issues.
 - Continued provision of specific CCAC and CSS that concentrate on prevention and health promotion and/or self management services can substantially reduce need for acute care services.
 - Continued expansion of assisted living spaces for at-risk seniors that was initiated in 2011/2012 as highlighted in the Sustainable Access Study.
 - Enhanced coordination between the CCAC and CSS agencies to support individuals in retaining their independence with a flexible range of support services. This is facilitated through the integration of CCAC and CSS staff at the point of client assessment and

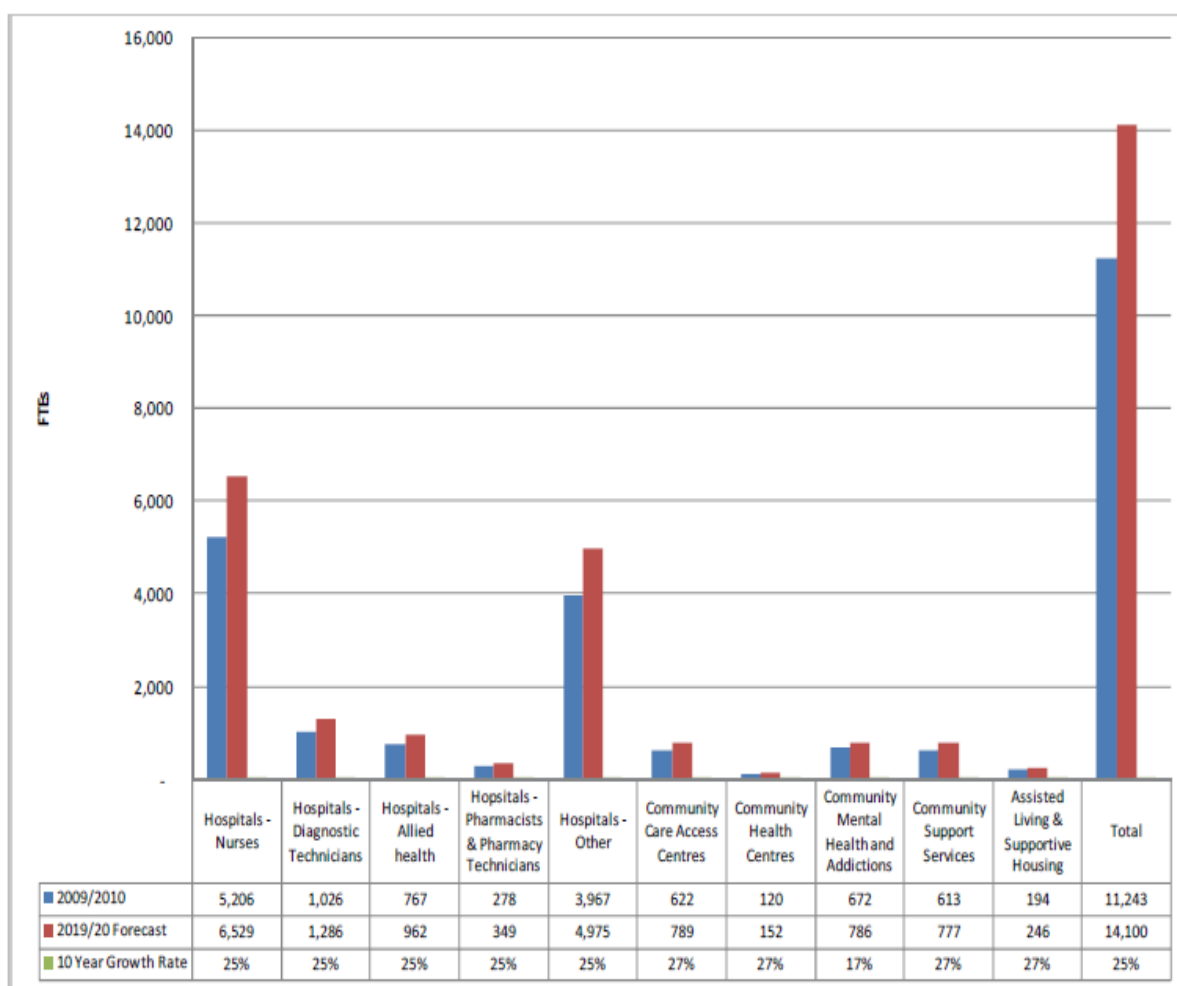
intake; and the continued implementation of client care assessment and health care records tools, such as the Resident Assessment Instrument – Community Health (RAI-CH) and Integrated Assessment Repository.

HEALTH HUMAN RESOURCES

Non-Physician Health Human Resources

The Sustainability Access Study provided a 10 year forecast in human resources across sectors. Overall, Central East LHIN required health human resources are forecasted to increase by 3,000 full time equivalents over the next 10 years. Most of the growth resides in nursing and undesigned human resources in hospitals as shown by the graph below.

Human Resources 10 Year Forecast in the CE LHIN



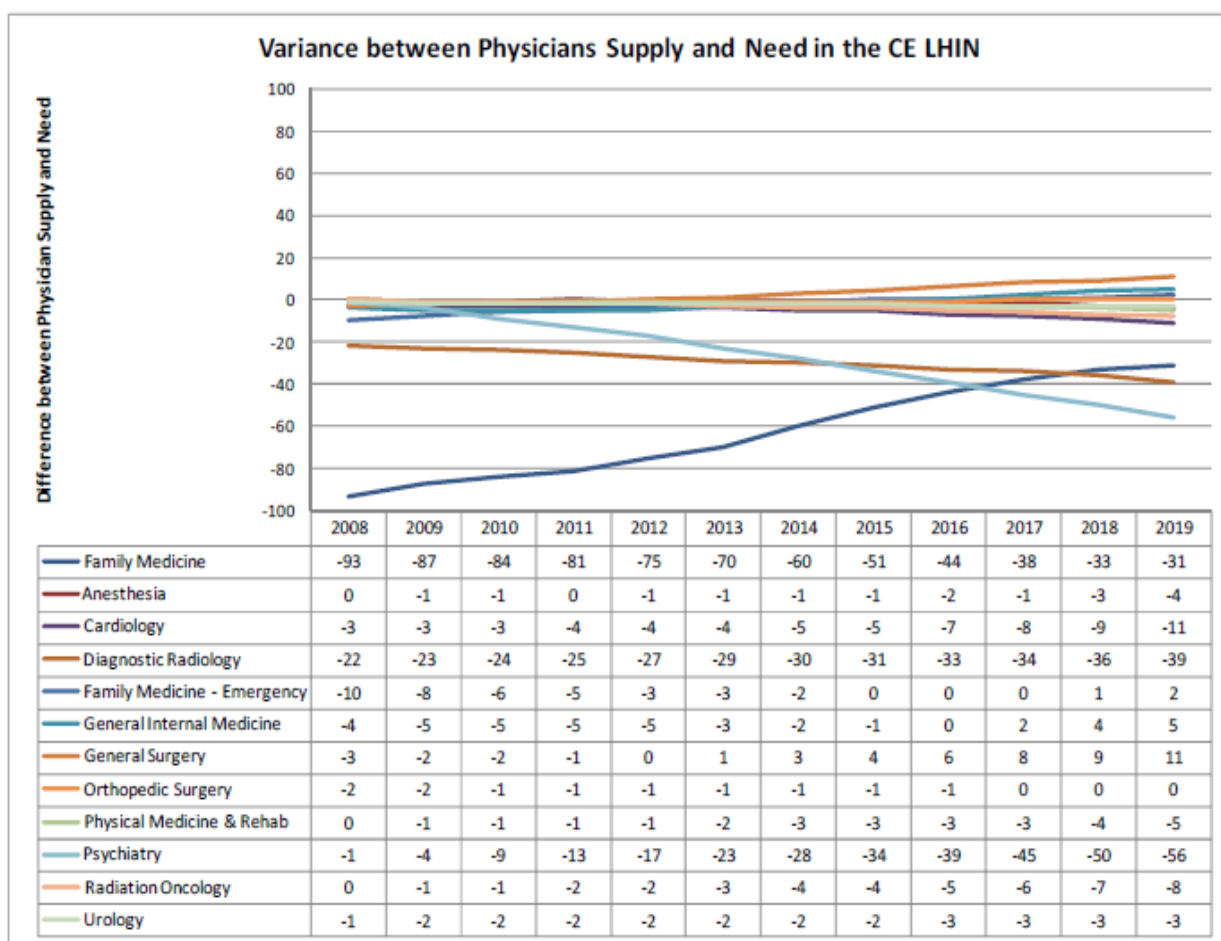
The Central East LHIN will face specific challenges in recruiting new specialized health human resources to support key initiatives, such as the **Behavioural Support Ontario** and new nursing positions supporting the **Expanded Role for CCAC**.

Physician Health Human Resources

The low level of access to family physician services in the Central East LHIN was corroborated by both the Sustainable Access Study and the Ontario Health Force October 2010 report entitled, "Ontario

Population Needs-Based Physician Simulation Model”. The results in the graph below arise from their models of supply and need. Physician supply estimates incorporate factors such as the expected number of graduating physicians, migration from and within Ontario, retirement, and productivity. The estimates of need for physicians incorporate factors such as population demographics, risk factors, disease incidence and prevalence. The Central East LHIN will face a growing shortage in psychiatry and diagnostic radiology physicians over the next 10 years. The shortage in family medicine physicians is forecast to get smaller but remain substantial.

Variance between Physicians Supply and Need in the CE LHIN



Mitigation

- Supporting Primary Care Teams:** Many primary care health service providers in the Central East LHIN now have the ability to investigate new models of service delivery that enhance service outcomes and sustainability, for example:
 - Family Health Teams (FHTs) provide comprehensive and interdisciplinary care and are now in the following Central East LHIN communities: Scarborough (2); Ajax/Pickering (1); Cobourg and area (1); Port Perry (1); Campbellford (1); Haliburton (1); Peterborough (1); Fenelon Falls (1), and the City of Kawartha Lakes (1).
 - Satellite sites of these FHTs are currently in the following communities: Warkworth, Hastings, Bobcaygen, Minden, Wilberforce, Havelock and Brock Township. We anticipate that there will be additional satellite sites in the coming years.
- Succession Planning, Recruitment and Training:** HealthForceOntario Marketing & Recruitment Agency (HFO MRA) has developed a Succession Planning module in their Recruiter U virtual campus. Recruiter U provides basic planning tools that recruiters, communities, and

employers can utilize to assist with recruitment. HealthForceOntario Marketing & Recruitment Agency also offers best practice support and guidance through the Community Partnership Program, a regional program based in the 14 LHIN offices.

- The Ministry has implemented a number of interventions to assist with nurse, physician, and physician assistant supply (recruitment). Examples include: introduction of new health care roles (i.e. Physician Assistants), full implementation of HFO MRA, Health Care Connect, Family Health Teams, increased number of medical school seats, College of Physicians and Surgeons of Ontario Pathways, Agreement on Internal Trade, and new residency programs.
- The Central East LHIN continues to work with the Health Professionals Advisory Committee to seek advice on development of health human resource recruitment strategies.
- **Primary Care LHIN Lead:** The MOHLTC in partnership with LHINs has invited Primary Care Physicians to apply to become a Primary Care LHIN Lead in each of the 14 LHINs. The Primary Care Lead role will help ensure that the extensive resources and capabilities in the primary health care sector are fully utilized in an integrated fashion to ensure the efficient attainment of local health system priorities, while also providing strategic advice to the LHIN and the Province of Ontario in facilitating enhancements in the primary care sector.

CULTURE AND CHANGE MANAGEMENT

Political and culture readiness and acceptance of on-going health system change, specifically as it relates to greater integration of services and health service providers is required to meet local demand, system performance, available resources and system sustainability.

Mitigation

- The Central East LHIN organization, at all levels, including governance, senior management and staff promote, support and reward system culture change that improves outcomes for patients and residents and also generate better value for money for the public's investment in their health care system. This culture is supported through effective communication and community engagement strategies, strong reliance on performance and measurement systems, the provision of the application of leading evidence and intelligence on systems design, quality improvement and population health, and the offering of tools and educational opportunities that support integration, project management and governance skills across the Central East LHIN.

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

Integrated Health Services Plan (IHSP) Priority Description

WHY IS THIS IMPORTANT?

Save 1 Million Hours of Time Patients Spend in Central East Local Health Integration Network (LHIN) Emergency Departments (ED) by 2013.

Saving one million hours of time patients spend in Central East LHIN ED aligns with the Ministry of Health and Long-Term Care (MOHLTC or the Ministry) priority of decreasing time patients spend in the ED. Saving one million hours is continuing to be accomplished by reducing the number of visits people make to the ED (reducing ED demand), improving the flow within the ED (improving ED 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 alternate levels of care (ALC) and improving bed utilization). Saving time spent by patients in Central East LHIN EDs will result in increased access to services, patient satisfaction, and service efficiency, while decreasing health burden on individual and health care costs.

HOW IS SUCCESS BEING MEASURED?

Success is being measured according to the government's ED wait time targets. These measures include:

- 90th Percentile Emergency Room (ER) Length of Stay for Admitted Patients
- 90th Percentile ER Length of Stay for Non-Admitted Complex Patients
- 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated Patients
- Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions
- Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions

The current performance trend, not including more recent improvements, is that by fiscal year 2013/2014 652,149 hours will be saved.

Current Status

Throughout 2011/2012, the Central East LHIN has engaged its health service providers (HSPs) to enlist their support in aligning their respective organizational directions with that of the LHIN. Communication has been clear and consistent: all LHIN-funded organizations have a role to play in collectively achieving, and ultimately exceeding, the targets established in relation to Ministry LHIN Performance Agreement (MLPA) indicators and by association, the two strategic aims. Engagement has occurred at both the governance and senior leadership levels of the organizations. In addition, all previously funded and newly funded projects through various LHIN funding streams must align deliverables to one or both of the strategic aims. Specific outcomes related to these deliverables are embedded within the service accountability agreements that the Central East LHIN has with its health service providers.

TARGET POPULATIONS

Focus is being placed on the targeted populations that have the highest risk for unscheduled visits to the Emergency Department utilization. Specifically, these target populations include:

- Persons with a mental health illness and/or substance abuse who are in crisis;
- At-risk, frail elders residing at home, including Long-Term Care (LTC);
- At-risk elders who have been hospitalized and require on-going specialized support; and
- Persons experiencing an acute episode resulting from an underlying chronic condition (e.g., diabetes, heart disease).

The first three of the above targeted populations are the focus of this section. The chronic disease population is covered in the next section, Reducing the Impact of Vascular Disease.

COMMUNITY ENGAGEMENT AND LEADERSHIP

Transitions in Care Steering Committee

Patients and clients do not access our health care system in a linear fashion. Rather, patients and clients generally tend to move in and out of different parts of the system based on their needs. No matter how efficient and effective the care has been in one part of the system, if the areas where there are “hand offs” of care between providers that are not functioning well, there will be significant potential for adverse events, errors, rework, even mortality. Poorly designed discharge practices, lack of information sharing and lack of awareness of the relationships between the “cogs” of the system all contribute to poor outcomes- be it for the individual and/or the health care the system as a whole.

The results of sub-optimal patient flow across the health system continuum are often felt in hospital emergency department utilization and wait times. Improving wait times and access in the emergency department requires a coordinated effort within an individual hospital – *and* across the broader health system.

The Central East LHIN Transitions in Care Steering Committee was established in Q4 2011/2012 and tasked with overseeing the full spectrum of quality improvement and/or business process initiatives designed to directly improve transitions in the patient/client/resident journey through the health care system. Its purpose and work are aligned with provincial level initiatives and Central East LHIN priorities. Strategic guidance is provided by the Executive Sponsor, a member of the Central East LHIN Senior Team.

The Central East LHIN Transitions in Care Steering Committee is a critical body at the pinnacle of a new and evolving strategic structure within the LHIN aimed at improving overall quality of care through better transition management of people and information by their care team. The intent is to provide improved cohesion of the following initiatives: Home First, Resource Matching and Referral (RM&R), and LHIN-wide information management projects (e.g. Community Care Information Management).

STRATEGIES AND PROGRAMS

The Central East LHIN has undertaken three direct approaches to achieve this strategic aim and MLPA targets:

1. Approach #1: Reducing ED Demand, Including Reducing Avoidable Hospital Readmission or Return Visits to the ED
2. Approach #2: Improving ED Capacity and Performance; and
3. Approach #3: Improving Hospital Bed Utilization, Including Reducing ALC Days.

The Central East LHIN has targeted specific initiatives in each of the above areas as noted in the following text. However, many other projects impacting this aim are embedded throughout various sections of the Annual Business Plan.

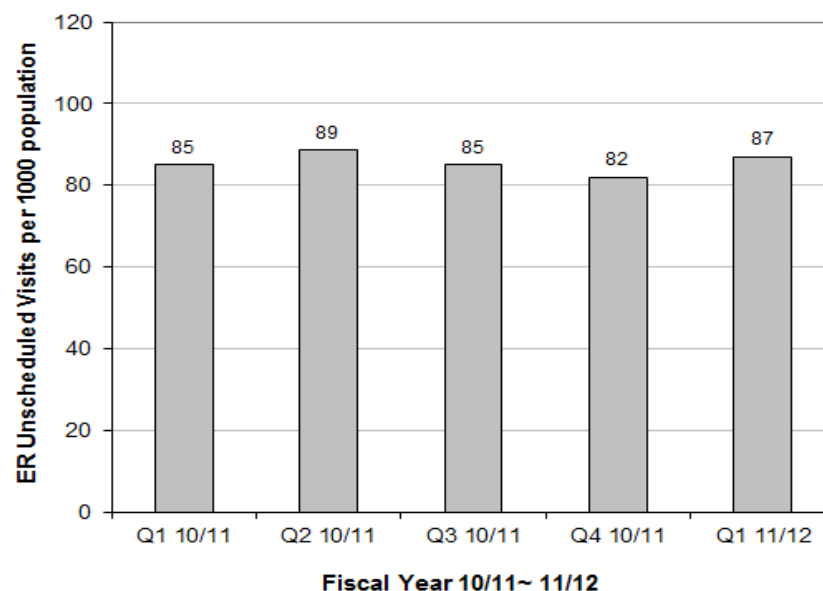
CURRENT ENVIRONMENT

Approach #1: Reducing ED Demand, including Readmissions

The total number of ED visits in the Central East LHIN between April 1, 2010 and March 31, 2011 was 493,589; an increase of approximately 33,550 visits over 2008/2009 and of approximately 19,960 visits over 2009/2010.

	Fiscal Year 2009				Fiscal Year 2010				Fiscal Year 2011 (YTD)	
Unscheduled Visits	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
High Acuity	72,360	71,594	72,771	69,728	73,423	75,954	78,126	77,698	79,462	81,549
Low Acuity	46,740	48,203	48,916	43,333	48,533	49,797	46,035	44,023	47,085	50,349
Quarterly Totals	119,100	119,797	121,687	113,061	121,956	125,751	124,161	121,721	126,547	131,898
Annual Totals	473,645				493,589					

In fiscal year 2010/2011, the number of ED unscheduled visits per 1,000 population for Central East LHIN increased from 86 in Q1 to 89 in Q2 and then dropped to 85 in Q3 and 82 for Q4. These numbers are consistently lower than the provincial numbers, but follow the same trend (provincial visits per 1,000 population were 100, 103, 98, and 98 for the same periods).

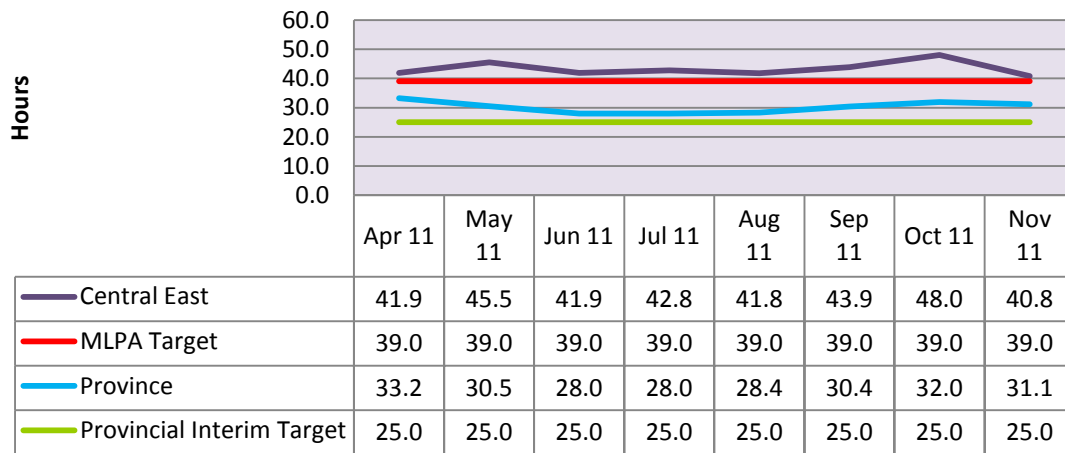


To reduce emergency department demand, the Central East LHIN is focused on decreasing the number of visits to the ED by patients with non-urgent or less urgent needs sometimes referred to as “avoidable visits.” In many cases, the type and level of care required by these patients could have been delayed or even referred to other areas of the health care system. The Central East LHIN is also investing in specialized services/programs to support the ED to improve flow and the care of specific populations including frail and individuals with mental health needs through ED avoidance

Approach #2: Improving ED Capacity and Performance

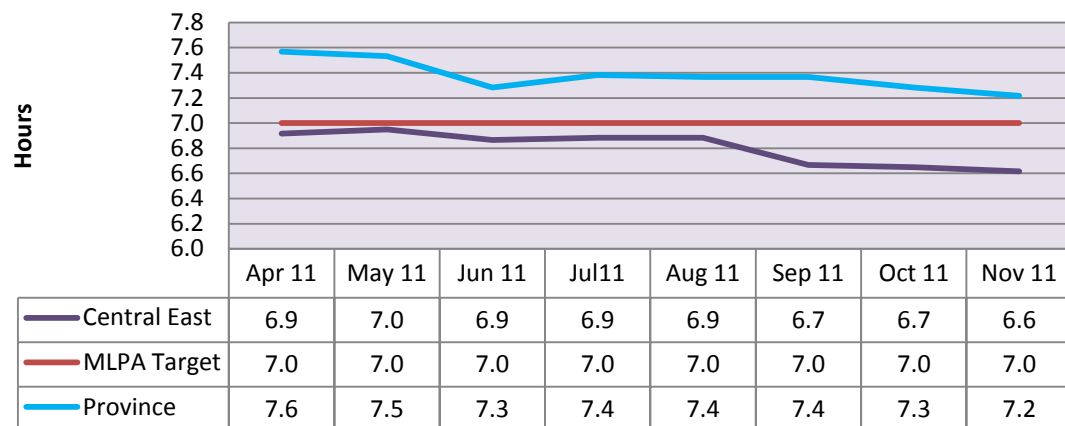
The graphs below show LHIN-wide performance in publicly-reported emergency department length of stay indicators:

90th Percentile ED Length of Stay--Admitted Patients



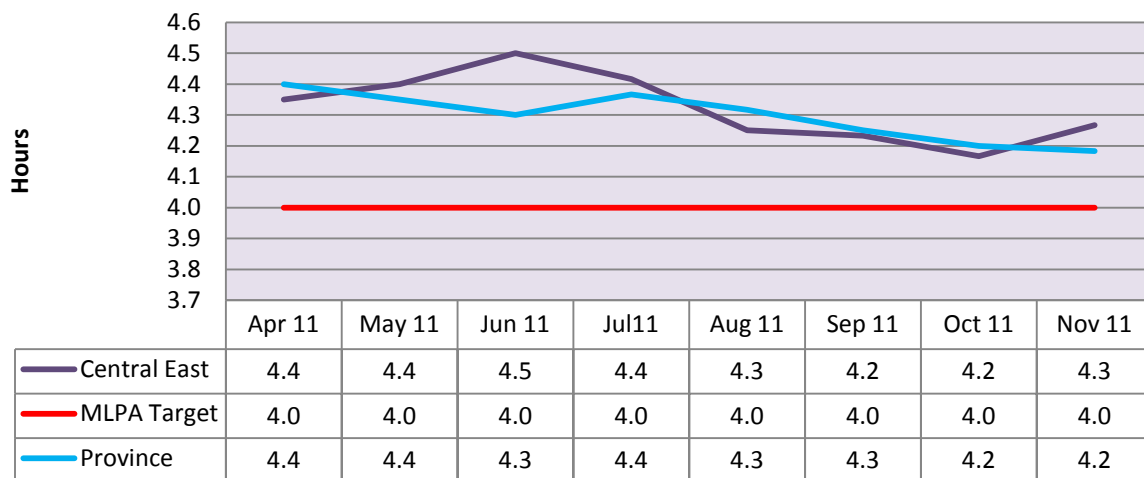
90th percentile length of stay in the ED for admitted patients has been longer than the provincial and LHIN targets for every month so far in 2011/2012. However, in November 2011, performance was only 108 minutes longer than target, and the LHIN is expected to achieve its target in Q4.

90th Percentile ED Length of Stay--Non-Admitted High Acuity Patients



90th percentile length of stay in the Emergency Department for non-admitted high acuity patients was shorter than the Central East LHIN fiscal year 2011 target and the provincial standard of 7.0 hours in all months.

90th Percentile ED Length of Stay--Non-Admitted Low Acuity Patients



90th percentile length of stay in the Emergency Department for non-admitted low acuity patients exceeded the Central East LHIN 2011/2012 target and the provincial standard of 7.0 hours in all months.

Approach #3: Improving hospital bed utilization, including reducing Alternate Level of Care Days

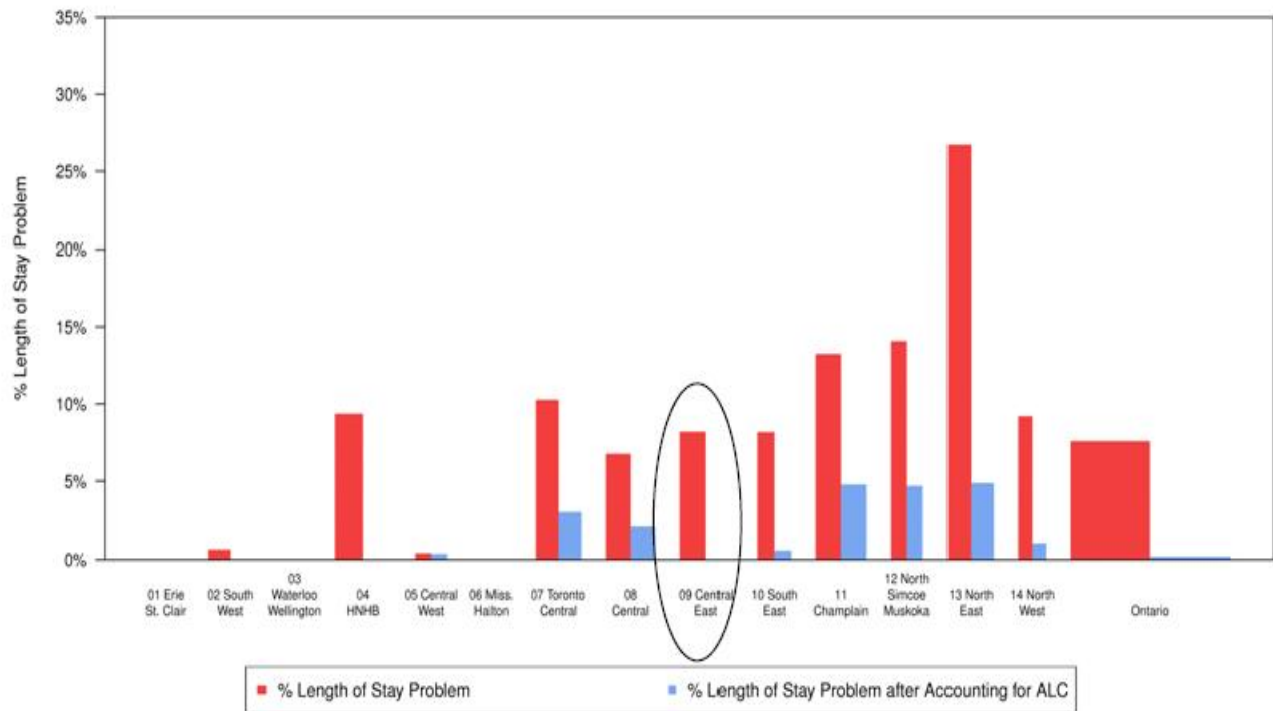
A significant means to reduced Emergency Department wait times, specifically for patients needing to be admitted to a hospital, is by maximizing the use of existing hospital beds. This means:

- Admitting only those patients into a hospital bed as required.
- Exploring other safe and effective methods, technologies and places of care that do not require a hospital stay, such as outpatient clinics and new surgical methods), and can safely shorten the length of stay.
- Ensuring proper patient flow both in and out of the hospital by reducing inefficient practices, and providing access to services, such as home care.

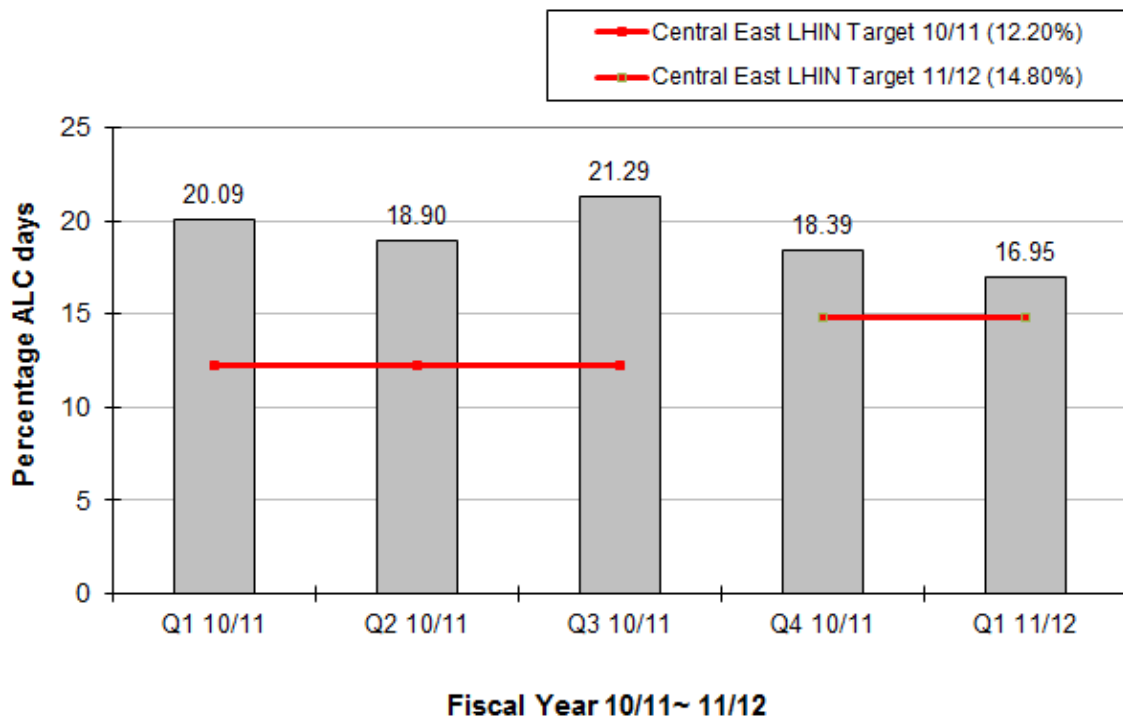
There are many initiatives within this Annual Business Plan that improve hospital bed utilization, such as quality improvement initiatives for patients receiving hip or knee replacements. This section is focused on the biggest barrier to improved bed utilization, ALC. Alternate level of care is defined as when a patient is occupying a bed in a hospital and no longer requires the intensity of resources/services provided in that particular care setting. This determination is made by the physician or his or her designate. Alternate level of care designation generally occurs after the hospital stay associated with the patient's presenting problem has been addressed, but barriers exist that prevent the patient from being discharged to the environment from which they entered the hospital.

The Sustainable Access Study found that length of stay in Central East LHIN hospitals is driven almost entirely by ALC days. As the graph below illustrates, after removing ALC days from hospital patient length of stay, the hospitals in the Central East LHIN are very efficient.

Percent Length of Stay Problem After Removing ALC, 2009/10 Data



The Central East LHIN ALC percent rate has decreased from 18.39% in Q4 2010/2011 to 16.95% in Q1 2011/2012. However, it remains above the provincial target of 9.46% and the LHIN target of 14.80%. During the same period, provincial performance decreased from 17.50% to 14.40%.



Using ALC percent as an indicator presents some challenges as it is retrospective (calculated on discharge) and focuses only on ALC in acute inpatient beds. As such, while it is a good indicator of patient experience, it is not a good indicator of system, corporation, or site-level performance. The Community Care Access Centre has indicated that the definition of this indicator may change in the next fiscal year to reflect all cases occupying inpatient beds in a given period. This change will reflect actual performance more accurately, and will allow hospitals and LHINs to make strategic decisions regarding future interventions.

In 2011/2012, the Central East LHIN included volume of ALC to LTC designated patients as a Health Service Accountability Agreement (HSAA) indicator, in order to track actual impact of ALC on inpatient capacity. In 2012/2013, the Central East LHIN is proposing a new and alternative performance measure for ALC that focuses on improving the creation and discharge of ALC cases. The new indicator being proposed is the ALC 'Throughput Ratio'. This indicator measures the ratio of newly designated ALC patients to the number of ALC designated patients discharged in a given period. A Throughput Ratio of 1 means that these numbers are the same—that as many ALC patients were created as were discharged. A Throughput Ratio above 1 means that more ALC patients were discharged than were designated and a throughput ratio below 1 means that more ALC patients were newly designated than were discharged.

For the 2012/2015 HSAA, the ALC throughput ratio will include all ALC designated patients, regardless of destination, and regardless of the bed type they are occupying. The performance period for the HSAA will be the entire fiscal year, with the actual throughput ratio for the entire year from 1 April through 31 March being used as each hospital's final performance. Monthly and year-to-date performance will be provided in the monthly hospital scorecards sent from the LHIN to the hospitals. Throughput ratio targets will occupy a corridor between 1.0% and 1.2% for all hospitals. Hospitals with a high baseline volume of ALC-designated patients will have a higher throughput ratio target, in order to drive reduction of total ALC.

Goals

CENTRAL EAST LHIN IHSP AIM:

Save 1 Million Hours of Time Patients Spend in Central East LHIN Emergency Departments (ED) by 2013.

Indicator	2011/2012 Baseline	2011/2012 Final Central East LHIN Target
90th Percentile ER length of stay for admitted patients	51.62%	39%
90th percentile ER length of stay for non-admitted complex patients	7.4%	7%
90th percentile ER length of stay for non-admitted minor/ uncomplicated patients	4.5%	4%
Percentage of ALC days	20.22%	14.80%
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions	17.50%	16.60%
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions	19.6%	19.00%
90th Percentile Wait Time from Community for CCAC In-Home Services – Application from Community Setting to first CCAC Service (excluding case management)	42%	39.9%

Consistency with Government Priorities

Reducing ED demand, improving ED wait times, and improving hospital utilization in the Central East LHIN contributes to the achievement of the MOHLTC's priorities of:

- Reducing ED wait times;
- Reducing overall ALC (avoidable admissions);
- Enhancing mental health services;

- Improving integration of mental health and substance abuse services; and
- Improving access to primary health care.

Action Plans/Interventions: Approach #1: Reducing ED demand, including reducing avoidable hospital readmissions or return visits to the ED

General

The **Health Care Connect** program (hosted locally by the Central East CCAC) was launched in February 2009 to support the placement or 'connection' of individuals without a primary care provider with a comprehensive primary care practice. According to the **2010 Primary Care Access in Ontario Report**, 93.9% of adults (age 16+) were attached to family doctors- an increase of 0.9% over the 2008 study. This translates into approximately 70,000 individuals aged 16+ who are without a regular primary care provider in Central East LHIN. As of October 31, 2011, 12,056 patients in the Central East LHIN have been referred to a primary care physician. Of those patients, approximately 73% live within 10 kilometers of their preferred primary care provider.

Persons with Mental Illness and/or and Substance Abuse

The Central East LHIN in conjunction with the Rouge Valley Health System has continued to support six new **Community Mental Health Crisis Beds** that were initially funded in 2009/2010 through the Pay-For-Results program. These six beds, located in close proximity to the Rouge Valley Health System Ajax site, provide crisis support to people dealing with a mental health issue, 24 hours per day, seven days per week. Community Crisis Beds provide support to people that can prevent an in-patient admission, reduce the amount of time that someone with a mental health issue spends in the ED, and may allow for earlier discharge from hospital. In addition, the Community Crisis Beds provide an alternative to the ED that people with mental health issues are able to access in the event of a future crisis. This reduces the rate of unscheduled return visits for people with mental health issues.

In the first year of operation (2009/2010), these beds had occupancies of 76% with an average length of stay of six days for 210 admissions. All discharges were either linked to new supports or reconnected with existing supports. In total, only seven referrals were made to hospital from the crisis beds. Ninety-seven percent of clients were discharged with a care plan (the remaining three percent were refusals).

There are clear outcomes and associated metrics tied to this initiative related to overall reduction of unscheduled visits to the ED for mental health issues. Rouge Valley Health System provides some of the operational funding from savings generated from their Psychiatric In-Patient Program.

In September of 2011, the Central East LHIN Board approved the **Hospital to Home ED Diversion Project** for both the Durham and Northeast Clusters. This revival of the "ED Avoidance Coalition, QI Project" is supported by annualized dollars and is bringing HSPs from both the community and hospitals together with the aim of reducing unscheduled return visits for both mental health and addictions issues at Lakeridge Oshawa, Ross Memorial Hospital and the Peterborough Regional Health Centre. The project is overseen by two local steering collaboratives and a systems based collaborative that ensure the sustainability and quality of the project. The aim is to reduce return visits for mental health and addictions by 10% by the end of fiscal year 2012/2013.

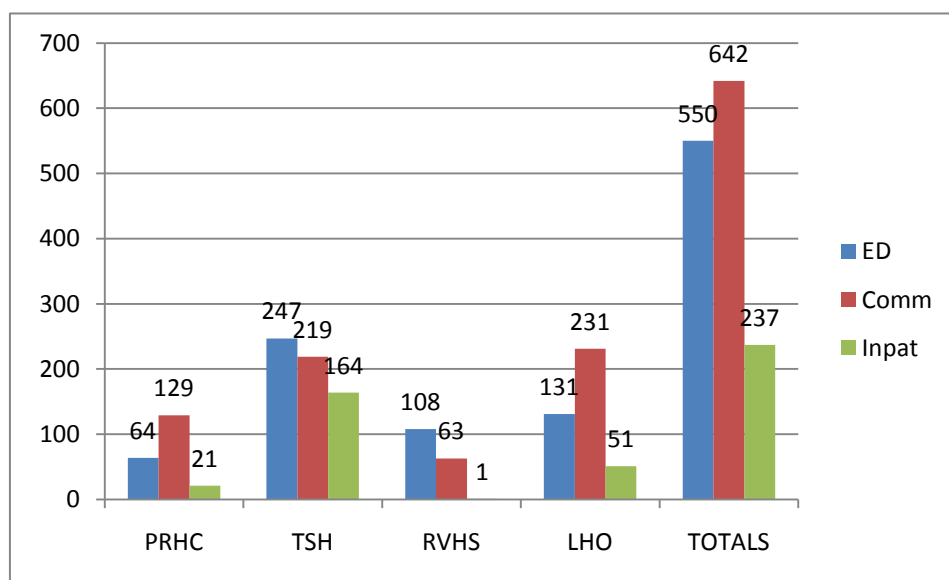
Assertive Community Treatment Teams (ACTT) have continued to provide service in all parts of the LHIN. Durham ACTT has considered ways in which they might work with community providers in order to create a more seamless continuum of service. In particular, the Rouge Valley Health System ACTT has partnered with Durham Mental Health to support those individuals appropriate for ACTT, living in Durham Mental Health housing. This has prompted discussions between the LHIN and the Chiefs of Psychiatry regarding a QI "Value Stream Mapping" exercise that will take place early in 2012. This process will identify opportunities to enhance client flow throughout the system, and consider opportunities to maximize the ACTT model in an effort to avoid repeat visits to the emergency department.

At Risk Seniors

The Central East LHIN has made specialized services for seniors its single largest investment area to date. In the summer of 2011, four new **specialized geriatric clinics** located within the four largest community hospitals in the LHIN became fully operational (The Scarborough Hospital, Rouge Valley Health System, Lakeridge Health, and Peterborough Regional Health Centre). These specialized clinics are being developed as part of ongoing efforts by the Central East LHIN to build an improved system of care for seniors within a regional geriatric framework. The **Geriatric Assessment and Intervention Network (GAIN)**, of which these clinics are the first component to be funded, is a “home grown” model that emphasizes coordinated specialized geriatric services. Each clinic is led by an interdisciplinary team specially trained for assessing, diagnosing and treating the frail elderly to enable, wherever possible, their continued ability to remain independent in the community. Each hospital with a clinic also has a dedicated “Acute Care of the Elderly” inpatient unit to accommodate individuals requiring admission directly from the clinic. Referrals to the clinics originate from the community, inpatient discharges and/or directly from the ED, thereby improving flow within the ED, reducing time spent in the ED as well as reducing ED demand by having direct community access.

Current data for the clinics is as of Q2 2011. Compared to Q1 2011, community assessment referrals increased from 687 to 742, an eight percent increase. Referrals from the emergency department decreased overall from Q1 to Q2 however community referrals increased markedly from 240 in Q1 to 402 in Q2. The table illustrates referral volumes by source (emergency department, inpatient hospital discharges, and community).

Year to Date Total Referrals by Referral Source and Clinic Location



As the table below indicates the total number of Comprehensive Geriatric Assessments (CGAs) have increased over 130% from Q1 to Q2. It is expected that the number of referrals, clients served and CGAs completed will continue to increase over the remainder of 2011/2012 and that each clinic will reach the projected 1,500 visits and 500 follow ups by March 31, 2013.

2011/2012 First Quarter Completed Comprehensive Geriatric Assessments

Site	CGAs			Follow Ups		
	Q1	Q2	YTD	Q1	Q2	YTD
PRHC	57	133	190	28	128	156
TSH	203	223	426	113	182	295
RVHS	79	90	169	32	71	103
LHO	192	188	380	161	67	228
TOTALS	531	634	1165	334	448	782

The Nurse Practitioner Outreach to Long-Term Care Program or **Nurse Practitioners Supporting Teams Averting Transfers** (NPSTAT) is an initiative that has been implemented across the Central East LHIN with the intention of decreasing the number of transfers to the emergency department from Long-Term Care Homes (LTCHs). The uptake has been so positive within the LTC sector that the demand could not be met and the program had to stop recruiting new homes into this program. Currently 41 LTCHs have a signed Memorandum of Understanding with NPSTAT out of a total of 70 LTCHs within Central East. In Q2 (fiscal year 2011/2012), the NPSTAT program had almost 1500 direct clinical encounters with LTC residents and diverted transfer to the ED 97.2% of the time. In the first two quarters of fiscal year 2011/2012 the NPSTAT program produced a virtual cost saving of over \$840,000 through diversion of emergency room visits.

The **Behavioural Supports Ontario (BSO)** Project was created to enhance services for Ontarians with behaviours associated with complex and challenging mental health, dementia or other neurological conditions wherever they live- at home, in LTCHs, or elsewhere. The goal of the project is system-wide reform that ensures these individuals are treated with dignity and respect in an environment that supports safety for all and is based on high quality and evidence-based care and practice. The provision of these services in LTCHs must comply with the requirements under the *Long-Term Care Homes Act, 2007* relating to, amongst others, plan of care and responsive behaviours.

Identified as one of four Early Adopter LHINs in 2011, the Central East LHIN developed an action plan articulating our local approach to serving a behaviourally complex population by directing new resources toward targeted service enhancement among selected health service providers. During the development of the action plan, the LHIN benefitted from quality improvement guidance from Health Quality Ontario, knowledge transfer and knowledge exchange resources provided by Alzheimer Knowledge Exchange and BSO knowledge transfer conferences.

The Central East LHIN believes it has a sound and results-oriented action plan that will result in positive changes for people requiring support with behavioural issues. The experts and frontline workers engaged in our Value Stream Mapping process, the BSO Advisory Committee and the BSO Design Team have discussed opportunities for improvement throughout the continuum of care from prevention and health promotion to tertiary treatment in all care settings.

As a result of the community engagement and quality improvement work undertaken, the Central East LHIN action plan includes the creation of the **Central East LHIN BSO Integrated Care Team**. This team will ensure timely access for seniors struggling with challenging behaviours, to a comprehensive basket of specialized psycho-geriatric services through an interdisciplinary team that works with a designated number of LTCHs.

The integrated BSO Care Team will function as in each of the service hubs identified and will be comprised of a number of professionals including: occupational therapists, physical therapists, behaviour therapists, physicians, nurse practitioners, psychogeriatric resource consultants, behavioural support nurses, and personal support workers. Although the BSO Integrated Care Team will be comprised of the professionals listed above, these staff will not be employed in a single agency but rather will collaborate to implement a comprehensive care plan and a standard education program for all members of the 'integrated' team. This will allow both clients and providers to benefit from the advantages of the new pathway of care as described in the Future State Value Stream Map.

It is expected that the behavioural supports for LTCH residents will include an acute care team from a local hospital; a nurse practitioner from NPSTAT; behavioural support nurses and personal support workers from LTC, and psycho-geriatric resource consultants from local agencies that provide education and training. These practitioners will be expected to form an accountable and unified team around clients within identified LTCHs and complete quality improvement projects to map out new patterns of care and collaboration that will meet the requirements of the future state. Specifically:

- Acute Care Team: provides outreach to LTC and in-hospital care when required. This team includes psycho-geriatricians, behavioural nurses, occupational therapists, physical therapists, and behaviour therapists.
- Nurse practitioners from NPSTAT: provide timely response to LTC to conduct assessments for residents with escalated behaviours and initiate medical care as appropriate.
- Behavioural support nurses and personal support workers: will provide dedicated in-house care over evening and weekend hours when possible and serve as an expert resource for education and capacity building opportunities.
- Psycho-geriatric resource consultants to provide expert input to care plans and education opportunities.

Although initiatives that have developed from previous Central East LHIN investments in seniors care – Geriatric Emergency Medicine (GEM) nurses, GAIN and activities related to the Home First philosophy - may not be formally represented on the BSO Care Team for LTC, some will be directly involved in the community model, and staff experienced with these initiatives will be valued members of the Improvement Teams. Similarly, existing experts in the community will be thoroughly integrated in the quality improvement team during the service redesign process for the BSO model in both LTC and the community.

To date, the Central East LHIN has: participated in coordinated planning efforts across the Province; identified 13 LTCHs who will receive BSO funding resources to hire designated behavioural support staff (\$2,727,300 annualized base funding for 20 registered nurses and registered practical nurses, 22.5 public support workers); proposed additional health care resources who will be hired to support the project (\$1,335,900 annualized base funding); held quality improvement events with the Integrated Care Team; developed both high level and detailed Improvement Plans; and distributed funding to the LTCHs.

The **Assisted Living Services for High Risk Seniors** project in the Central East LHIN addresses the needs of high risk seniors who can reside at home but require the availability of personal support, homemaking, security check and reassurance services on a 24 hour per day, seven days per week basis. This project is targeting high risk seniors whose needs cannot be met through home and community care services provided solely on a scheduled visitation basis. The Sustainable Access Study identified the need to focus on assisted living and supportive housing services. Included in the study was the finding that although Central East LHIN spent near the provincial average on seniors care across the continuum, approximately 60% less than the Ontario average was spent on assisted living services in supportive housing for seniors.

A majority of persons designated ALC are often waiting for the availability of a LTC bed for which provincial occupancy exceeds 99%. Many studies in the past have shown that about 20% to 30% of people on these waitlists can be well supported in the community provided that the essential homemaking and personal support services are readily available and sufficient. The objective for implementing assisted living services in the Central East LHIN is to create effective community-based assisted living services as a viable alternative to LTC for high risk seniors and make it possible for them to stay safely at home longer, thereby avoiding hospitalization and premature admission to a LTCH.

In 2011, the Central East LHIN board approved new community funding to support the expansion of Assisted Living Services for High Risk Seniors. An analysis of greatest need and opportunity was also conducted by the Central East LHIN with the support of the Central East CCAC. Two health service providers were chosen to implement the new program in a phased approach:

- Phase 1: Jan 2012 to July 2012: Community Care Durham is establishing the program in both **Oshawa** and **Whitby** Cluster with a service target of approximately 50 new units.
- Phase 2: Feb 2012 to Aug 2012: Victoria Order of Nurses is establishing the program in **Scarborough** (30 units), **North Durham** (30 units), **Peterborough** (30 units) and **Lakefield** (30 units).

Action Plans: “We will deliver the following”		Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
		2012/2013		2013/2014		2014/2015	
System Level	How Will Success be Measured/Impacted	Status	%	Status	%	Status	%
Community crisis supports for mental health clients: - Ongoing monitoring and evaluation of existing program to determine efficacy of spreading the initiative.	• Reduce avoidable admissions for patients who require crisis support, but do not require medical intervention, or involuntary admission. • Reduce return unscheduled visits to the ED within 30 days for people with mental health issues by ensuring patients receive follow up support, and case management where indicated. This will also establish the patient’s relationship with community crisis services and encourage their return to those services if necessary. • Reduce length of inpatient hospitalization for people with mental health and concurrent disorder issues by providing a community alternative to hospitalization. • Provide opportunities for reducing the rates of ALC for people with mental health and concurrent disorder issues. • Improve patient satisfaction and quality of care. • Reduce ED wait times modestly.	In Progress	45%	In Progress	20 %	Complete	0%

	Continue to evolve into 2013/2014 in order to effectively mitigate return visits to the ED for mental health and concurrent disorder issues.						
GAIN: - Full implementation of four GAIN Clinics. - Health human resource plan for clinics. - First full year of operation of this LHIN regional program. - Mechanisms established to enable access to clinic expertise beyond the four sites. - Ongoing monitoring and evaluation.	- Support four geriatric clinics operating at capacity. - Reduce avoidable admissions for patients able to be seen in the geriatric clinics and through this, have an indirect impact on reducing ALC. - Reduce percent ALC by admitting, when necessary, directly to Acute Care of the Elderly Unit. - Improve patient satisfaction and quality of care. - Reduce ED wait times modestly.	In Progress	25%	Complete	0%	Complete	0%
NPSTAT: - Maximize capacity of the NPSTAT teams by increased numbers of enrolled LTCHs. - Pursue expansion funding to eventually realize 100% of LTCH enrollment. - Enhance system coordination with BSO Program, GAIN, GEM nurses aligned with the Regional Specialized Geriatric Service program as it evolves. - Ongoing program monitoring and evaluation.	- Avert 3600 ED visits and save 18000 hours in Central East LHIN EDs. - Decrease the number of admissions and in-patient hospital days by LTCH residents. - Decrease ED length of stay by expediting return to LTCH in collaboration with GEM nurse and LTCH nursing staff. - Decrease the volume of ALC days modestly by expediting return to LTCH. - Improve patient experience and satisfaction by avoiding transfer to hospital or reducing time spent in hospital.	In Progress	20%	In Progress	15 %	Complete	0 %

BSO Program • Behavioural support nurses and PSWs: will provide dedicated in-home care to all 70 LTCHs in Central East LHIN (including over evening and weekend hours when possible) and serve as an expert resource for education and capacity building opportunities. • Acute Care Team component of BSO provides both outreach to LTC and in-hospital care when required. • Nurse practitioners from NPSTAT provide timely response to LTC to conduct assessments for residents with escalated behaviours and initiate medical care as appropriate. • Psycho-geriatric resource consultants to provide expert input to care plans and educational opportunities and ongoing program monitoring and evaluation.	• Decrease transfers to ED for LTCH patients with behavioural issues. • Decrease the number of admissions and in-patient hospital days by LTCH residents for behavioural issues. • Decrease the number of admissions and in-patient hospital days by LTCH residents for behavioural issues.	In Progress	44%	In Progress	34 %	Complete	0 %	
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What are the risks/barriers to successful implementation?

Change Management

- Health service provider stakeholder resistance to change; lack of stakeholder commitment/confidence
 - Multi-stakeholder projects take time to build and foster relationships and projects have to move forward at a rapid rate
- Client perception of need (i.e. perception that only the ED is able to meet their needs)
- Need to develop more effective working relationships and referral patterns between hospital and community providers

Resources and Work Flow

- Limited human resources and lack of appropriately trained staff – increasing demand for nurse practitioners with a limited supply of experienced nurse practitioners and new graduates
- Funding availability/sustainability for community services provided by the CCAC and CSS agencies

Policy/Legislative

- LHINs will need to work within the operational and funding policy for the LTC Sector while enabling cross-sector collaboration on the BSO initiative

What are some of the key enablers that would allow us to achieve our goal?

- Continued improvement of decision support and quality improvement capacity within the health system
- Implementation of common assessment tools and information technology that will support patient care across the continuum
- Continued support from Health Quality Ontario in leading quality improvement processes for the BSO project and in training quality improvement facilitators/advisors will be a key enabler of success
- Collaboration of physicians, administrators and professional staff in all health sectors, from the emergency department, hospital inpatient units, LTCHs and community programs
- Continued implementation of eHealth projects including:
 - **The Connecting GTA** Project which works with the five Greater Toronto Area (GTA) LHINs to “integrate electronic patient information from across the care continuum and make it available at the point-of-care to improve the patient and clinician experience”. Connecting GTA will provide better access to information for up to 700+ health care organizations resulting in better care delivery for 5.8 Million GTA residents
 - **The Timely Discharge Information System (TDIS)** Project which ensures family doctors and other community physicians receive information concerning a patient’s hospital stay within 72 hours of transcription.

Action Plans/Interventions: Approach #2: Improving ED Capacity and Performance

General

The Central East LHIN feels strongly that the leadership of physicians is critical to ensure sustainable change within the system. A concerted effort is made to incorporate physician input into processes and in fact, many LHIN initiatives have physicians as leads, sponsors and/or engaged participants. The **ED LHIN Lead** is a local ED physician leader who convenes and co-chairs bi-monthly meetings of all Chiefs of EDs in the LHIN and also represents the LHIN on the Provincial ED LHIN Leads group. Joint meetings between the ED LHIN Lead and the LHIN Senior Team occur quarterly.

To improve emergency department 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. Every Central East LHIN hospital has participated at some level in the **ED Process Improvement Program (ED-PIP)**. The Scarborough Hospital, General Campus, participated in the full program in Wave 2 (2008/2009). In Wave 3 (2009/2010), four Central East LHIN sites participated in the full program (Northumberland Hills Hospital, Peterborough Regional Health Centre, Ross Memorial Hospital, and The

Scarborough Hospital - Birchmount Campus). Remaining sites participated as “light touch,” which meant that they attended provincial forums, but did not have dedicated internal staff assigned to the program or coaches provided by the Ministry. Wave 4 of ED-PIP was the final wave offered by MOHLTC. Lakeridge Health Bowmanville, Lakeridge Health Oshawa, Rouge Valley Ajax/Pickering and Rouge Valley Centenary all participated fully in this Wave, which culminated in December 2011. The program has contributed to improved performance at all sites, and has provided every hospital in the LHIN with the Daily Access Reporting Tool (DART), which gives hospital senior management and front-line staff an easily and quickly read visual display of the previous day's, week's, and month's performance on a large number of ED and ALC indicators. The Emergency Department Performance Improvement Program has also contributed to the full adoption of LEAN methodology at all hospitals, and has supported the development of front-line staff into project leaders.

In 2011/2012, nine hospital sites in the Central East LHIN remained designated as eligible to participate in the Pay-for-Results program. Conditions of fixed Pay-for-Results funding require all designated hospital sites to achieve an aggregate reduction in 90th percentile ED Length of Stay across three patient categories. The amount by which each site must reduce this time varies depending on fiscal year 2010/2011 baseline performance. Although the MOHLTC Pay-for-Results program does not require patient stream-specific reductions, the Central East LHIN has established each hospital's HSAA target as the Pay-for Results target¹. Achievement of the HSAA targets will result in achievement of the Pay-for-Results aggregate targets for eight of the nine designated sites.

Year-to-date (October 2011) performance for the nine designated hospitals against their HSAA targets is as follows:

Site	Admitted 90th Percentile Time (interim provincial target 25 hours)			Non-Admitted High Acuity 90th Percentile Time (provincial target seven hours)			Non-Admitted Low Acuity 90th Percentile Time (provincial target four hours)		
	Fiscal Year 2010 Baselin e	HSAA Targe t	YTD Performanc e	Fiscal Year 2010 Baselin e	HSAA Targe t	YTD Performanc e	Fiscal Year 2010 Baselin e	HSAA Targe t	YTD Performanc e
LHB	38.83	34.42	27.42	6.05	6.05	5.45	3.92	3.92	3.48
LHO	80.10	61.45	77.22	6.82	6.60	7.18	4.48	4.00	5.00
NHH*	14.02	14.02	18.98	5.88	5.88	6.20	4.23	4.00	4.58
PRH C	41.52	38.43	35.15	7.80	7.60	7.78	4.40	4.00	4.33
RMH	45.70	37.38	29.25	6.72	6.72	6.72	3.92	3.92	4.25
RVA P	77.60	56.41	74.00	6.05	6.05	5.77	4.17	4.00	3.83
RVC	50.82	42.75	37.30	6.62	6.62	6.63	4.78	4.00	4.28
TSB	30.03	26.78	27.03	8.32	7.49	6.88	4.92	4.00	4.38
TSG	40.53	34.46	27.95	8.28	7.46	7.27	5.20	4.00	4.53
Legend :	Baseline above provincial target								
	Baseline below provincial target								
	YTD performance meeting HSAA target								
	YTD performance improving, but not yet at HSAA target								
	YTD performance longer than previous year's baseline								

¹ Northumberland Hill Hospital is the exception to this practice, as its baseline performance in the admitted category was below the interim provincial target of 25 hours. NHH was assigned a P4R target in this category of 10 percent reduction over baseline, or 12.62 hours.

*Note that NHH performance for patients admitted to an inpatient bed, although increased over last year's baseline, remains the lowest of the group, and below the interim provincial target of 25 hours, but still above the provincial standard of eight hours.

Each designated Pay-for-Results site is also required to achieve a 10% reduction in the time to physician initial assessment at the 90th percentile. Year to date (October 2011) hospital performance in this indicator is as follows:

Site	Hours to PIA		
	Fiscal Year 2010 Baseline	Target	YTD
LHB	2.7	2.4	2.5
LHO	3.1	2.7	3.3
NHH	3.6	3.3	3.8
PRHC	3.7	3.3	3.6
RMH	2.9	2.6	3.1
RVAP	2.7	2.4	2.5
RVC	3.5	3.1	3.0
TSB	3.4	3.1	3.1
TSG	4.3	3.9	4.1

Legend	YTD performance meeting target
	YTD performance improving, but not yet at target
	YTD performance longer than previous year's baseline

Through the implementation of Home First (See page 35) across the Central East LHIN in 2010/2011, the Central East CCAC is ensuring that there is **case management support** located within each of the EDs across the LHIN. The CCAC case management staff work collaboratively with hospital emergency department staff to facilitate early identification of individuals that could be supported within the community thereby averting an admission. Additionally, Home First facilitates early engagement of the CCAC and CSS with admitted individuals to initiate proactive discharge planning with the ultimate goal being patient discharge home at the end of the necessary hospital stay. By ensuring that only appropriate patients are occupying inpatient beds, Home First business processes free up available space for patients awaiting admission from the ED. Thus, these measures are expected, indirectly, to shorten the length of stay for admitted patients in all Central East hospital emergency departments.

Through the Pay-for-Results program the LHIN has funded 10 new "**short stay**" beds at Rouge Valley Ajax and Pickering Hospital, with the expectation that this expansion of medical inpatient capacity will have a significant impact on ED length of stay for admitted patients at that site. These beds became operational in January 2012, and are expected to continue to operate in 2012/2013.

Action Plans: “We will deliver the following”		Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
System Level	How Will Success be Measured/Impacted	2012/2013		2013/2014		2014/2015	
		Status	%	Status	%	Status	%
ED PIP - Implement Wave 4 of the ED-PIP across remaining eligible Central East LHIN hospitals - Support sustainability of the program	- Improve patient flow in the ED and across the hospital. - Increase capacity of hospital staff to implement and sustain a quality improvement agenda. - Positively affect all the ED length of stay metrics	Complete	0 %	Complete	0 %	Complete	0 %

What are the risks/barriers to successful implementation?

Change Management

- Stakeholder (physicians, nursing staff, hospital administration) resistance to change
- Family demands
- Lack of stakeholder commitment/confidence
- Ongoing sustainability

Resources and Workflow

- Limited human resources and lack of appropriately trained staff
- Increasing demand for skilled staff with gerontology/geriatric training
- Increasing demand for staff with formal quality improvement training
- Funding availability/sustainability for programs

Policy/Legislative

- None

What are some of the key enablers that would allow us to achieve our goal?

- Clear alignment between desired outcomes and metrics
- Acknowledgment that substantial organizational change is accomplished over multiple years
- Ongoing engagement with Emergency Management Services leadership from across the Central East LHIN to identify barriers and opportunities to improve ED capacity and performance

Action Plans/Interventions: Approach #3: Improving Hospital Bed Utilization, Including Reducing ALC Days

General

To improve hospital bed utilization, the Central East LHIN has focused on moving patients through the hospital to the most appropriate community care setting using initiatives, such as Home First and RM&R. While many of these initiatives were started prior to 2012/2013, the upcoming fiscal year will focus on weaving together these improvements under a single and cohesive governance and project management structure called the **Transitions In Care Steering Committee** (See page 18).

Home First was rolled out across the LHIN between September 2010 and April 2011, and all hospitals remain engaged in regular sustainability activities in conjunction with the CCAC and with community service providers. The Central East CCAC is the lead of this initiative, working closely with each hospital and associated community support service agencies. The intent of Home First is to facilitate, wherever possible, the timely and safe return home of every individual who enters the hospital. This involves early engagement of the CCAC and of community care organizations with patients, especially when there is a risk of delayed discharge identified. With the mandate of being the “system navigator” the CCAC, works collaboratively with the family, the physician and community support services to establish a plan of care. The Central East LHIN and Ministry funding has enabled the Home First initiative to provide enhanced service levels in the community of both CCAC and community supports, for a defined timeframe, to enable patients to transition to living at home immediately upon the completion of their acute length of stay. Additionally, those at a transition point in their lives can now be supported in the community to make necessary decisions about future housing and care needs, as opposed to making these critical decisions in the unfamiliar environment of an acute care stay in hospital. Extensive education and training is undertaken with staff and physicians to support a culture change that will realize a sustained reduction in ALC designations.

In support of the LHIN's ED/ALC initiatives like Home First, the MOHLTC provided the Central East LHIN with \$11,103,100 in three year cumulative base funding for 2010/2011 to support an increase in **CCAC service maximums** for home care (personal support and homemaking services). This allocation targeted persons with high levels of need to remain at home, or return safely home from hospital while they recover or wait for LTC placement. The Central East LHIN also allocated additional base funding of \$2,927,800 in 2011/2012 to Central East CCAC to maintain and enhance services especially for high-needs and complex clients.

As with past years, 2012/2013 will see continued attention on driving enhanced system performance through health service providers working better together. Specifically, efforts will continue to strengthen and solidify relationships among the hospitals, CCAC and CSS. Historically, the CSS sector, which relies extensively on volunteers, has been undervalued in the role it plays in enabling independence in the community. Through Home First, a true partnership is being forged to ensure proper “hand offs” of care and information are occurring between health care providers. The Central East LHIN has committed over \$1.2 Million in 2011/2012 and again in 2012/2013 to enable the removal of **barriers to discharge** that community support service agencies can fulfill. Additionally, funding has been allocated to recruit “**Supported Referral Coordinators**” to be located directly within the three Central East CCAC intake centres. This relatively small investment is yielding significant dividends in improving the number of referrals from CCAC to community support services and improved care coordination and knowledge transfer among sectors. Ultimately, the intent is to help facilitate hospital discharges, avoid ED visits and hospital admissions by appropriately and collectively supporting individuals in the community.

Local Health Integration Networks have unanimously demonstrated continued support for a provincial **RM&R** solution. A Resource Matching and Referral solution is an electronic information and referral system that automates and standardizes the referral process and matches patients/clients to the program or services that best meets their individual needs. On November 4th, 2010 the MOHLTC Health System Accountability and Performance Division's Implementation Branch selected the Toronto Central LHIN as the project sponsor for this provincial project. To date, all LHIN's have completed a Current State Assessment of their existing referral processes and two LHINs have progressed further by procuring (and implementing) an electronic RM&R solution.

The Resource Matching and Referral project purpose is to develop a model and implementation approach for the provincial ALC RM&R project, in a manner that is representative of, and with the best interests of, the Province of Ontario. As part of the Provincial Steering Committee discussions, the Committee drafted guiding principles for the project:

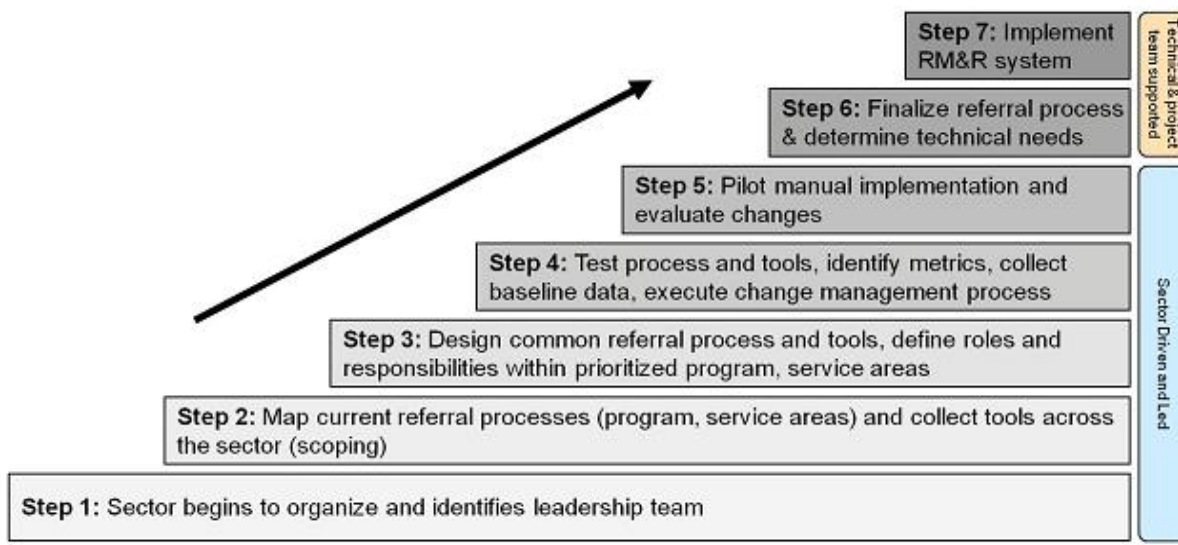
- Alternate levels of care RM&R is a sub-set of the overall RM&R solution, currently being rolled out across the Province to standardize tools and terminology used for four pathways:
 1. Acute to LTC
 2. Acute to Home with CCAC
 3. Acute to Complex Continuing Care
 4. Acute to Rehab

For the roll-out of ALC RM&R, the Province has been divided into three Clusters, with Central East included in Cluster 2:

	Cluster 1	Cluster 2	Cluster 3
Lead LHIN	ESC	TC	Champlain
Cluster Delivery Lead		UHN	
Cluster LHIN's	SW WW HNHB	CW MH Central CE NSM	SE NE NW

Each Cluster is working through a seven-step model developed by the Toronto Central LHIN:

Resource Matching & Referral 7-Step Model



In 2009/2010, steps 1 and 2 took place in the Central East LHIN. These steps included centrally held Fuzion sessions with representation from multiple stakeholders. These sessions generated high-level baseline information on current processes and tools. However, there have been substantial changes, refinements and standardizations in the processes for the first two pathways since the original Fuzion sessions, largely as a result of the Home First roll-out across the LHIN.

In order to capture the current state processes, future state and a gaps analysis for the Complex Continuing Care and rehabilitation pathways, the Central East LHIN, the Central East CCAC and all hospitals engaged in a quality improvement process in 2011/2012 to identify current and desired end-state for these patient pathways.

The implementation of the preferred future state for all of the patient pathways – specifically Step 4 to 7 in the above graphic – will continue in 2012 thereby improving both patient flow to the right level of care, and hospital bed utilization.

Through a Request for Proposal process, the Central East LHIN selected **Medworxx** as the successful vendor to deliver **Clinical Utilization Management** services to all Central East LHIN hospitals. The services provided include evidence-based, objective recommendation for admission or non-admission to an inpatient bed from the ED, evidence-based, objective recommendation for acute length of stay/estimated date of discharge for patients who are admitted, bed matching with available inpatient beds for admitted patients, a daily evaluation of the appropriateness of acute bed occupation for each admitted patient, evidence-based, objective recommendation for ALC designation for patients who are not discharged, and identification at a patient and unit level of barriers to discharge (community, hospital, and physician). Also included are a bed management system and interface with provincially mandated reporting systems, thus resulting in a single data entry at the frontline staff level.

The Medworxx solution has been implemented for over 20,000 beds across Canada, with several LHIN-wide and province-wide implementations. Sites that have implemented fully and successfully have reported a reduction in conservable bed days and improvement in patient flow.

The Central East LHIN is expecting to support a LHIN-wide, single-instance implementation with participation from all hospitals. The LHIN is considering taking advantage of end of year opportunities by funding the initial, one-time start-up costs and possibly a period of time for annual licensing fees for all participating hospitals.

At Risk Seniors

In 2011/2012, the Central East LHIN funded a total of 50 **transitional or restorative care beds** in hospital and LTC settings: 28 transitional care beds, seven interim LTC beds and 15 convalescent care beds. The Transitional Care Program Reporting System quarterly reports have indicated almost all clients have length of stay well within the 30 or 60 day targets. Of the 103 clients discharged from transitional care in Q2 fiscal year 2011/2012 81% were discharged home. The Central East LHIN has and will continue to fund four hospital-based **geriatric activation programs** where enhanced therapies are available on acute units to mobilize and activate the elderly patients, preventing de-conditioning and functional decline.

Action Plans: "We will deliver the following"		Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
		2012/2013		2013/2014		2014/2015	
System Level	How Will Success be Measured/Impacted	Status	%	Status	%	Status	%
Full implementation of Home First approach - Supported Referral Coordinators in CCAC Intake Offices. - Sustainability of Home First - Ongoing monitoring and evaluation.	- Reduce volume of ALC designated patients in all hospitals. - Reduce ALC designation rate at all hospitals. - Able to support people effectively in the community through the Home First approach. - Low recidivism (coming back to ED with same issue they have been seen about recently). - Engaging in the discharge process very early with the client/family. - A Community Care Access Centre that has balanced budget and is capable of sustaining services to patients pulled into the community from hospital on enhanced services as well as services to existing clients within the community. - Improved relationships among hospital, CCAC and CSS.	In Progress	5%	Complete	0%	Complete	0%
Pan LHIN Priority: RM&R - Continued commitment to enabling options for appropriate post acute care e.g. restorative/rehab beds, convalescent care beds. - Ongoing monitoring and	- Improved patient transitions through RM&R. - Reduce admission rate at all hospitals in 2010/2011, the new beds will provide 4500 patient care days in more appropriate setting with more appropriate care having a direct impact on ALC. In subsequent years, contribute 18,500 patient days with direct impact on ALC. - Enhance skill capacity of staff for restoration/activation type care.	In Progress	25%	In Progress	25%	Complete	0%

evaluation.	Improved internal patient flow due to defined role and criteria for rehab and CCC resources.						
Full implementation of new models of geriatric activation on acute units. Ongoing monitoring and evaluation.	- Low recidivism (coming back to ED with same issue they have been seen about recently). - Significant decrease in ALC 2 day designations contributing to reduced ALC days overall. - Engaging in the discharge process very early with the client/family.	Complete	0%	Complete	0%	Complete	0%
Pan LHIN Priority: 1) Rehab and CCC Expert Panel 2) ALC 2 Day Designation - Information gathering, analysis, interpretation. - Implementing solutions.	Significant decrease in ALC 2 day designations contributing to reduced ALC days overall.	In Progress	35%	Complete	0%	Complete	0%

What are the risks/barriers to successful implementation?

Change Management

- Stakeholder (physicians, nursing staff, LTCH and hospital administration) resistance to change
- Lack of stakeholder commitment/confidence

Resources and Workflow

- Limited human resources and lack of appropriately trained staff
- Increasing demand for skilled staff with gerontology/geriatric training
- Funding availability/sustainability for programs
- Gaining common understanding in a timely fashion of how existing resources are being used, and agreement on how they should be used going forward
- Funding to support pan-LHIN projects

Policy and Legislation

- None

What are some of the key enablers that would allow us to achieve our goal?

- Information systems/decision support tools providing timely and relevant information to manage performance, and identify and correct problem areas
- Continuation and on-going refinement of the Pay-for-Results Program
- On-going collaboration of health service provider leadership and other stakeholders
- Additional funding for CCAC and CSS HSPs to bolster services provided in the community as identified in the Sustainable Access Study

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

Integrated Health Services Plan (IHSP) Priority Description

Reduce the impact of vascular disease in the Central East Local Health Integration Network (LHIN) by 10% by 2013.

WHY IS REDUCING THE IMPACT OF VASCULAR DISEASE IMPORTANT?

What is vascular disease?

Vascular disease is characterized by a thickening or narrowing of the arteries that move blood through our bodies (atherosclerosis). Atherosclerosis is a disease that affects the entire circulation system. As such, 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.

Cardiovascular disease is the most prevalent disease in Canada and the second most common cause of death in all provinces of Canada. Although heart attack and stroke are the most common presentation, it also includes peripheral vascular disease, some forms of renal disease and vascular dementia.

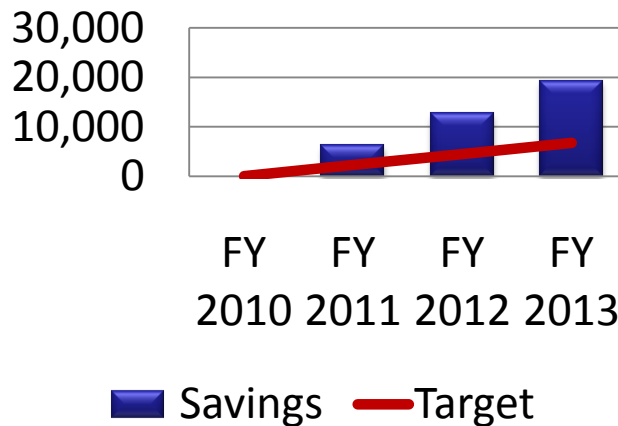
Reducing the risk of people developing and effectively and efficiently managing vascular disease will reduce the impact of vascular disease on individuals and the health care system. Vascular disease is prevalent in the Central East LHIN, results in high numbers of hospital admissions and emergency department visits and is costly to individuals and the health care system.

Cardiovascular secondary prevention (action to prevent a second event) is an evidence-based strategy. Modification of risk factors reduces morbidity (illness) and mortality (death) by at least 25% to 30%. Medical measures including medications such as aspirin, ACE inhibitors, beta-blockers and lipid lowering therapies also have independent effects that further reduce risk.

It has been estimated that among patients with cardiovascular disease that a comprehensive strategy of secondary prevention including risk factor modification and effective medical therapies could reduce cardiovascular morbidity and mortality by as much as 80%.

HOW IS SUCCESS BEING MEASURED?

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 alternate levels of care (ALC) and acute days) by 10% by the end of 2013. As of May 2011 we were on track to exceed our goal of a 10% reduction. See graph below.



Current Status

Disease Prevalence and Incidence

The Central East LHIN has the highest number and prevalence rates of diabetes of all the 14 LHINs.

The Central East LHIN has the second highest growth/prevalence of Chronic Kidney Disease (CKD) in Ontario, with significant at-risk populations including Asian and Aboriginal groups. Regional renal programs provide education and intervention for more than 10,000 pre-dialysis CKD patients. Figures from the recent Dialysis Capacity Assessment indicated that Central East LHIN will not have the capacity to support the 2013 patient forecasts.

In 2009, there were 4,871 index hospital admissions for vascular disease across the Central East LHIN (Vascular Related Case Mixed Groups (CMGs) included: cardiovascular disease, congestive heart failure (CHF), cerebrovascular disease and diabetes mellitus). Of those 4,871 patient admissions, 699 were readmitted to hospital within 30 days of their admission (14.4%). This represents a 5.2% decrease from 2008 (270 cases).

Prevalence of Vascular Disease Risk Factors

Risk Factor	Prevalence in the Central East LHIN October 2011	Provincial Reference
Overweight (BMI 25-29) Age 18+	33.4%	3rd highest rate in the Province
Obesity (BMI > 30) Age 18+	18.5%	Provincial average 17.38%
Smoking (age 12 +)	13.9%	Provincial average 19.73%
Physical Inactivity (age 12 +)	54.9%	2 nd highest rate in Province
Diabetes (age 12 +)	8.2%	2 nd highest rate in Province
Hypertension (age 12+)	17.8%	3rd highest rate in the Province

Canadian Community Health Survey, 2011

According to the Ontario Diabetes Strategy Key Performance Measures (Second Report, Health Analytics Branch, 2010) during 2008/2009 over 8,000 Ontarians with diabetes received renal replacement therapy. There is considerable variation in rates between LHIN areas. In the Central East LHIN 875 of 100,000 diabetics received renal replacement therapy; the 4th highest rate in the Province.

30 Day Readmission Hospital Quality Improvement Initiatives

The Central East LHIN has consistently been one of the top three performing LHINs in the Province with respect to 30 day readmission rates for the select CMG indicator. In May 2011, the Central East LHIN demonstrated the largest overall improvement of all LHINs at 1.37%. For the past four years, based on direction in past and current IHSP, Central East LHIN has invested in chronic disease prevention and management initiatives targeting chronic kidney disease, diabetes, stroke and cardiovascular conditions and self management. This LHIN wide focus and targeted investment has contributed to the strong performance of the Central East LHIN on this indicator.

As evidenced by the Sustainable Access Study, admission to hospital is an important marker for future hospital use and represents an opportunity to organize the post acute care required to reduce future re-hospitalization. A review of the 30 day readmission rates has identified that heart failure (Congestive or Pulmonary) and Chronic Obstructive Pulmonary Disease (COPD) are primary contributors to readmissions. The table below depicts Central East LHIN and Ontario residents who were admitted for CHF, and their rate of hospitalizations in over a five year period.

LHIN of Patient	People Admitted (Cohort)	Year 1 Hospital Activity				Admissions per Person			
		Total Admissions	Admissions per Person	Days per Person	RIW per Person	Year 2	Year 3	Year 4	Year 5
Central East	1,027	1,773	1.73	14.2	2.7	0.73	0.50	0.38	0.29
Province	9,409	16,004	1.70	15.1	2.7	0.85	0.57	0.43	0.35

As the data shows the Central East LHIN has lower re-hospitalization rates for CHF and COPD, however some LHINs have lower re-hospitalizations than the Central East LHIN. This represents an opportunity for the Central East LHIN to develop further strategies for managing CHF and COPF patients.

As a condition of 2011/2012 Health Service Accountability Agreement (HSAA) hospitals were asked to select two CMGs, from within the seven included within the provincial indicator and develop Quality Improvement CMG Plans to achieve a minimum 10% improvement. Hospitals have identified the following select CMGs on which they will focus improvement initiatives to reduce 30 day readmissions, with most hospitals focusing on CHF and COPD improvement.

- Diabetes Mellitus (All Ages - Type 1 & 2)
- Congestive Heart Failure without Cardiac Catheter (>=Age 45)
- Pneumonia (All ages)
- COPD

Congestive Heart Failure - 30 day Readmission Rates 2010/2011

Hospital	2009/10	Q1 Apr-June	Q2 July-Sept	Q3 Oct-Dec	Q4 Jan-Mar	Expected Readmit Rate (Evidence based Target) Q4
TSH – CHF	19.70%	19.7%	20.6%	25.0%	21.7%	17.6%
RVHS - CHF	18.60%	21.9%	16.5%	13.0%	16.7%	17.4%
LHC – CHF	23.86%	20.4%	25.4%	25.0%	24.0%	18.1%

RMH – CHF	18.20%	20.6%	15.4%	14.7%	17.6%	18.2%
PRHC - CHF	18.50%	25.5%	21.1%	15.9%	20.6%	18.2%
CMH – CHF	18.92%	20.0%	22.2%	10.0%	14.6%	17.4%
HHS - CHF	27.78%	50.0%	100.0%	25.0%	37.5%	18.5%

Hospital improvement initiatives will focus on implementing best practice care, performance improvements and strengthening partnerships across the continuum of care within the hospital and community to address one or more of the following key components of care:

- Admission Assessment
- Standard Order Sets
- Care Path
- Patient Disease Education and Literature
- Ambulatory Care
- Medication Reconciliation /Counseling
- Written Discharge Instruction
- Follow up appointment with Primary Care
- Community follow up on discharge
- Self Management /Caregiver Support

Based on a review of the impact of reducing 10% of readmitted cases for the CMGs selected by each hospital, if every hospital was to meet their 10% overall target (i.e. 100% success across all sites within one year) the overall 30 day readmission rate within the Central East LHIN would be approximately 14.7%.

Given that 2010/2011 was the initial year for the select CMG quality improvement plans at each hospital in Central East LHIN, we anticipate that there will be substantial progress made in the assessment and review of the current state and in the redesign of in-hospital processes and systems to support reduced readmissions during 2012/2013. However, given the need to both redesign internal hospital processes/procedures and build the processes and relationships with primary care and other community based services to successfully avoid readmissions, it is estimated that 50% of the ultimate ability to impact readmissions will be realized in 2011/2012. The Central East LHIN 2011/2012 target for 30 day readmission rate for all CMGs is 14.5%.

TARGET POPULATIONS

Patients with established vascular disease use a disproportionate share of health care and hospital resources. The prevalence of cardiac-related death, recurrent heart attack or congestive heart failure is highest among patients with prior myocardial infarction. This population accounts for the majority of hospitalizations, most of which occur within a five year time frame. There is comparable evidence for all vascular disease types including peripheral vascular disease, stroke, heart failure, renal failure and ischemic cardiac disease.²

The target of the task force recommendations are specifically:

- Persons with established vascular disease (secondary prevention); and
- Persons at high risk of developing vascular disease (high risk primary prevention).

Specific populations who have higher prevalence of cardiovascular diseases including:

- Seniors;
- People with diabetes;
- People with reduced kidney function;
- Visible minorities; and
- People with mental health conditions and addictions issues.

COMMUNITY ENGAGEMENT AND LEADERSHIP

The **Vascular Health Strategic Aim Coalition (VHSAC)** is a LHIN wide strategic leadership team established

² Ontario Cardiac Rehabilitation Pilot Project

in 2009/2010 to be the first point of contact for the Central East LHIN and its health service providers on achieving the vascular health strategic aim.

VHSAC Vision: Optimize the vascular health of our communities.

VHSAC Mission: To promote the transition to an integrated Vascular Health Care System within the Central East LHIN

The Central East LHIN Vascular Health System will:

- Promote a consistent and shared vision for best practice vascular health promotion, disease prevention and management to reduce the burden of vascular disease for patients, their families and health care system.
- Support strategies for health promotion and prevention that are evidence based and expected to improve the health of the community and/or reduce utilization of resources.
- Promote standardization of delivery of care and accountability for achieving health outcomes expected for each implemented strategy.
- Support equity in accessing health care and support across communities providing access to continuum of vascular care regardless of their geographic or cultural community.
- Improve the integration of vascular health promotion and disease management across the Central East LHIN through the primary health care system.
- Promote self management and self management support to enable individuals and their care team to effectively manage their conditions.
- Develop partnerships and inter-professional activities that improve quality of clinical care and delivery.
- Integrate with stroke, cardiac, diabetes and renal (chronic kidney disease) chronic care delivery systems related to shared prevention needs and risk factors.
- Improve the ability of knowledge and information to flow between care providers to support effective, seamless (integrated care) for consumer and their family/friend caregivers.
- Recognize, support and incentivize leadership in vascular health within the Central East LHIN.

Utilizing quality management methodologies to transition to an integrated Vascular Health Care System the VHSAC will:

- Validate needs and system gaps.
- Identify, prioritize and recommend effective and efficient strategies to improve vascular health.
- Support patient and care-giver self care education.
- Support integration of Community, hospital and primary care based services and supports.
- Recommend related vascular health policies.

STRATEGIES AND PROGRAMS

Our Approach

Strategies undertaken in the Central East LHIN related to this strategic aim focus on four distinct goals:

1. Approach #1: Improving Prevention and Primary Health Care
2. Approach #2: Improving Acute Vascular Services and Access
3. Approach #3: Improving Secondary Prevention of Disease Progression and Adverse Events
4. Approach #4: Improving System Design and Policy

Goals

CENTRAL EAST LHIN IHSP AIM:

Reduce the impact of vascular disease in the Central East LHIN by 10% by 2013. Save 10,000 in-patient days.

Indicator	2011/2012 Baseline	2011/2012 Final Central East LHIN Target
Readmission within 30 Days for Selected Case Mix Groups (CMGs)	14.77%	14.50%

Consistency with Government Priorities

The achievement of this aim supports many government priorities, including:

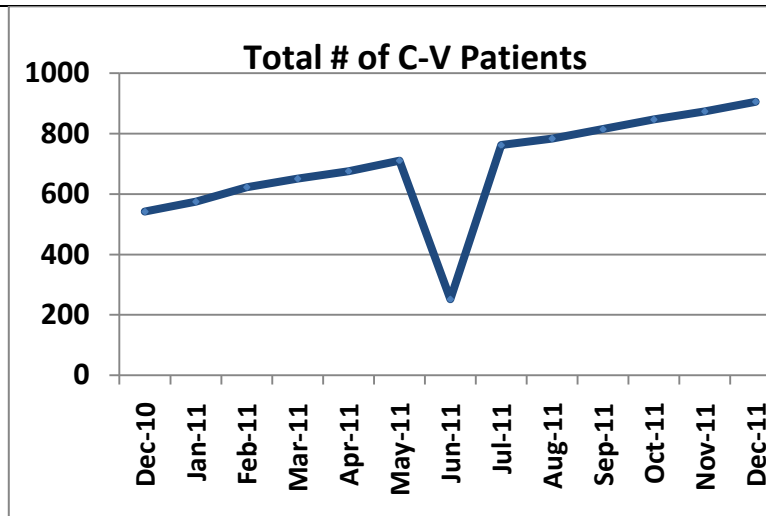
- Reducing ED wait-times;
- Reducing the number of days that patients spend waiting in hospital for an alternate, more appropriate care setting (alternate level of care (ALC) days);
- Reducing 30-day hospital readmissions for selected CMGs;
- Improving access to integrated diabetes care;
- Increasing access to diabetes care/education in community and primary care settings;
- Improving access to integrated renal care;
- Improving patient access to coordinated, integrated cardiac rehabilitation services;
- Improving access to comprehensive primary care by reducing the number of individuals who are 'unattached' to primary care providers; and
- Improving health outcomes and satisfaction for patients.

Action Plans/Interventions: Approach #1: Prevention and Primary Health Care

The Health Care Connect program (See page 23) provides placement or 'connection' of individuals without a primary care provider with a comprehensive primary care practice. As of December 31, 2011, 109,477 patients (56%) were referred to a primary care physician. Of those patients, approximately 73% live within 10 kilometers of their preferred primary care provider.

The program also provides monthly reports to the Central East LHIN which present an overview of overall program performance. These reports are monitored and analyzed by the LHIN on a regular basis. The table below illustrates total number of Complex Vulnerable (CV) patients referred to a primary care physician between December 2010 and December 2011. Patients are assigned CV based on the following categories evaluated by the physician during the initial assessment:

- General health status
- Presence of one or more chronic conditions
- Activity limiting disability
- Mental health issues
- Obesity



Comprehensive Vascular Disease Prevention and Management Initiative (CVDPMI) is a collaborative initiative including many of Peterborough's family physicians, allied health professionals, registered nurses, cardiologists and nephrologists, working collaboratively to implement a proactive and preventative approach to vascular disease. The Comprehensive Vascular Disease Prevention and Management Initiative is dedicated to educating and informing "non help seeking patients" about the risk factors of vascular disease, as well as its early detection, prevention, management and treatment. Review of patient outcomes after three visits has determined that patients identified as at risk of having a cardiac event in the next 10 years has been reduced by up to 50%. The Comprehensive Vascular Disease Prevention and Management Initiative pilot was designed to be a transferable model that will enable any interested community, both provincially and nationally, to introduce this program. The pilot project phase completed in March 2011. Current dialogue is underway with various provincial partners to explore options to spread the learnings of this highly promising practice.

Action Plans: "We will deliver the following"		Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
		2012/2013		2013/2014		2014/2015	
System Level	How Will Success be Measured/Impacted	Status	%	Status	%	Status	%
Metabolic Syndrome: Expansion of the Ontario Shores Weight Metabolic Clinic to build capacity among various mental health HSPs.	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease the number of hospital admissions related to ambulatory care sensitive conditions. - Improve patient satisfaction.	In Progress	20 %	Complete	0%	Complete	0 %

Hospital, Public Health and Primary Care Smoking Cessation Initiative

Given the correlation between smoking and hospitalization, illness and death related to vascular diseases, a smoking cessation initiative targeting hospitalized patients has been designed. The project will include representatives from hospitals, Public Health Units across the LHIN, primary care, Cancer Care Ontario, the community, pharmacies, and the Central East Anti-Smoking (CEASE) Network. A phased approach to roll-out based on the four public health unit catchment areas within the LHIN and including identification of a lead hospital in each community is proposed.

Action Plans: "We will deliver the following"		Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
		2012/2013		2013/2014		2014/2015	
System Level	How Will Success be Measured/Impacted	Status	%	Status	%	Status	%
Smoking cessation: Hospital-based and community partnership for smoking cessation (also see Acute Care)	- Decrease the number of hospital admissions and in-patient hospital days - Decrease the rate of ED visits that could be managed elsewhere - Decrease the rate of ED visits per 1,000 population - Decrease the number of hospital admissions related to ambulatory care sensitive conditions	In Progress	15%	Complete	0 %	Complete	0 %

What are the risks/barriers to successful implementation?

- Funding availability/sustainability for programs
- Limited human resources/competing priorities at health service provider (HSP) and LHIN level
- Ministry does not award Complex Diabetes Centre for Central East LHIN
- Need for improved Ministry of Health and Long-Term Care (MOHLTC)/HSP/Community Care Access Centre (CCAC) collaboration with regard to Health Care Connects to improve patient attachment and flow/transfer
- Absence of dedicated resources to support expansion of Ontario Shores Weight and Metabolic Clinic and Program with diverse partner agencies as there is high demand for support from various communities/partners

What are some of the key enablers that would allow us to achieve our goal?

- Provincial resourcing of Central East LHIN Complex Care for Diabetics proposal including resources to expand the Ontario Shores Weight and Metabolic Clinic and Program for people with serious mental health issues

Action Plans/Interventions: Approach #2: Acute Vascular Services and Access

Cardiac Services

Following recommendations from the Central East LHIN Clinical Services Plan, cardiac services, Primary Percutaneous Coronary Intervention (PCI/Code STEMI) is currently being offered at Rouge Valley Health

System where the service is provided within the recommended guideline of 90 minutes. In November 2012, the MOHLTC approved resources to provide PCI by providing this service to the Northeast Cluster of the LHIN through Peterborough Regional Health Centre. Service will initiate in 2012/2013.

Vascular Surgical Services and Vascular Access for Dialysis Patients

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 (The Scarborough Hospital and Peterborough Regional Health Centre). Peterborough Regional Health Centre and Lakeridge Health Centre are finalizing development of an Integrated Vascular Program servicing the North East and Durham Region (including the addition of Endovascular Abdominal Aortic Aneurysm Repair (EVAR), identified as a patient standard of care service. Integrated service will commence in 2012/2013. The Scarborough Hospital and Rouge Valley Health System are currently developing a proposal to better integrate care for patients in the Durham West/Scarborough Cluster.

Action Plans: "We will deliver the following"		Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
		2012/2013		2013/2014		2014/2015	
System Level	How Will Success be Measured/Impacted	Status	%	Status	%	Status	%
Enhance the integration of regional Cardiac Programs through creation of two service hubs and designated lead hospitals (Northeast, (PRHC) and Durham/ Scarborough, (RVHS).	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease ED length of stay. - Decrease the rate of ED visits per 1,000 population. - Increase the % of the population with a primary care provider. - Decrease the number of hospital admissions related to ambulatory care sensitive conditions. - Improve patient satisfaction.	In Progress	20 %	In Progress	20%	Complete	0 %
Provide equitable access to all Central East LHIN residents for Primary PCI by providing this service to the Northeast Cluster of the LHIN through Peterborough Regional Health Centre (PRHC), the	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease ED length of stay. - Decrease the number of hospital admissions related to ambulatory care sensitive conditions.	In Progress	20 %	In Progress	20%	Complete	0 %

designated regional cardiac service provider in the Northeast Cluster.	Improve patient satisfaction.						
Enhance the integration of regional Vascular Surgery Programs (including a Vascular Access program for Dialysis patients) through creation of two service hubs and designated lead hospitals (Northeast/Durham, PRHC and Durham West/Scarborough, TSH).	- Decrease the number of hospital admissions related to ambulatory care sensitive conditions. - Improve patient satisfaction.	In Progress	40 %	In Progress	20%	Complete	0 %
Develop capacity for EVAR. EVAR is a minimally invasive catheter-based procedure that offers a viable alternative to open surgical repair.	Decrease the number of hospital admissions and in-patient hospital days.	In Progress	20 %	In Progress	20%	Complete	0 %
Continued implementation of the Central East Unified Stroke System (in partnership with Ontario Stroke Network) which will have improved access to Telestroke on-call neurologist support for area hospitals and an improved ability to access Enhanced District Stroke Centre and Regional/Tertiary Stroke Centre supports for LHIN residents .	Decrease the number of hospital admissions and in-patient hospital days.	In Progress	30 %	In Progress	20%	Complete	0 %
Continued implementation of the Central East LHIN Renal Network to promote best practices in Renal chronic disease prevention and management; in-centre efficiencies;	- 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 hospital admissions related to ambulatory	In Progress	20 %	In Progress	20%	Complete	0 %

common reporting standards; improved access to home hemodialysis options and organ transplant care - in partnership with Ontario Renal Network (ORN).	care sensitive condition. Improve patient satisfaction.						
Ontario Heart Institute (OHI) Hospital based and Community partnership Smoking Cessation Initiative.	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease ED length of stay. - Improve patient satisfaction.	In Progress	20 %	In Progress	30%	Complete	0 %
Heart Failure Strategy (Congestive Heart Failure (CHF)) is a key CMG contributing to long length of stay and readmissions.	- 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 hospital admissions related to ambulatory care sensitive conditions.	In Progress	30 %	In Progress	20%	Complete	0 %
Standardized protocols and hospital-level order sets for vascular disease treatment/ management (CHF, Cardiac, Stroke and Diabetes).	- 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 hospital admissions related to ambulatory care sensitive conditions.	In Progress	40 %	In Progress	30%	Complete	0 %
Venous Thrombosis Prophylaxis (Blood Clot prevention) best practice treatments for all hospital patients at risk (e.g. cool core temperature)	Decrease the number of hospital admissions and in-patient hospital days.	In Progress	30 %	In Progress	30%	Complete	0 %

What are the risks/barriers to successful implementation?

- Need to develop Emergency Management Services protocols to support CODE STEMI in Northeast once PCI operational
- Stakeholder resistance to change/confidence
- Variability in physician specialist funding models

- Resistance to clinical integrations across Clusters by physicians, communities
- Capital equipment investments required
- Leadership and change management support from senior hospital administration
- Provincially equitable access to on-call neurology/physician resources
- Resources to develop Enhanced District Stroke Centre capacity within Central East LHIN

What are some of the key enablers that would allow us to achieve our goal?

- Adequate funding for implementation of Northeast PCI program and capital equipment
- Leadership by the Ontario Stroke Network in partnership with Central East LHIN to redesign stroke system in Central East

Action Plans/Interventions: Approach #3: Secondary Prevention of Disease Progression and Adverse Events

In addition to clinical advantages, there are significant cost savings realized with secondary prevention. The direct costs associated with prevention are substantially less than the hospital admissions and morbidity that can be avoided. Today, secondary prevention strategies are endorsed as the recommended standard of care for patients at risk of cardiovascular disease by national organizations in Canada and the United States. 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, Rouge Valley Health System and Lakeridge Health Centre developed an **Integrated Regional Cardiovascular Rehabilitation Program** servicing Scarborough and Durham Region in 2011/2012. In the Northeast Cluster of the Central East LHIN, the current providers of Cardiac Rehabilitation (Ross Memorial Hospital and Kawartha Cardiology Clinic) have initiated dialogue along with Peterborough Regional Health Centre regarding proposed models of care for Cardiac Rehabilitation Services, the finalization of the Lakeshore/Durham model provides opportunity to review the application/extension of the model in the Northeast Cluster.

In April 2010, the Central East LHIN **Self Management Program** was created under the leadership of the Central East CCAC. This was the first provincial roll-out of a LHIN wide Self Management Program. The program offers 80+ workshops for consumers and caregivers and has trained leaders from 60+ organizations across the Central East LHIN. The year 2011/2012 saw further expansion and development of the Central East LHIN Self Management Program to support the objectives of the Ontario Diabetes Strategy. Specifically, self management support for clinician training was introduced through the Choices and Changes Program – over 300 health care clinicians have been trained and Central East LHIN faculty/mentor identified from primary care, hospital and community settings.

Action Plans: “We will deliver the following”		Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
		2012/2013		2013/2014		2014/2015	
System Level	How Will Success be Measured/Impacted- Not divided by programs	Status	%	Status	%	Status	%
Create integrated, evidence-based Cardiac Rehabilitation program (Northeast Cluster of the	• Decrease the number of hospital admissions and in-patient hospital days. • Decrease the rate of ED visits that could be managed elsewhere. • Improve access to and standardize care for all	In Progress	30%	In Progress	20 %	Complete	0 %

Central East LHIN).	cardiac rehabilitation patients. Provincial renal outcome indicators are being developed (i.e. increase the incident rate of venous catheters compared to either a fistula or graft; patient access to dialysis care within recommended drive times from home; ER visits and inpatient admissions for in-station hemodialysis (HD) and home peritoneal dialysis (PD) patients.						
Continue implementation of Self Management Training opportunities for Consumers and Caregivers and expanded capacity for follow-up.	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease the rate of ED visits per 1,000 population. - Increased long-term (six month) quit rate for smokers hospitalized with vascular and related conditions (see Prevention and Primary Health Care Section).	In Progress	10%	Complete	0 %	Complete	0 %
Develop Self Management Support tools/toolkit to better enable health care providers/clinicians to support their clients to self-manage their chronic conditions.	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease the rate of ED visits per 1,000 population - Increased long-term. (6month) quit rate for smokers hospitalized with vascular and related conditions (see Prevention and Primary Health Care Section).	In Progress	25%	Complete	0 %	Complete	0 %
Evaluate and spread CDVPMI .	- 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 hospital admissions related to ambulatory care sensitive conditions.	In Progress	30%	Explore Spread of Program			
Expand best practices for Renal Chronic Disease Prevention and	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease the rate of ED visits that could be	In Progress	25%	In Progress	25 %	Complete	0 %

Management (Renal CDPM) through early identification, screening and effective disease management for people with chronic kidney disease.	- managed elsewhere. - Improve access to and standardize care for all cardiac rehabilitation patients. - Increased long-term (six month) quit rate for smokers hospitalized with vascular and related conditions (see Prevention and Primary Health Care Section).						
System capacity planning across three programs and with Toronto Central LHIN (ORN, LHIN, Regional Programs) including equitable access to home dialysis modalities and Continuous Renal Replacement Therapy in Intensive Care Units.	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease the rate of ED visits that could be managed elsewhere. - Improve access to and standardize care for all cardiac rehabilitation patients. - Increased long-term (six month) quit rate for smokers hospitalized with vascular and related conditions (see Prevention and Primary Health Care Section).	In Progress	20%	In Progress	20 %	Complete	0 %
Continue distribution and development of complementary tools/ translations of the Living Well with Diabetes in Central East LHIN – Resource Guide to continue to support the uptake of best practice and self care.	- Decrease the rate of ED visits that could be managed elsewhere. - Increased long-term (six month) quit rate for smokers hospitalized with vascular and related conditions (see Prevention and Primary Health Care Section).	In Progress	15%	Updates and Reprints each year by HSP partner			
Ensure equitable access to Secondary Stroke Prevention	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease the rate of ED visits that could be managed elsewhere.	In Progress	40%	In Progress	20 %	Complete	0 %

supports/clinics across Central East LHIN. Build on current capacity at LHC and through Vascular Health Network in Peterborough.							
Heart Failure Management (Includes: CHF, Pulmonary Heart Failure – Also see Acute Care Goal).	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease the rate of ED visits that could be managed elsewhere.	In Progress	30%	In Progress	20 %	Complete	0 %
Blood Pressure (BP) Monitoring - Expand BP monitoring initiatives through primary care, pharmacy, home settings, individual action.	- 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 hospital admissions related to ambulatory care sensitive conditions. - Increased long-term (six month) quit rate for smokers hospitalized with vascular and related conditions (see Prevention and Primary Health Care Section).	In Progress	10%	In Progress	20 %	Complete	0 %
Medication management/ patient safety initiative involving community agencies, pharmacy and hospital and primary care.	- 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 hospital admissions related to ambulatory care sensitive conditions. - Increased long-term (six month) quit rate for smokers hospitalized with vascular and related conditions (see Prevention and Primary Health Care Section).	In Progress	10% - as part of CMG improvements only	In Progress	20 %	Complete	0 %

What are the risks/barriers to successful implementation?

- Funding availability/sustainability for programs limit human resources – determination of full impact of

service integrations on health human resources

- Stakeholder resistance to change
- Current capacity to support vascular health/disease management in various HSP settings
- Integration of screening and treatment protocols into physician's own Client Management Systems

What are some of the key enablers that would allow us to achieve our goal?

- Provincial investments in cardiovascular rehabilitation for Northeast Cluster
- Completion of the Ontario Integrated Vascular Health Strategy including identification of provincial system performance/health outcome improvement indicators
- Primary care incentives aligned to achieving vascular health outcomes

Action Plans/Interventions: Approach #4: System Design and Policy Development

Central East LHIN Diabetes Regional Coordinating Centre

The Central East LHIN Diabetes Regional Coordinating Centre (DRCC) became fully operational in 2011/2012 under the strategic leadership/oversight of the Charles H. Best Centre for Diabetes. There is on-going collaboration between the LHIN and DRCC through participation of the DRCC Steering Committee and with a variety of initiatives and a LHIN wide regional proposal to organize, integrate and coordinate complex regional diabetes programming including primary care, specialty care and diabetes education programs and other community resources in the Central East LHIN. Collaboratively, to date the DRCC and the Central East LHIN have developed and circulated over 55,000 copies of the Living Well with Diabetes Guide. The Guide is available in English, French, Tamil and Cantonese and an adaptation for patients with chronic kidney disease has been developed.

Renal Chronic Disease Prevention and Management in Partnership with the Ontario Renal Network

Continued implementation of the objectives identified by the Central East LHIN **Renal Network** in partnership with Ontario Renal Network, namely: to promote best practices in renal chronic disease prevention and management; in-centre program efficiencies; common reporting standards; improved access to home hemodialysis options and organ transplant care.

Metabolic Syndrome

Ontario Shores Centre for Mental Health Sciences developed an award winning Weight Metabolic Clinic (WMC) to improve the health of inpatients at Ontario Shores. Based on the success of the program, Ontario Shores has been working to extend support and build capacity to offer similar programming within some Schedule 1 facilities. Ontario Shores would like to further expand the program, to support additional hospitals, community-based mental health organizations and primary care- to reach full potential benefit. In anticipation of a successful award by the Ministry for a Complex Diabetic Care Centre for Central East LHIN, the LHIN would be able to work with Ontario Shores further to identify requirements to grow the program. The needs of individuals with mental health and addictions create significant pressures in various health care settings including the ED, hospital in-patient units and Diabetes Education Centres. The objective is to build on the successes and lessons learned at the WMC and expand access to this program and build capacity to establish similar programming in various mental HSPs.

Action Plans: "We will deliver the following"		Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
		2012/2013		2013/2014		2014/2015	
System Level	How Will Success be Measured/Impacted	Status	%	Status	%	Status	%
Development of a Central East LHIN Vascular Health Strategy .	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease the rate of ED visits that could be managed elsewhere. - Improve patient satisfaction. - Number of voluntary and facilitated	In Progress	10 %	Advance to implementation and monitoring			

	integrations to improve efficiency and patient transitions/flow.						
Improved Referral to primary care and community-based programs (i.e. self management, next day appoints with primary care).	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease the rate of ED visits that could be managed elsewhere. - Improve patient satisfaction.	In Progress	35 %	In Progress	25 %	Complete	0 %
Support roll-out of Ontario Diabetes Strategy (ODS) : - Establishment and operation of Central East LHIN Regional Coordinating Centre. - Establishment of Complex Diabetes Care Centres. - Ontario Diabetes Strategy: Expansion of Diabetes Education Teams (Wave 1 & 2). - Identify priority areas for system and clinic level improvements (through a LHIN wide Value Stream Mapping & Analysis) for Type 1, Type 2 and Gestational diabetics.	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease the rate of ED visits that could be managed elsewhere. - Improve patient satisfaction.	In Progress	10 %	Complete	0 %	Complete	0 %
	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease the rate of ED visits that could be managed elsewhere. - Improve patient satisfaction.	In Progress	10 %	Pending Approval			
	- Decrease the number of hospital admissions and in-patient hospital days. - Decrease the rate of ED visits that could be managed elsewhere. - Improve patient satisfaction.	In Progress	25 %	In Progress	10 %	Complete	0 %
Improve knowledge and clinical information flow across settings (e.g. Timely Discharge Information System roll-out).	- Decrease the rate of ED visits that could be managed elsewhere. - Improve patient satisfaction.	In Progress	20 %	In Progress	10 %	Complete	0 %

OTN more fully utilized for clinical and education opportunities.	- Decrease the rate of ED visits that could be managed elsewhere. - Improve patient satisfaction.	In Progress	40 %	In Progress	40 %	Complete	0 %
What are the risks/barriers to successful implementation?							
- Funding available to invest in integration to improve system capacity - Limited human resources to support change/integration initiatives - Stakeholder resistance to change - The Ministry's Diabetes Strategy is not committed beyond 2011/2012 - Ability to advance local/LHIN eHealth strategies during development of provincial eHealth strategies (i.e. diabetes portal and the Baseline Diabetes Dataset Initiative) - Need to align policy and priorities across MOHLTC							
What are some of the key enablers that would allow us to achieve our goal?							
Provincial commitment to a comprehensive chronic disease management strategy across the MOHLTC							

Ministry-Local Health Integration Network Performance Agreement Surgical and Diagnostic Wait Times

IHSP Priority Description

WHY IT IS IMPORTANT?

MLPA Wait time Targets by 2013.

Maintaining and improving wait times for key services aligns with the Ministry of Health and Long-Term Care's (MOHLTC or the Ministry) priority of improving public access to surgeries and procedures delivered to Ontarians by reducing wait times for key health services including: cancer surgery, cataract surgery, hip and knee replacement and Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scans. The Central East Local Health Integration Network (LHIN) is also committed to reporting on hospital wait time performance as an important part of the Ministry's goal to create a system of accountability through transparent reporting of wait time information.

HOW IS SUCCESS BEING MEASURED?

Success is being measured according to the Ministry-LHIN Performance Agreement (MLPA) performance targets including:

- Average Length of Stay of Patients Discharged Home for Orthopaedic Surgery
- Proportion of Patients Discharged Home for Orthopaedic Surgery
- 90th Percentile Wait Times for Cancer Surgery
- 90th Percentile Wait Times for Cataract Surgery
- 90th Percentile Wait Times for Hip Replacement
- 90th Percentile Wait Times for Knee Replacement
- 90th Percentile Wait Times for Diagnostic MRI Scan
- 90th Percentile Wait Times for Diagnostic CT Scan
- Median Wait Time to Long-Term Care Home (LTCH) Placement – All Placements

Current Status

TARGET POPULATIONS

Seven hospitals in the Central East LHIN provide wait time related services:

- Campbellford Memorial Hospital– CT and general surgery
- Lakeridge Health– cancer, cataracts, hip/knee, CT and MRI surgery
- Northumberland Hills Hospital– cancer, cataracts, CT, MRI and general surgery
- Peterborough Regional Health Centre– cancer, cataracts, hip/knee, CT and MRI
- Ross Memorial Hospital – cancer, cataracts, hip/knee, CT, MRI and general surgery
- Rouge Valley Health System– cancer, cataracts, hip/knee, CT, MRI and general surgery
- The Scarborough Hospital– cancer, cataracts, hip/knee, CT, MRI and general surgery

COMMUNITY ENGAGEMENT AND LEADERSHIP

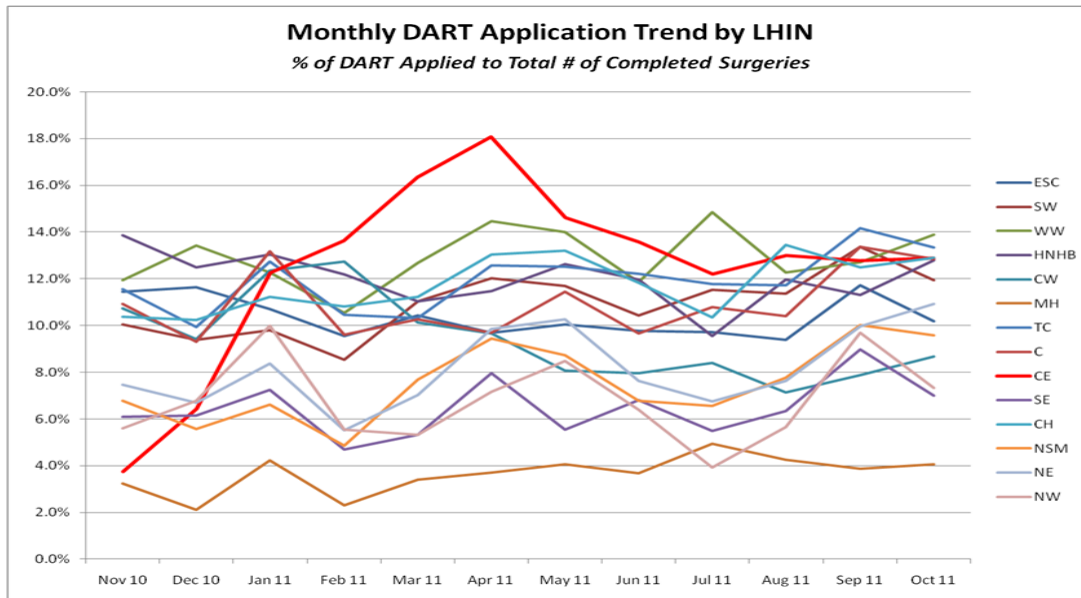
Wait Times Strategy Working Group

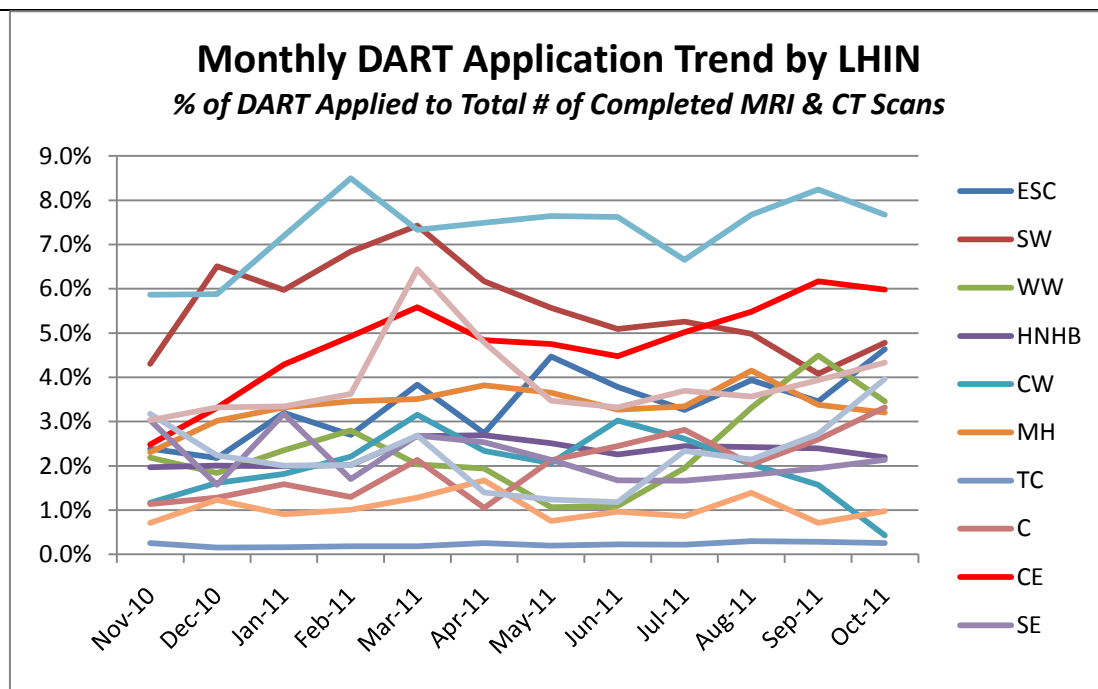
The Central East LHIN has established a Wait Times Strategy Working Group (WTSWG) that is comprised of representation from all of our hospitals and meets monthly to discuss issues, risks and mitigation strategies (e.g. aging machines, increases in referrals, etc). The Wait Times Strategy Working Group also evaluates monthly performance at a system and hospital level, taking into account current year-to-date wait lists for each hospital, identification of capacity versus needs, referral patterns etc. This is done in collaboration with other Central East LHIN working groups, such as the Hospital/Community Care Access Centre (CCAC) Financial Leadership Group, the DI Working Group, the Data Quality Improvement Group, the Central East Executive Council and the Regional Lab Working Group to enhance outcomes and meet MLPA targets.

STRATEGIES AND PROGRAMS

The Central East LHIN has undertaken five direct approaches to achieve this goal:

1. Approach #1: Data quality improvement initiatives
2. Approach #2: Engagement sessions with hospital physicians and surgeons
3. Approach #3: Use of standardized best practices in hospitals
4. Approach #4: Published hospitals wait time performance by key services on Central East LHIN public website on a monthly basis and highlighted issues and strategies/actions for each key service
5. Approach #5: Continued improvement of the application of Dates Affecting Readiness to Treat (DART) in the Central East LHIN's hospitals as shown in the graph below (note that this initiative was implemented in early 2011). The application of DART will reduce the 90th wait times by excluding wait times caused by the unavailability of patients. The Central East LHIN initiated a series of DART training sessions and developed various tools for physicians' offices to support this approach.



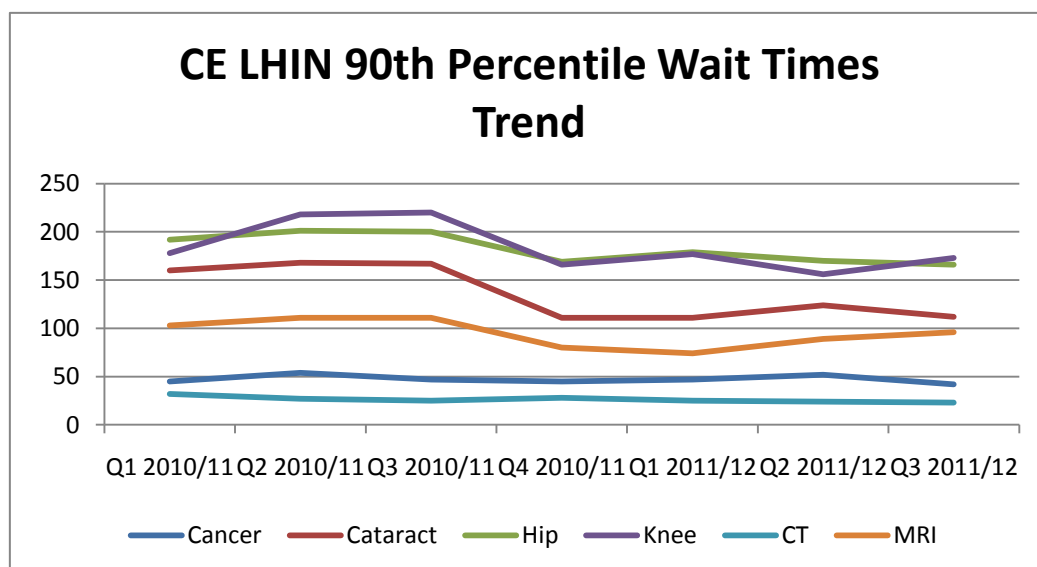


CURRENT ENVIRONMENT

Key Issues and Successes

There are systemic issues impacting wait time performance across almost all indicators. The key issues include: referral patterns, demand exceeding funded volumes, and patient preferences. Historically, hospitals have also provided services over and above the funded volumes from their global budget. Due to fiscal pressures facing the hospital sector, many hospitals are beginning to cap services to funded volumes only.

The Central East LHIN has seen wait times improvement in 2010/2011 Q4 as shown below as a result of the combined effort of planned actions to improve wait times including data quality improvement initiatives and engagement sessions with hospital physicians/surgeons (e.g. Medical Advisory Councils, Chief of Staff/Surgery). The Central East LHIN will continue to work with health service providers (HSPs) and other key stakeholders to identify opportunity to improve key services wait times in 2011/2012 and 2012/2013.



The following lists a numbers of successful and ongoing initiatives for surgical and Diagnostic Imaging (DI) priorities, including:

- Hospital and the Central East LHIN on-going data quality improvement initiatives utilizing key strategies (e.g. Lunch & Learn sessions at each hospital, chart audits, etc.).
- The development of engagement sessions with hospital physicians/surgeons (e.g. Medical Advisory Councils, Chief of Staff/Surgery).
- Incorporating wait time performance indicators into the Hospital Service Accountability Agreement (HSAA) with hospital-specific negotiated targets since 2011/2012.
- One-on-one meetings with each hospital are help as needed and include Chief Financial Officers, Chiefs of Surgery, Central East LHIN WTS Working Group members and WTIS Coordinator.
- Utilizing the web-based Surgical Utilization Booking Management Integration Tool (SUBMIT) to improve patient wait list management and wait times reporting for surgeons and hospitals in the Central East LHIN. The product, Novari Health, is being implemented in seven hospitals with surgical programs and will be completed by March 2012, as a means to improve wait time performance in surgical wait time procedures. Detailed business values of SUBMIT include:
 - Offering a web-based solution to surgeons to electronically manage their wait lists and provide automated rule-based data to the provincial WTIS without data duplication.
 - Connecting the surgeon's wait list management, operation room booking, pre-screening clinics and Admissions areas to provide a real-time and transparent view of patient progress.
 - Providing electronic transfer of booking packages and supporting documentation.
 - Providing access for surgeons to all their operation room bookings at multiple privileged site(s)
 - Providing aggregate data (viewing and reporting) to improve the data quality and reporting of wait times at a regional level.

Orthopedic Quality: Average Length of Stay-All Patients of Patients Discharged Home; Proportion of Patients Discharged Home

- As of 2011/2012 Q2, the Central East LHIN's Length of Stay- All Patients (Average Days) was 4.2 days.
- As of 2011/2012 Q2, the Central East LHIN's Proportion of Patients Discharged Home was 75.2%.
- *Key issues and success:*
 - To meet these targets, hospitals will need to reduce hospital rehabilitation services and discharge more patients directly to their home, which will increase the demand of in-home rehabilitation service and require additional resources from the already financial pressured CCAC. The Central East LHIN will require the CCAC to identify and propose a solution that is cost effective to meet with this challenge. The Community Care Access Centre will service clients and perform assessment (for mainly high risk clients), which may reduce the financial impact.
 - The proposed Ministry patient-based payment system is expected to address the financial pressure however, implementation details are unknown at this time.
 - Meetings were initiated with the support of the Orthopaedic Expert Panel with three Central East LHIN hospitals (Ross Memorial Hospital, Lakeridge Health and Rouge Valley Health System) for the following purposes.
 - To understand their issues/challenges related to the key performance indicators in the areas of efficiency, effectiveness / safety and accessibility.
 - To explore possible remedy strategies and develop work plans.
 - Hospital Orthopaedic Quality Indicator performance was discussed in the monthly Central East LHIN WTS Working Group meeting. As an outcome of the meeting, a task force was established. An Expert Panel information session regarding the new Orthopaedic Quality Scorecard Guidelines will be held for Central East LHIN physicians on January 31, 2012.
- It is the Central East LHIN's expectation to see improvements starting from Q3 2011/2012.

90th Percentile Cancer Surgery Wait Time Performance

- As of November 2011, the Central East LHIN Cancer Wait Times (90th percentile) was **48** days versus the 2011/2012 negotiated target of **49** days.

- *Key issues and successes in addition to the above:*
 - Not all Central East LHIN hospital accountable for the wait time of cancer surgeries are funded for cancer surgery.
 - Meeting with Cancer Care Ontario, the hospitals and the Central East LHIN have been arranged to explore possible solutions to further improve wait time for cancer surgery.
- It is the Central East LHIN's expectation that the negotiated MLPA target will be met.

90th Percentile Cataract Surgery Wait Time Performance

- As of November 2011, the Central East LHIN Cataract Wait Times (90th percentile) was **112** days, versus the 2011/2012 negotiated target of **140** days.
- *Key issues and successes in addition to the above:*
 - The Scarborough Hospital performs approximately one-third of the Central East LHIN's volume and has indicated it is experiencing growing demand, much of which is due to rising referrals, and in part, to physician preference. This poses a risk to the Central East LHIN. A meeting with the Scarborough Hospital was held to discuss the impact of the identified and consider solution. An additional \$312,200 was approved by the Central East LHIN for 543 cases on top of the inter-LHIN year reallocations.
- It is anticipated that the Central East LHIN will meet the 2011/2012 target, but doing so remains a challenge for 2012/2013.

90th Percentile Hip/Knee Replacement Surgery Wait Time Performance

- As of November 2011, the Central East LHIN's Hip Replacement Wait Times (90th percentile) was **163** days versus the 2011/12 negotiated target of **179** days. The Central East LHIN's Knee Replacement Wait Times (90th percentile) was **170** days versus the 2011/2012 negotiated target of **179** days.
- Key Issues and Successes are highlighted in the above mentioned LHIN initiatives.
- It is anticipated that the Central East LHIN will meet the 2011/2012 target.

90th Percentile MRI Wait Time Performance

- As of November 2011, the Central East LHIN's MRI Wait Times (90th percentile) was **97** days versus the 2011/2012 negotiated target of **63** days.
- *Key issues and successes in addition to the above:*
 - The Magnetic Resonance Imaging Ministry target of 63 days is not attainable in 2011/2012. The Central East LHIN requests that the target be renegotiated to recognize increasing local demand associated with residents seeking local services with the addition of two new machines and one replacement machine (repatriation issue).
 - The Central East LHIN DI Group holds monthly meetings to improve data quality and share best practice. The Diagnostic Imaging Group has completed 2011/2012 CT/MRI Inventory Survey. Repatriation of Central East LHIN residents to utilize new machines and access by other non-LHIN residents who live in areas along Highway 401 has substantially increased demand relative to supply. Hospitals were requested to monitor the demand closely and keep the Central East LHIN updated.
 - The Central East LHIN has been reviewing MRI best practices at one of the hospitals in another LHIN to determine other potential measures that may improve MRI performance.
 - In 2011/2012, the MOHLTC introduced the Ontario Breast Screening Program, which has impacted wait time performance.

90th Percentile CT Wait Time Performance

- As of November 2011, the Central East LHIN's CT Wait Times (90th percentile) was **22** days versus the 2011/2012 negotiated target of **28** days.
- *Key issues and successes in addition to the above:*
 - Recommended new and more efficient CT machines in the Ministry business proposals.
 - Monthly meetings of the Central East LHIN DI Group to improve data quality and share best practice.
- It is anticipated that the Central East LHIN will meet the 2011/2012 target.

Median Wait Time to Long-Term Care Home Placement – All Placements

- As of November 2011, the Central East LHIN's Median Wait Time to Long-Term Home Placement was **86** days versus the 2011/2012 negotiated target of **75** days.
- *Key issues and successes:*
 - There is a concern with the indicator as wait list is not standard and needs to be reviewed.

Goals**CENTRAL EAST LHIN IHSP AIM:*****MLPA Targets for Surgical and Diagnostic Imaging by 2013.***

Indicator	2011/2012 Baseline	2011/2012 Final Central East LHIN Target
Orthopedic Quality: • Length of Stay- All Patients (Average Days) • Proportion of Patients Discharged Home	TBD	• 4.4 days • 90%
90 th Percentile Wait Times for Cancer Surgery	44 days	49 days
90 th Percentile Wait Times for Cataract Surgery	131 days	140 days
90 th Percentile Wait Times for Hip Replacement	175 days	179 days
90 th Percentile Wait Times for Knee Replacement	180 days	179 days
90 th Percentile Wait Times for Diagnostic MRI Scan	95 days	63 days
90 th Percentile Wait Times for Diagnostic CT Scan	22 days	28 days
Median Wait Time to Long-Term Care Home Placement- All Placement	86 days	75 days

Consistency with Government Priorities

The Central East LHIN's 2010/2013 IHSP is aligned with the Ministry's priorities and strategic directions. Wait times are an important component of the 2010/2011 MLPA as well as legislated responsibilities concerning the dimensions of care involving:

- Continuously engaged communities and partnerships;
- Improvement in the health status of Ontarians;
- Equitable access to quality care and services;
- Continuous improvement in the quality of care Ontarians receive and resulting health conditions; and
- A sustainable health system framework.

Action Plans/Interventions						
Action Plans “We will deliver the following”	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2012/2013		2013/2014		2014/2015	
System Level	Status	%	Status	%	Status	%
Hospitals and the Central East LHIN have implemented a Task Force for Data Quality Improvement Initiatives with plans to make the group permanent. Physician consultation, peer best practices, and standardization of processes are some of the areas that are being explored to improve outcomes.	Ongoing	-	Ongoing	-	Ongoing	-
Manage wait-time performance through the Central East LHIN's WTSWG, DI Working Group, Data Quality Improvement Group and Orthopaedic Quality Improvement Task Force . Monthly monitoring of volumes, targets, issues, challenges, and mitigation strategies at the hospital and system level at WTSWG allows for effective management of wait time performance including expedient in-year re-allocations.	Ongoing	-	Ongoing	-	Ongoing	-
One-on-one meetings with each hospital as needed to discuss hospital-specific performance issues such as additional capacity and integration. Wait Time performance is also an integral part of the HSA negotiation process .	Ongoing	-	Ongoing	-	Ongoing	-
Engagement sessions at the hospital level with physicians/surgeons are being implemented (e.g. Medical Advisory Councils, Chief of Staff/Surgery).	Completed	100 %	Maintain	-	Maintain	-
Implement the Surgical Utilization Booking Management Integration Tool (SUBMIT) system, which is a web-based project to improve patient Wait List management and Wait Times reporting for surgeons and hospitals in the Central East LHIN. Business Values include: 1. Offer a web-based solution to the surgeons to electronically manage their wait lists and provide automated rule-based data to the provincial Wait Time Information System (WTIS) without data duplication; 2. Connect the Surgeon's Wait List management, operating room (OR) booking, Pre-screening Clinics and Admissions areas to provide a real-time and transparent view of patient progress;	In Progress	100 %	Maintain	-	Maintain	-

3. Provide electronic transfer of booking packages and supporting documentation; 4. Provide access for surgeons to all their OR bookings at multiple privileged site(s); and 5. Ability to provide aggregate data (viewing and reporting) to improve the data quality and reporting of Wait Times at a regional level. It is expected that SUBMIT, when fully implemented, will allow for better management of wait times, both at the hospital and system level.						
Re-allocation of a portion of the Central East LHIN's surplus dollars from other sectors, targeting key service areas for improvement where demand exceeds capacity for those hospitals able to demonstrate that this one-time funding will improve access to care as well as data quality.	Annual Exercise	-	Annual Exercise	-	Annual Exercise	-
Centralized Booking System – a longer-term system solution is to investigate a centralized booking system, ensuring optimal use of wait times services and volumes across the LHIN.	In Progress	10 %	In Progress	60%	In Progress	30%
Consider LHIN-wide Centres of Excellence with capacity and expertise where the majority of wait times services (i.e. for cataracts) would be concentrated.	Concept Phase	0%	In Progress	70%	In Progress	30%
How will we measure success?						
The Central East LHIN utilizes a monthly dashboard system to monitor and manage MLPA Indicators. The dashboard is discussed at a variety of leadership forums including the Central East LHIN Senior Team, the hospital/CCAC Financial Leadership Group, the Central East LHIN Executive Council as well as the Central East LHIN Boards of Directors. The desired outcomes include not only to achieve the Central East LHIN targets, but to further improve wait times and patient experience for each key procedure/scan for all wait times service hospitals within the Central East LHIN. This information is published on Central East LHIN public website on a monthly basis. See examples below.						

CENTRAL EAST LHIN MLPA PERFORMANCE INDICATOR DASHBOARD

Performance effective as of October 2011

PI No.	Performance Indicator (PI)	Indicator Type	Provincial Target	LHIN Starting Point or Baseline 11/12	LHIN FY2011/12 Target	Actual LHIN Performance	Current Status	Trend	LHIN Ranking	Data Source	Reporting Period
1	90th Percentile Wait Times for Cancer Surgery ¹	Access	84 days	48	49	48	●	↑	5	WTIO, CCO	Nov2011
2	90th Percentile Wait Times for Cataract Surgery ¹	Access	182 days	153	140	112	●	↓	6	WTIO, CCO	Nov2011
3	90th Percentile Wait Times for Hip Replacement ¹	Access	182 days	190	179	163	●	↓	6	WTIO, CCO	Nov2011
4	90th Percentile Wait Times for Knee Replacement ¹	Access	182 days	187	179	170	●	↓	3	WTIO, CCO	Nov2011
5	90th Percentile Wait Times for Diagnostic MRI Scan ¹	Access	28 days	102	65	97	●	↑	9	WTIO, CCO	Nov2011
6	90th Percentile Wait Times for Diagnostic CT Scan ¹	Access	28 days	28	28	22	●	↔	2	WTIO, CCO	Nov2011
7	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution ⁴	Integration	9.46%	20.22%	14.8%	16.9%	●	↓	11	DAD	2011/12Q1
8	90th Percentile ER Length of Stay for Admitted Patients ²	Access	25 hours	51.62	39.0	40.8	●	↓	13	ERNI	Nov2011
9	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients ²	Access	7 hours	7.40	7.0	7.2	●	↑	4	ERNI	Nov2011
10	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients ²	Access	4 hours	4.50	4.0	4.3	●	↑	11	ERNI	Nov2011
11	Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions ⁵	Access	TBD	17.50%	16.6%	17.5%	●	↓	8	NACRS	2010/11Q4
12	Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions ⁵	Access	TBD	19.60%	19.0%	22.7%	●	↑	6	NACRS	2010/11Q4
13	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management) ^{4,6}	Access	TBD	42	39.9	47	●	↓	13	HCD	2011/12Q1
14	Readmission within 30 Days for Selected CMGs ⁵	Efficiency (Quality)	TBD	14.77%	14.50%	15.2%	●	↓	8	DAD	2010/11Q4

NOTES:

1 Data sources may vary depending on the availability of data sources (e.g. WTIO vs CE LHIN WTSWG monthly survey)

2 Data Source: WTIS = This month/quarter's data source via the Wait Times Information Office (WTIO), Cancer Care Ontario (CCO).
 *Hospital-specific waitlists for MRI & CT are a combination of either Hospital-submitted data and/or CCO.
 ALC = CIHI Inpatient Discharge Abstract Database (DAD), Intellihealth. Note: Jan, Feb, Mar source data is considered 'interim' until final data cut by ministry.
 ERNI = National Ambulatory Care Administrative Database (NACRS, CIHI) via Ontario's ER NACRS initiative (ERNI-Level 1).
 NACRS = National Ambulatory Care Reporting System (NACRS).
 HCD = Home Care Database (HCD), OACCC, Health Data Branch SAS EG Server.
 CE LHIN WTSWG = Central East LHIN's Wait Time Strategy Working Group monthly survey.
 *Trend analysis comparison to prior month and/or established baseline (where applicable) of current reporting period

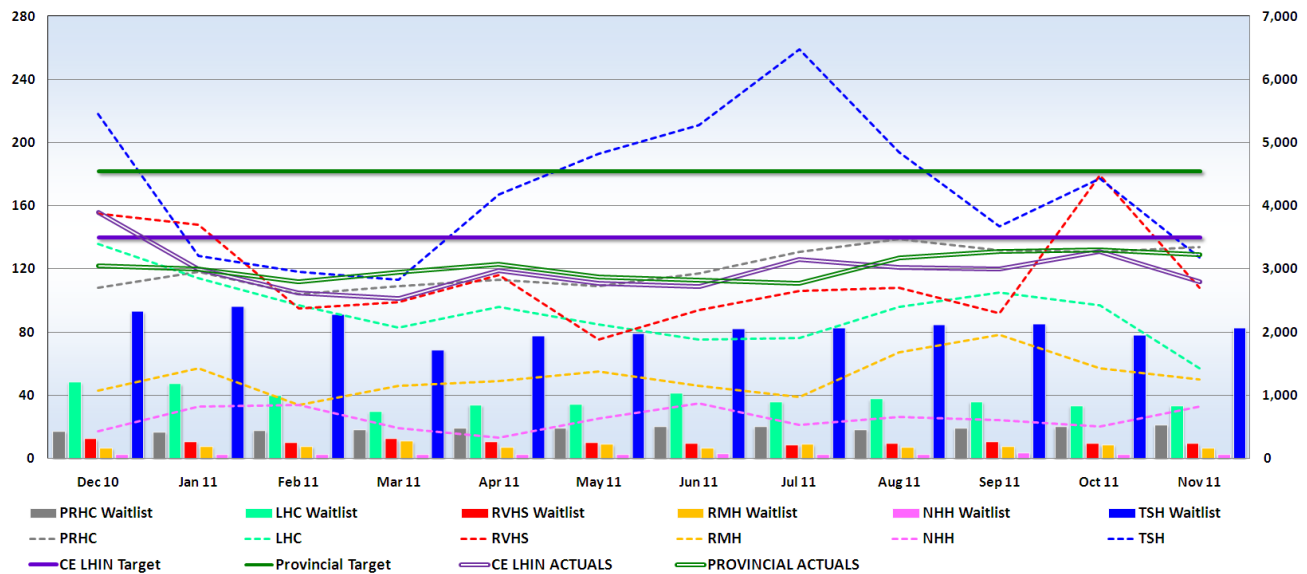
3 LHIN Ranking (1 = shortest, 14 = longest) indicates how the LHIN's current value compares against all other LHINs in the province.

4 Q4 2010/11 data (Jan, Feb, Mar 2011) *Trend analysis comparison to prior reporting period

5 Q4 2010/11 data - Most recent available data

6 No established Target, monitoring indicator only

Performance Trend - Tracker 90th Percentile Wait Times for Cataract + Waitlist (# of Patients Waiting)



Performance Commentary

As of Nov 2011, CE LHIN Cataract Wait Times (90th percentile) was 112 days, vs the 2011/12 negotiated target = 140 days.

Hospital-Specific Issues/Best Practice:

In Nov 2011, all CE LHIN hospitals were below the CE LHIN target. CE LHIN wait times decreased from 131 days in October to 112 days in November, as a result of the following actions/strategies.

Action/Strategy:

- Hospitals & CE LHIN implemented on-going Data Quality Improvement Initiatives with specific key strategies underway (e.g. Lunch & Learn sessions at each hospital, chart audits, etc.).
- Engagement sessions with Hospital Physicians/Surgeons are in development (e.g. Medical Advisory Councils, Chief of Staff/Surgery).
- Wait Time Performance Indicators have been incorporated into the Hospital Service Accountability Agreement with Hospital-specific Negotiated Targets.
- One-on-One meetings with each hospital including CFO, Chief of Surgery, CE LHIN WTS Working Group member & WTIS Coordinator are held as needed.
- A meeting with TSH was held to discuss the impact of the identified and consider solution. Additional \$312,200 was approved by the LHIN for 543 cases on top of the inter-LHIN in-year reallocations.
- Additional funding at \$20k to improve data quality for each hospital was approved.

* Where applicable, wait time is approximated as the average of the last 3 months, when wait time is not reported.

What are the risks/barriers to successful implementation?

- Current funding to hospitals includes base funding and one-time funding, if available.
 - Additional funding is required to operate at services levels to meet growing demand.
 - In-year one-time funding is helpful in the absence of base funding however, one-time funding, if available, is known very late in the year; hospitals have asked for funding confirmation early in the year to facilitate recruitment and better planning.
- In 2011/2012, the Central East LHIN was able to identify one time savings in the Community Health Centre sector due to delays in recruitment of physicians, a situation that is not likely to repeat in 2012/2013. Without one-time funding, meeting wait time targets would be difficult in 2012/2013.
- Present Ministry funding allows for 2,080 hours of operation per MRI machine. Additional hours to achieve full utilization will require additional funding. New capital investments are required to cope with demand.
- Challenges in recruitment of physician staff represent barriers.
- The Central East LHIN implemented SUBMIT in 2011/2012 at three public hospitals as a means to improve wait time performance in surgical wait time procedures. In 2012/2013, this tool is being expanded to all seven public hospitals. A key barrier is the availability of funding to expand the system to include DI procedures.

What are some of the key enablers that would allow us to achieve our goal?

- **Information Technology funding** and support from the Ministry would assist the LHINs in moving forward with LHIN-wide solutions for standardization in processes and solutions for more streamlined data collection, reporting and analysis. These solutions will facilitate centralized booking, tracking and forecasting of wait times. The Central East LHIN has limited discretionary funding to implement solutions that require longer-term planning and implementation.

Health System Design and Integration

Integrated Health Services Plan (IHSP) Priority Description

System design and integration are core functions of Local Health Integration Networks (LHINs) that support the achievement of the government and LHINs vision and mission for the public health care system. More plainly, system design and integration are means to achieve improved patient experience, health outcomes, and value-for-money.

All of the goals and activities in the Central East LHIN IHSP and this supporting Annual Business Plan are premised on the value of integration and system design in achieving our Ministry of Health and Long-Term Care (MOHLTC or the Ministry)- LHIN performance targets and the IHSP's two strategic aims. Specifics on those integration and design activities have been outlined above. The activities listed in this section go beyond any one specific performance goal, and instead are aimed to improve overall performance and sustainability of the health delivery system, and ultimately the health outcomes for patients and our communities.

Current Status

HEALTH SYSTEM DESIGN AND INTEGRATION: FOCUS ON SENIORS

Central East Regional Specialized Geriatric Services Entity

By 2019, there will be a 19% increase in the number of seniors aged 65+ in the Central East LHIN, and a 47% increase in the number of seniors aged 85 and older. This growth will include 42,449 frail seniors with significant health care needs – an increase of 36%. The impact of these demographic trends will be profound. For example, the current population of seniors in the Central East LHIN aged 75+ is 6.5%, yet they utilize 45% of all acute hospital days and 70% of all alternate level of care (ALC) days. The latter already represents a 128% increase over the last five years.

The current system of health services for frail seniors is confusing, frustrating and difficult to navigate for the individual requiring the services as well as the providers of the various services. There is an array of services across the LHIN that generally operate individually, rather than as part of a broader system of care. There is a collective understanding and acknowledgement that there is room for improvement in how services are arranged and provided to seniors that could realize better outcomes from both a client and system perspective.

Specialized geriatric services provide a range of supports to older individuals who are frail - those who, for a multitude of reasons, have lost their resilience/ability to “bounce back” from a change in their lives. Specialized geriatric services include: specialized geriatric assessments, consultations, short-term treatments, rehabilitation, and short-term specialty case management. It uses inter-professional teams with expertise in the care of the elderly, including geriatric medicine and geriatric psychiatry services. While it is critical to have a variety of services in the community to assist in supporting and maintaining the independence of seniors, access to a coordinated system of specialized geriatric services can significantly contribute to a frail senior's ability to remain in their home. Some current programs and initiatives that will be aligned under the Central East Regional Specialized Geriatric Services (RSGS) Entity include:

- Geriatric Assessment and Intervention Network (GAIN);
- Behavioural Supports Ontario initiative (BSO); and
- Nurse Practitioner Outreach to Long-Term Care (LTC) Program or Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT).

With the looming demographic reality and the current state of the “system” of specialized geriatric services, in August 2011, the Central East LHIN Board of Directors approved the implementation of a regional model for the organization, coordination and governance of specialized geriatric services with the formation of the Central East RSGS Entity that will provide a platform and structure to facilitate clinical and service delivery integration activity and to build better health outcomes for frail seniors across the Central East LHIN.

Northumberland Hills Hospital has been selected as the host agency for the RSGS entity and as such committed to meeting three key deliverables by the end of the 2011 calendar year as follows:

- Establish a shared governance model;
- Recruitment of the RSGS program staff; and,
- Citing of RSGS offices and back office support.

The Central East RSGS entity has a shared funding model between the LHIN and all hospitals as well as the Central East Community Care Access Centre (CCAC). Throughout 2012/2013, the entity will be expected to develop and submit to the LHIN an annual service plan for the organization and delivery of specialized geriatric services in the LHIN.

HEALTH SYSTEM DESIGN AND INTEGRATION: FOCUS ON THE FRANCOPHONE & ABORIGINAL POPULATIONS

French Language Services Planning and Delivery

The Central East LHIN, in conjunction with the Central and North Simcoe Muskoka LHINs have entered into a partnership with the recently created Centre South-West French Language Health Services Planning Entity (the Entity) to strengthen the engagement of, and health outcomes for the francophone community within the region. The specific terms of this partnership is outlined in a Service Accountability Agreement between the Entity and the three LHINs, but is supported by a collaborative spirit of shared purpose to improve health outcomes for local francophone residents.

The Service Accountability Agreement requires that the LHINs and the Entity identify annual priorities in a joint action plan. In 2012/2013 the LHINs and Entity will continue to build on the current joint action plan that identifies the following priorities:

- Engage the Francophone community on actions taken by each LHIN to achieve IHSP strategic priorities with regards to:
 - Identification of 2013/2016 objectives to improve access to French language health services in each LHIN.
 - The diversion of patients/individuals from Emergency Rooms to appropriate health service providers in the community;
 - Improved access for patients/individuals to the appropriate care, in the appropriate place, at the appropriate time in the community in order to reduce the number of ALC days in hospitals.
 - Enhanced quality of life for Francophone's living with chronic illness (specifically, diabetes) and reduced complications resulting from such illnesses. Improve mental health and reduce drug addiction in Francophone youth in elementary and secondary schools.

At an operational level, the Entity and the LHINs will:

- Collect data and information on the Francophone community's use of the health services applicable to the above LHIN strategic priorities.
- Make information on French service providers easily accessible on websites of each LHIN and the Entity.

Aboriginal Engagement

The Central East LHIN estimates that the First Nation, Métis and urban-based Aboriginal peoples residing in the region represents about one percent of the total regional population. First Nation, Metis, Inuit and Non-Status people face a number of health issues and challenges and their health status is below that of the general population. First Nation, Metis, Inuit and Non-Status people have identified a number of barriers to receiving equitable access to health services including jurisdictional and funding issues, lack of sensitivity to their culture, and a lack of targeted programs that focus on their particular health needs.

One of the main goals of the Central East LHIN is to work with the First Nation, Metis, Inuit and Non-Status peoples to improve their overall health status. The Central East LHIN is committed to working with all Aboriginal people to align health services with existing regional, provincial and federal health planning, health programming and service delivery systems to improve health outcomes.

The Alderville First Nation, Curve Lake First Nation, Hiawatha First Nation, Métis Nation of Ontario, Mississaugas of Scugog Island First Nation and the Central East LHIN have established a significant partnership that will benefit the health, communities and the future of First Nations, Metis, Inuit and Non-Status people.

Through two advisory circles - the First Nations Health Advisory Circle and the Métis, Inuit, Non-Status People's Advisory Committee, the Central East LHIN has received advice on a variety of topics reflecting on provincial and Central East LHIN priorities pertaining to the First Nations people represented. Both advisory groups continue to be active participants and supporters of Central East LHIN initiatives.

HEALTH SYSTEM DESIGN AND INTEGRATION: FOCUS ON MENTAL HEALTH AND ADDICTIONS

Mental Health Common Assessment and Bed Registry

The Central East LHIN has established a Common Assessment Tool and Schedule 1 Bed Registry Implementation Project in accordance with the Central East Clinical Services Plan, (2009). This initiative has been endorsed and supported by the Central East LHIN Chiefs of Psychiatry. Ontario Shores has taken responsibility for managing the project. A Central East LHIN-wide Steering Committee is in place, with representation from all Central East LHIN hospitals, including those who do not have Schedule 1 Beds, Chiefs of Psychiatry, Central East LHIN Staff, and **Canadian Mental Health Associations** (CMHA) providers. The Steering Committee has been overseeing the implementation of the Common Assessment Tool and the Bed Registry itself. The Common Assessment Tool is in its final stages of completion with approval from the Emergency Department Chiefs expected in January of 2012. The Common Assessment Tool and Bed Registry will enter its pilot phase in January of 2012, with full implementation expected by March 31, 2012. The Bed Registry and Common Assessment Oversight group will continue to oversee the project until full implementation has been accomplished. A process for ongoing oversight will be determined at that time.

An integration involving the CMHA in the Northeast Cluster, Peterborough and Kawartha Lakes is well underway. Community consultations and the determination of a final model will be complete by the end of the fiscal year. It is anticipated that this integration will initiate another facilitated integration opportunity with the newly established CMHA and Forecast Addiction Services.

HEALTH SYSTEM DESIGN AND INTEGRATION: FOCUS ON PALLIATIVE CARE

Hospice palliative care is appropriate for any patient and/or family living with, or at risk of developing, a life threatening illness due to any diagnosis, with any prognosis, regardless of age and at any time they have unmet expectations and/or needs. Hospice palliative care may complement and enhance disease-modifying therapy or it may become the total focus of care. This approach to care is most effectively delivered by an interdisciplinary team of health care providers and volunteers skilled in all domains of care (physical, psychological, social, spiritual, practical, disease management, end-of-life care/death management, and loss/grief) and the processes of care (assessment, information sharing, decision-making, care planning, care delivery, and confirmation).

With the vision to provide a *"comprehensive, integrated and coordinated system of hospice palliative care services that meets peoples' needs"* the Central East LHIN will continue supporting and working with the **Central East Hospice Palliative Care Network** (CEHPCN). The mandate of the Network is to:

- Provide leadership for the development and evolution of a comprehensive, integrated and coordinated system of hospice palliative care for Central East
- Develop standards and supports for delivery of care;
- Support for implementation of best practices;
- Promote education and knowledge transfer; and
- Support for building system capacity and access to hospice palliative care.

The Central East LHIN Sustainable Access Study examined the need for hospice palliative care services, and found there to be significant gaps across the continuum, including residential-based hospice palliative care. It also found that across all regions of the Central East LHIN, patients diagnosed as palliative were consistently in the top three of all diagnosis for ALC patients. It concluded that the Central East LHIN should focus its ALC

reduction efforts on the types of long-stay, frail seniors such as hospitalized seniors requiring palliative care.

Using the findings from the Sustainable Access Study, the CEHPCN undertook a strategic planning exercise to look at system design and integration opportunities that could improve access and outcomes for palliative care patients and their families, and also improve system performance (e.g., ALC reduction and ED improvement).

The Central East Hospice Palliative Care Network report recommended the following:

1. Expert-level multi-disciplinary consultation teams are needed in all care settings.
2. At least 80% of funds are needed to operate residential hospice beds, equitably distributed across the Central East LHIN.
3. Enhance early intervention:
 - Support the Central East CCAC in adopting the Integrated Client Care Program as their hospice palliative care program.
 - Establish partnership with various departments to ensure coordinated and simultaneous care (e.g., cardiology, nephrology).
 - Enhance or create hospice day programming.
4. Enhance access to ambulatory hospice palliative care services:
 - Establish function of ambulatory hospice palliative care services and preferred model(s).
5. Ensure sufficient primary care and secondary level hospice palliative care experts are available in the Central East LHIN:
 - Work with Health Force Ontario to identify target numbers of physicians for each Cluster who are doing home visits and who have expert-level training.
 - Delineate educational requirements for team members (primary and specialist level) in all care settings and services including cultural competency.
 - Build the capacity of the health human resources in hospice palliative care by increasing the availability of training.
 - Continue to foster the development of pediatric hospice palliative care services.
 - Expand the use of eHealth/Telehealth and other technologies to support care and education delivery, particularly in under serviced areas.
 - Work with the CCAC to establish specific contracts for designated hospice palliative care teams with service providers who are salaried at equal rates to other hospice palliative care services (e.g. hospital).
6. Enhance community support services focused on hospice palliative care:
 - Enhance or create bereavement services.
 - Enhance caregiver support services.
 - Enhance volunteer visiting.
7. Create a common message and brand for hospice palliative care programs across all care settings and services:
 - Engage in public awareness of hospice palliative care campaigns – raise awareness of issues, services, advance care planning, and need for early referrals.
 - Standardize language, tools, forms, and processes such as common referral form, standard orders, and the death at home package.

While anticipating further policy direction from the MOHLTC and provincial Palliative Care stakeholders, the Central East LHIN will continue in 2012/2013 with local improvements to the hospice palliative care system. Those include:

- Expand **Community Based Palliative Care Outreach Teams**: Based on the success of a demonstration program in Scarborough, the Central East LHIN has funded the Central East CCAC to expand nurse-led community palliative care programs across all regions.
- Support the **Integrated Client Care Program** through the Central East CCAC.
- Examine the feasibility of establishing **Residential Hospices** as well as promoting the continued hospital-community based palliative care program at **Haliburton-Highlands Health Services**.

HEALTH SYSTEM DESIGN AND INTEGRATION: FOCUS ON THE HEALTH DELIVERY SYSTEM

Community Support Services and Community Health Centres

Based on the success of multiple facilitated integrations – integrations that have led to reinvestments in front-line services and ensured the future sustainability of much needed local health services – the Central East LHIN will be working through a facilitated integration process with all Community Support Services (CSS) and Community Health Centres (CHC) in 2012/2013.

The aim of this integration process is to strengthen the overall operational and governance capacity of these sectors so that it can meet the rising challenges of health care clients and health care funders. While it is premature to identify the structural outcomes of this facilitated integration process, it is expected that:

- *The process will:* be guided by shared principles and interests determined by all parties; include all functions of the health service providers- such as back office, service delivery, and governance; includes examining integration of CSS and CSS functions; and will seek to identify a pre-established goal of financial savings that can be redirected to direct service delivery.
- *The outcomes will:* achieve the vision and goals established by all parties, including financial opportunities; reflect the Central East LHIN Cluster model or other sub-regions and their diversity; and be implementable within a timely basis.

Community Care Information Management

The Central East LHIN is working with Community Care Information Management (CCIM) on the following projects:

- Ontario Common Assessment of Need (OCAN) tool for the Community Mental Health sector
- InterRAI Community Health Assessment (Inter RAI CHA) tool for the Community Support Services sector (CSS).
- Integrated Assessment Record (IAR) repository and viewer for CMH, CSS, Long-Term Care Homes (LTCHs), CCAC and Hospitals.
- Ontario Healthcare Reporting Standards/ Management Information Systems (OHRs/MIS) for LTCHs.
- Human Resource Information System (HRIS) is being offered to CSS and Mental Health organizations. The Human Resource Information System project is being offered to interested and approved sector organizations. The system includes a human resources, payroll and scheduling, as well as other modules (Quadrant Workforce) business solution.

The Assessment Projects (OCAN, interRAI CHA and IAR) are fundamental to Central East LHIN's eHealth strategy. The Ontario Healthcare Reporting Standards/Management Information Systems project will help establish a framework, define standards, collect financial and statistical data related to daily health service provider operations. Management Information Systems Solution software manages core tools/functionality, financial / statistical information and facilitates OHRs/MIS submissions.

The projects align with the Central East LHIN's vision of an integrated, cost-effective, efficient health care system, which will provide timely access to services, and enhance performance and accountability.

Details of initiatives underway in the Central East LHIN by sector:

- Long-Term Care Homes currently using RAI-MDS 2.0 assessments are being encouraged to implement IAR for all residents. A kick-off session is being planned for early January 2012.
- Long-Term Care Homes in the Central East LHIN are currently implementing the provincial reporting standards tool for financial, statistical data collection for the OHRs/MIS. Some homes are also implementing Microsoft Dynamics Great Plains, to streamline data collection and automate reporting.
- Central East CCAC, using interRAI CHA, RAI-HC assessments, will be invited to the kick-off session on the IAR in early January 2012.
- The Community Support Services – interRAI CHA – is the core comprehensive assessment for CSS that assists the client and assessor to determine overall client needs to inform the most appropriate services. The assessment provides standardized, clinical information to inform decision making, planning, performance monitoring and quality of care. Additionally, the CSS sector has chosen the interRAI Preliminary Screener for Primary Care and Community Care to support Community Support

Services clients with less intensive needs. This shorter assessment will help inform the need for a more comprehensive assessment should one be required. The InterRAI Community Health Assessment and IAR implementations are in the planning stages within the Central East LHIN. Health Service Providers will be divided into two phases. Phase 1 will kick off in January 2012 with a scheduled Go Live of May 2012 and implementation complete date of December 2012. Phase 2 is scheduled to Kick-off in March 2012 with a Go Live in June 2012 and implementation complete date of February 2013. The Central East LHIN has selected the Hamilton Niagara Haldimand Brant LHIN model and will leverage the CCAC Provincial Assessment tool in tandem with the CCIM hybrid model. The Central East LHIN will provide governance and project management within Central East LHIN boundaries. The Central East LHIN will work with the Central East CCAC on development of an implementation plan and sustainability model for Central East CCAC provided education and support of the Central East LHIN selected vendor solution.

- Human Resource Information System: 12 CSS organizations are live and using the system. Currently 14 CSS organizations are implementing in the Central East LHIN and implementation will be complete for these organizations by the end of fiscal year 2011/2012.
- Community Mental Health and Addiction (CMHA): 14 community mental health organizations have completed all their pre Go-Live Ontario Common Assessment of Need education. The tool is being implemented in the remaining two CMH organizations and implementation has commenced in November 2011 and will be completed by March 2012. It is worthy of mention that CMHA Durham is the first organization in the Central East LHIN (and in all five Greater Toronto Area LHINs) to completed all their OCAN and IAR implementation milestones. There is only one other HSP in the Province that has done this. Integrated Assessment Record Repository and Viewer is being implemented by the Cluster of the five LHINS (including Central East LHIN) to house all common assessment tools, including RAI-MH for Hospital mental health inpatients.
- Human Resource Information System: eight organizations are live and using the system. Currently one organization is implementing will be complete by the end of fiscal year 2011/2012.

Capital Planning Process and Review

A joint Ministry and LHIN capital planning process was introduced across the Province in November 2010 with new policy and procedural guidelines for pre capital, Stage 1 and Stage 2 submissions. This was required to meet the objectives of the Ministry LHIN Performance Agreement (MLPA). The objective is to improve alignment of expectations for capital builds between Ministry facilities and LHIN programs/services, and integration and operations funding.

Work will continue with the MOHLTC and health service providers to identify current and emerging capital planning priorities within Central East LHIN. Expectation for all LHINs is review/comment and endorsement, as appropriate, regarding the alignment of proposed changes to program and service needs within the LHIN. The Central East LHIN Board will continue to receive quarterly updates from staff and senior team related to capital developments within the LHIN.

Pilot testing and finalization of the Central East LHIN web-enabled pre capital submission tool given provincial directions continues. Monthly meetings between the Central East LHIN and the Ministry Health Capital Investment Branch will continue throughout 2012/2013.

Critical Care Capacity and Improvement

In 2012/2013 the Central East LHIN will continue to work with the Central East LHIN Critical Care Lead, the provincial Critical Care Secretariat and local stakeholders to further improve the capacity, quality and system-level coordination of hospital critical care resources.

In particular, the LHIN and Critical Care Lead will support:

1. Performance improvement and health system accountability: Performance management will be supported by monitoring of the Critical Care Information System and reporting to the LHIN and Ministry.
2. The provincial critical care strategy implementation and other system improvements. This includes: utilization of coaching and education opportunities such as the Nurse Training Funds; support activity related to critical care land and air ambulance; support of provincial initiatives related to trauma, transplant and neurosurgery. With particular reference to the Central East LHIN, the LHIN and Critical

Care Lead will:

- Explore enhancing system capacity to support patients requiring long-term ventilation;
 - Identify opportunities to mitigate health human resource (physician, nursing) challenges at both the local and LHIN level; and
 - Better leverage technology, specifically Telehealth, to support rapid resuscitation of critically ill patients, and reduction in unnecessary transfers.
1. Critical care service delivery, surge planning and event management: The LHIN Lead will:
 - Oversee the implementation, maintenance and management of local surge capacity management plans with a focus on moderate and major surge. This will be in conjunction with the Central East LHIN ED Lead;
 - Identify opportunities to improve system efficiency and optimization of resources;
 - Create or maintain a Critical on-call roster for the LHIN to support surge capacity response; and
 - Work with local and provincial stakeholders to enhance a patient referral framework that will improve patient transfers in the LHIN.
 2. Central East LHIN Critical Care Network: The LHIN Critical Care Lead will engage critical care leaders from across the Central East LHIN to support the above deliverables.

Surge Capacity Planning

In 2012/2013 the System Surge Management Committee will continue to meet quarterly when there is no existing or pending surge activity, bi-monthly during surge planning and more frequently during surge management. The committee will continue to provide a forum for managing and coordinating a system level response to moderate surge and major surge events impacting the local health care system. The committee will continue to provide a forum for communication and sharing of best practices between health care providers, local public health officials, in the event of a regional/sub-regional moderate surge or major surge event. The committee will also continue to provide linkages with other LHIN structures and activities, for example the Primary Care Working Group.

Expanding the Role of the Community Care Access Centre

Provincially, with the new legislation pertaining to CCACs is an increased role in enhancing the CCAC as the health system navigator for rehabilitation programs, and some CSS such as adult day programs and assisted living services. Building on the successes of Home First that saw increasing collaboration of hospitals and the CCAC in assisting patient's access to home care from the ED or upon discharge, 2012/2013 will see further progress into other patient pathways through the **Transitions in Care Committee, Resource Matching and Referral**, and the expansion of **Assisted Living Services for At-Risk Seniors**.

Central East Project Management Office

The Project Management Office (PMO) will continue to provide project management leadership to the Central East LHIN and health service provider project teams. The Project Management Office has developed a comprehensive range of best practices, tools, training opportunities and advice to support an overall framework for managing projects aimed at transforming healthcare in the Central East LHIN. Project Management Office services are available on a self-serve basis through a secure website or through direct consultation channels with the PMO Lead. The Project Management Office also serves as a point of contact for health service providers on new project ideas and integration opportunities and has developed several tools supporting health system integration within the Central East LHIN.

Expanded Integration Capacity

The Central East LHIN will expand its capacity to support health service providers looking at opportunities to integrate the health care system. The Project Management Office, which has been instrumental in the development of guides/toolkits supporting integration and has facilitated several integration initiatives, will expand its mandate to address an increasing demand from health service providers for integration support. The expanded capacity will include increasing the availability of skilled resources, developing additional tools and establishing best practices and making these available to health service providers to advance integration of the health system. The Integration Team is in the process of finalizing an Integration Repository that will be updated regularly, along with an Integration Tool Kit. The finalization of both will mark a process of continuous

Quality Improvement in order to ensure the relevance of these processes and tools. Under the leadership of the Senior Director of Systems Design and Integration, the Central East LHIN initiated a “Community of Practice” around integration, which includes the other LHINS. This will provide opportunities for the LHINS to share information and expertise as the work of integration moves forward. During 2011, the Central East LHIN did expand its integration capacity, as opportunities were investigated both by the LHIN and by Health Service Providers. The process of a “grass roots”/“partnership” approach became more evolved and refined. This led to a clear process of outcomes monitoring that was able to determine the sustainability of integration initiatives.

Consistency with Government Priorities

These system design and integration activities support a broad range of government priorities, including:

- The achievement of the MOHLTC mission and strategic plans;
- Consistency with the LHIN mandate and the provisions of the Local Health Integration Act;
- Quality goals as outlined in the Excellent Care for All Act;
- System goals as identified in the provincial eHealth Strategy, French Language Service, Critical Care Strategy, Palliative Care Strategy, Emergency Management planning; and
- Financial goals as embedded within the provincial Budget, and the Ministry’s Results Based Plan.

Action Plans/Interventions

Action Plans: “We will deliver the following”		Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
		2012/2013		2013/2014		2014/2015	
System Level	How Will Success be Measured/Impacted	Status	%	Status	%	Status	%
Regional Specialized Geriatric Services Entity.	• GAIN as part of RSGS Entity. • Four geriatric clinics operating at capacity. • Reduce avoidable admissions for patients able to be seen in the Geriatric Clinics and through this, have an indirect impact on reducing ALC. • Reduce percent ALC by admitting, when necessary, directly to Acute Care of the Elderly unit. • Improve patient satisfaction and quality of care. • Reduce ED wait times modestly.	In Progress	25%	Complete	0%	Complete	0%
French Language Service		Annual Exercise	-	Annual Exercise	-	Annual Exercise	-

Planning							
Mental Health Common Assessment and Bed Registry	- Improved access to and optimized use of acute mental health inpatient beds across the Central East LHIN such that Central East LHIN residents receive timely mental health treatment and support from within the Central East LHIN. - Reduced wait times in EDs across the Central East LHIN. - Improved quality of mental health care processes in EDs across the Central East LHIN. - Development of a more integrated mental health and addictions system within the Central East LHIN.	In Progress	25%	Complete	0%	Complete	0%
Palliative Care - Community Outreach Teams. - Integrated Client Care Project. - Residential Hospice Services.		In Progress Concept Phase Concept Phase	100 % 25 % 25%	Complete In Progress In Progress	0% 75% 25%	Complete In Progress In Progress	0% 0% 25%
Community Support Services and CHC integration.		In Progress	40%	In Progress	40%	In Progress	20%

Community Common Information Management.	Usage of assessment tools and Integrated Assessment repository.	In Progress	50%	In Progress	25%	In Progress	25%
Capital Planning and Review.		Annual Exercise	-	Annual Exercise	-	Annual Exercise	-
Critical Care System Improvements.		Annual Exercise	-	Annual Exercise	-	Annual Exercise	-
Surge Capacity Planning.		Annual Exercise	-	Annual Exercise	-	Annual Exercise	-
CCAC Expanded Role.		In Progress	40%	In Progress	50%	Complete	0%
Project Management Office and Integration Capacity.		Annual Exercise	-	Annual Exercise	-	Annual Exercise	-

Quality and Performance Improvement

Current Status

Since 2007, the Central East LHIN Board and Staff have been guided by four strategic directions:

- **FISCAL RESPONSIBILITY and ORGANIZATIONAL HEALTH:** *Resource investments in the Central East Local Health Integration Network (LHIN) will be fiscally responsible and prudent.*
- **TRANSFORMATIONAL LEADERSHIP:** *The LHIN Board will lead the transformation of the health care system into a culture of interdependence.*
- **HEALTH SERVICE AND SYSTEM INTEGRATION:** *Create an integrated system of care that is easily accessed, sustainable and achieves good outcomes.*
- **QUALITY AND SAFETY:** *Health care will be people-centred in safe environments of quality care.*

To support the achievement and monitoring of these strategic directions, the Central East LHIN has developed a balanced scorecard that aligns the performance indicators included in each health service providers (HSPs) accountability agreement to its respective domain.

Notable performance on key safety and quality indicators in the Central East LHIN are noted below:

- **Hospitalizations for Falls among LTCH Residents:** The rate of hospitalizations for falls per 1,000 Long- Term Care Home (LTCH) residents in the Central East LHIN has been consistently below the Provincial rate during the last four quarters.
- **In-Hospital Hip Fracture in Elderly (65+) Patients:** The rate of in-hospital hip fractures among acute care inpatients aged 65 years and older has been higher in the Central East LHIN compared to the Province for the last two years.
- **Hospital Associated Clostridium Difficile Infection (CDI) Rate:** The number of Clostridium Difficile (C-dif) cases per 1,000 inpatient days has fluctuated in the Central East LHIN from Q3 2009/2010 (0.21%) to Q2 2011/2012 (0.45%).
- **Hospital Standardized Mortality Ratio:** Hospital Standardized Mortality Ratio (HSMR) is used to track a hospital's mortality over time. It is a tool that allows hospitals to measure and monitor progress in quality of care. The Central East LHIN HSMR value was consistently above the relative value of 100 between fiscal year 2004/2005 and fiscal year 2008/2009. Beginning fiscal year 2009/2010, HSMR has dropped to below 100 suggesting that the Central East LHIN local mortality rate is lower than the national experience.

In support of improving health system performance and quality, the Central East LHIN collaborates with Health Quality Ontario and local health service providers to implement the provisions and objectives of the **Excellent Care for All Act (ECFAA), 2010**.

In April 2011, Ontario hospitals developed their first Quality Improvement Plans and submitted them to Health Quality Ontario (HQP), as required under the ECFAA). Health Quality Ontario reviewed the plans and summarized their analysis into three key messages:

- **Priority Setting** - Organizations should have a limited set of priorities- not too few, not too many.
- **Target Setting** - It is important for organizations to set stretch targets for improvement.
- **Change Ideas** - The best plans provided a broad range of change ideas to implement best practices.

The Central East LHIN has included many of these plans into the Hospital Service Accountability Agreements, including reductions of readmissions for select case mix groups.

The Central East LHIN continues to support other initiatives that improve patient experience and health outcomes in all parts of the system. The highlights of these are noted below.

Residents First

The Residents First quality improvement initiative in long-term care homes that is being led by HQO in partnership with the LHIN, moved from a focus on Quality Improvement Collaboratives to a focus on Leading Quality. Impact of the quality improvement projects within each home will have continuing impact on ED visits

by improving processes for avoiding ED transfers and reducing the need for transfer to hospital resulting from improved continence care and wound care. However, in 2011/2012, the Central East LHIN was not kept abreast of the progress and impact of the Residents First program on individual homes because the agreement between HQO and LTC was directly negotiated and did not allow for sharing results with the LHINs. In the last quarter of 2011, the Central East LHIN Residents First Lead became the Chair of the Residents First LHIN Working Group and a revised terms of reference is expected to enhance the role of individual LHINs in the design and implementation of Residents First moving forward as well as enhance the reporting by LHIN and individual home.

Senior Friendly Hospital Initiative

The Senior Friendly Hospital (SFH) Strategy was launched across the LHINs in 2010/2011 as a LHIN high priority project and is focused on enhancing the care and reducing the risk of functional decline of seniors when 'in hospital'. The Central East LHIN has representation on the SFH Strategy Group and the SFH Indicator Working Group. Senior Friendly Hospital Initiative Indicator Working Group is identifying indicators to measure the success of the SFH Initiative overall. Fiscal year 2012/2013 outcome measures for this strategy will be based on the development of SFH Plans across the Province. These 'process-focused' outcome indicators will be replaced by larger 'system-level' outcome indicators in subsequent fiscal years. The short-term role of the SFH Indicator Working Group is to identify the primary outcomes sought for this strategy and to name cross-LHIN outcome indicators related to functional decline and delirium at an organizational level. Draft indicators were to be chosen early in 2012. Senior Friendly Hospital Initiative regional champions will be identified and hospitals will submit SFH action plans to the LHIN by April 1st, 2012. Senior Friendly Hospital Initiative action plans were to be developed concurrently with refreshed 2012/2013 Hospital Quality Improvement Plans where possible. Hospital implementation of 2012/2013 action plans will be monitored by the LHIN in accordance with accountabilities established in the Hospital Service Accountability Agreements.

Provincial Falls Prevention Strategy

In September 2010, falls prevention was identified as a key priority by the LHINs. In response, the *Integrated Provincial Falls Prevention Project* was initiated as a LHIN-priority project, in partnership with Ontario's Public Health Units. The *Integrated Provincial Falls Prevention Framework & Toolkit* was developed to improve quality of life for Ontario seniors aged 65 years and over, and to lessen the impact of falls on the health care system by reducing the number and impact of falls. Phase I is marked by the completion of Toolkit while Phase II will focus on releasing the report to stakeholders across the Province as well as implementing some of the key actions.

In 2012/2013, once the Regional Specialized Geriatric Services (RSGS) entity is operational, the Central East LHIN will move this Framework into action. The mandate of the RSGS is to support cross-sectoral collaborations that will collectively advance the health and health care experience of frail seniors in the Central East LHIN. In identifying implementation strategies and next steps, an extensive stakeholder consultation process will be planned.

Central East Local Health Integration Network Staffing

Central East LHIN Staffing Plan (Full-Time Equivalents)				
Position Title	2011/2012 Actuals as of March 31/2011 FTEs	2012/2013 Forecast FTEs	2013/2014 Forecast FTEs	2014/2015 Forecast FTEs
CEO	1	1	1	1
Senior Director	2	2	2	2
Manager/Controller	1	1	1	1
Team Lead/Lead	6	6	6	6
Consultant	5	5	5	5
Planner	3	3	3	3
Public Affairs	1	1	1	1
Coordinator	5	5	5	5
Analyst	4	4	4	4
Assistants	4	4	4	4
Receptionist	1	1	1	1
Total FTEs	33	33	33	33

Central East Local Health Integration Network Operations

Central East LHIN Operations Spending Plan					
LHIN Operations (\$)	2010/2011 Actuals	2011/2012 Forecast	2012/2013 Plan	2013/2014 Outlook	2014/2015 Outlook
Operating Funding (excluding initiatives)	4,659,791	4,772,730	4,534,130	4,534,130	4,534,130
Initiatives Funding (e.g. eHealth, Aging at Home, ED, Wait Time, etc.)	1,119,318	1,169,750	451,000	451,000	451,000
Salaries and Wages	2,700,001	2,871,354	2,785,836	2,785,836	2,785,836
Employee Benefits					
HOOPP	255,777	287,135	278,584	278,584	278,584
Other Benefits	373,062	344,562	334,300	334,300	334,300
Total Employee Benefits	628,839	631,697	612,884	612,884	612,884
Transportation and Communication					
Staff Travel	38,720	48,400	48,400	48,400	48,400
Governance Travel	26,099	30,000	30,000	30,000	30,000
Communications	72,964	45,000	40,000	40,000	40,000
Others					
Total Transportation and Communication	137,783	123,400	118,400	118,400	118,400
Services					
Accommodation	274,279	239,632	260,584	260,584	260,584
Community Engagement	65,253	65,000	24,000	24,000	24,000
Consulting Fees	67,118	20,075	20,075	20,075	20,075
Governance Per Diems	87,519	150,000	124,000	124,000	124,000
LSSO Shared Costs	409,495	410,000	390,000	390,000	390,000
Other Meeting Expenses	23,874	34,000	35,000	35,000	35,000
Other Governance Costs	7,672	40,000	20,000	20,000	20,000
Staff Development	36,817	73,000	43,000	43,000	43,000
Other Services		49,572	43,351	43,351	43,351
Total Services	972,026	1,081,279	960,010	960,010	960,010
Supplies and Equipment					
IT Equipment	24,494	10,000	10,000	10,000	10,000
Office Supplies & Purchased Equipment	118,572	40,000	37,000	37,000	37,000
Other S & E					
Total Supplies and Equipment	143,066	50,000	47,000	47,000	47,000
Capital Expenditures	166,962	15,000	10,000	10,000	10,000
LHIN Operations: Total Planned Expense	4,748,677	4,772,730	4,534,130	4,534,130	4,534,130
Annual Funding Target		5,942,480	4,985,130	4,985,130	4,985,130
Operating Surplus (Shortfall)					
Amortization of Tangible Capital Assets					

Communication and Community Engagement Plan

Part 1 - General Communication Plan

Objectives: What is the purpose of the Annual Business Plan?

The Annual Business Plan (ABP) is one a number of guiding documents that are critical to the work of the Central East Local Health Integration Network (LHIN). The other documents are the Integrated Health Services Plan (IHSP) 2010/2013, Building a Model of Sustainable Access to Community Health Care Services (Sustainable Access) and Regional Specialized Geriatric Services (RSGS) in the Central East LHIN: Options for Coordinated Delivery, Organization and Governance.

The Annual Business Plan demonstrates progress made toward reaching the IHSP goals and objectives, and also provides the opportunity to fine tune strategies for the upcoming year. It provides a framework for communicating to stakeholders the impact local decision making has on health care delivery in our communities.

Context: Why do we do an Annual Business Plan?

Under the Local Health Systems Integration Act (LHSIA) 2006, and the Ministry-LHIN Performance Agreement (MLPA), LHINs are required to publish their ABP to inform stakeholders about the LHIN's strategies and initiatives for addressing IHSP priorities. The Central East LHIN's ABP communication plan ensures that all stakeholders have full and easy access to our strategic and operational plans.

The document also includes an overview of the activities to support key provincial activities and a management plan to identify the future challenges faced by our health care system.

Local Health Integration Networks are responsible for engaging health care providers, consumers, and the general public in the work that is required to build an accessible and sustainable quality health care system.

Target Audience

The Central East LHIN deals with many stakeholder audiences, each with its own, and often differing, understanding of the health care system and the role of the LHIN in funding, planning and integrating the system. Stakeholders can be categorized in several categories and sub-categories:

- Ministry of Health and Long-Term Care (MOHLTC or the Ministry)
- Internal to the Central East LHIN
 - Central East LHIN Board of Directors
 - Central East LHIN Senior Leadership Team
 - Central East LHIN Staff
- Central East LHIN Advisory and Reference Groups
 - Central East LHIN Executive Council
 - First Nations Health Advisory Circle
 - Métis, Inuit, Non-Status People's Advisory Committee
 - Governance Advisory Councils
 - French Language Health Services Collaborative
 - French Language Health Services Planning Entity #4
 - Medical Officers of Health Liaison Committee
 - System Surge Management Committee
 - Health Professionals Advisory Committee
 - Central East Hospice Palliative Care Network
 - Central East LHIN Self Management Program Advisory Council

- eHealth Steering Committee
- Information Management/ Information Technology Advisory Committee
- Hospital/Community Care Access Centres (CCAC) Financial Leadership Group
- Primary Care Working Group
- Wait Time Strategy Working Group
- Community Support Services Community Assessment Project (CSS CAP) Steering Committee
- Emergency Room Chiefs and Emergency Management
- Medical Staff Societies – Ontario Medical Association (OMA) supported
- Vascular Health Strategic Aim Coalition
- Emergency Department Strategic Aim Coalition
- Medical Leadership Group – Chiefs of Staff
- Chief Nursing Executives
- Home First Sustainability Steering Committee (in development)
- Regional Specialized Geriatric Services (RSGS) Governance Authority (in development)
- Transitions in Care Steering Committee (in development)
- Resource Matching and Referral (RM&R) Steering Committee (in development)
- Central East LHIN Communications Network
- Central East LHIN Communications Sub-Committee
- Central East Mental Health and Addictions Network
- Medical Officers of Public Health
- Internal to the Health Care System
 - Hospitals
 - Central East CCAC
 - Long-Term Care Homes (LTCHs)
 - Community Health Centres
 - Community Service Agencies
 - Mental Health and Addictions Agencies
- External Stakeholders
 - Members of Provincial Parliament (MPPs)
 - Regional and Municipal Councils
 - General Public
 - Media
 - Associations e.g. Ontario Medical Association, Ontario Long-Term Care Association

Strategic Approach: What type of announcement?

The Annual Business Plan describes many key initiatives to advance the priorities of the IHSP and each of these has its own communication strategy. In addition, the Central East LHIN has an overall strategic communications plan that outlines the various tactics used to communicate with stakeholder groups. This section of the ABP therefore will focus on the strategy to build awareness and understanding of the ABP among all stakeholder groups.

Tactics			
Stakeholder	Timing	Tactic	Details
DRAFT ABP			
Central East LHIN Board of Directors	January 2012	Open Board meeting	A summary presentation and the full text of the draft ABP
MOHLTC	January 31, 2012	Electronic submission	Submission of draft ABP to MOHLTC once approved by the Board of Directors
Final ABP			
Central East LHIN Board of Directors	May 25, 2012	Open Board meeting	A summary presentation and the full text of the final ABP
Central East LHIN Advisory and Reference Groups	Upon Ministry approval	Meetings/formal presentations	Summary presentation plus full text of ABP
Hospitals/CCAC/LTCH/CHCs/Community agencies/MH&A agencies MPPs	Upon Ministry approval	Email notification	An email, from the LHIN Chief Executive Officer (CEO), including attachment of full text ABP, in advance of public posting
Media/General Public	Upon Ministry approval	Localized press release, posting on LHIN website with web alert	Simultaneous posting by all LHINs of MLPA and ABP
Part 2 - Communication Plan for Specific Initiatives			
Specific Initiatives- Provincial all 14 LHINs			
While the LHIN system enables health planning to address local issues, there are a number of common initiatives and platforms that can best be addressed in a coordinated and consistent fashion. To support these activities, and to enhance the awareness of the LHIN role with key stakeholders, LHINs, with the support of the MOHLTC, have worked together to ensure a consistent overarching communication plan and branding approach to support the following key provincial priorities: Home First - Home First is a philosophy and common understanding that when a person enters a hospital with an acute episode, every effort is made to ensure adequate resources are in place to support the person to ultimately go home on discharge, if appropriate. Senior Friendly Hospitals - Research shows that seniors are more vulnerable to adverse events and complications the longer they stay in the hospital. They have a two-fold risk of adverse events (e.g. falls, pressure ulcers, surgical complications, and hospital acquired delirium). One-third of frail seniors lose independent function as a result of hospital practices. These risks increase the likelihood that seniors will not be able to be discharged and will become ALC. The Senior Friendly Hospital strategy strives to foster hospital environments that respond to seniors' physical and mental health needs, promote good health (e.g., nutrition, activation), are safe (e.g. prevent drug interactions, infections, falls), and involve seniors, their families and caregivers fully in the client's care. After their acute care is completed, seniors regain their health so that they can transition to the next level of care - post-acute, home, community or LTC. Provincial Falls Prevention Strategy - In September 2010, falls prevention was identified as a top priority by the MOHLTC. In response, the <i>Integrated Provincial Falls Prevention Project</i> was initiated as a LHIN-priority project, in partnership with Ontario's Public Health Units.			

The *Integrated Provincial Falls Prevention Framework & Toolkit* was developed to improve quality of life for Ontario seniors aged 65 years and over, and to lessen the impact of falls on the health care system by reducing the number and impact of falls.

4. **Resource Matching and Referral** - Some of the most significant quality of care issues occur in transition points in the health care system as patients/clients move from one provider to the next. In the absence of an electronic system to support patient referrals, health care providers frequently base referrals on incomplete knowledge of available services and significant time and resources are spent on the administrative burden of completing and faxing multiple forms.

To address this issue, Ontario's LHINs are working together towards an electronic referral information solution based on a system first introduced in the Toronto Central LHIN. A Resource Matching & Referral (RM&R) system expedites referrals and matches individuals to the earliest available services that best meet their needs, improving quality of care and the experience of individuals and families.

5. **Behavioural Support Ontario** - In January 2010, the MOHLTC funded a working group to undertake the first phase of an Ontario Behavioural Support System (BSS) Project and develop a principle-based Framework for Care. The framework would enhance services for elderly Ontarians with complex and 'responsive' behaviours wherever they live – at home, in long-term care homes or elsewhere. Responsive behaviours are aggression, wandering, agitation as well as others and for many people are the trigger for a crisis visit to hospital and transfer to LTC. The reasons identified to undertake this project were:
- The numbers of people at risk for responsive behaviours is increasing.
 - Challenges are experienced across all health sectors and services.
 - The person and family required better quality experiences.
 - There are significant costs associated with managing behaviours.
 - There are recognized best practices that could be more systematically adopted.
 - There is an opportunity to leverage existing initiatives in Ontario.
 - There is a stakeholder readiness for change.
6. **The Community Care Access Centre Expanded Role** - In 2010, a LHIN/CCAC working group was established to define a consistent/common approach to ensure legislative changes to enable an expanded role for the CCAC. This group has defined how the expanded role should be implemented, outlined what needed to be done consistently across the LHINs and what flexibility would be required for local implementation.

The working group concluded that a more global review of the CCACs' role was needed and it was agreed the focus of their work would be on:

- Defining a vision and directional plan for an expanded CCAC role within an integrated system; and,
- Developing a practical framework to support the consistent implementation of the CCACs' expanded role in placement.

In late 2010, the 14 LHINs and 14 CCACs CEOs agreed upon carrying out the following five ***Directions for Actions***:

1. To ensure the right care at the right place at the right time, the CCACs and LHINs are working in partnership to optimize CCAC capacity: i) to be the single point of access for defined health services; and ii) to be a connection for Ontarians to the most appropriate health care services.
2. Community Care Access Centres will be the single point of access for expanded services for placement (i.e. adult day programs, complex continuing care, rehabilitation, and supportive housing/assisted living). Access for placement will incorporate best practices and a standard approach throughout the Province. Each LHIN/CCAC will develop an implementation plan for their area by March 31, 2011.
3. Community Care Access Centres will be the single point of access for assisted living services described in the Assisted Living Services for High Risk Seniors Policy.
4. The practical steps and success factors identified through a survey and interviews with LHINs and CCACs will be used as a common, practical framework and provincial directional plan to implement the

expanded role of CCACs. Each LHIN/CCAC will develop more detailed directional plans that will include deliverables, responsibilities and timelines.

5. Each LHIN/CCAC will determine whether to implement the opportunities associated with new prescribed services, new care settings, and use of therapy assistants/aides given that these implementations are highly dependent on local needs and circumstances (e.g. availability of health human resources, financial constraints). Community Care Access Centers will share best practices information to build on others' successes.

Communicating the Provincial Local Health Integration Network Priorities

The overarching communications plan is a shared responsibility between the 14 LHINs, the MOHLTC and the Minister's Office. The plan speaks to both a shared communication strategy and communication and operational activities to be undertaken by all LHINs, specifically related to a number of LHIN priority projects. It is the platform upon which the LHINs reinforce the LHIN brand and value of the organizations in leading the important transformation of Ontario's health system.

It is to be noted that the progress of programs supporting the provincial LHIN priorities varies among the LHINs. For example, one LHIN may be deeply entrenched in one priority while at the planning stage of another. For this reason, the overarching plan provides a commonality from which each LHIN can then develop a local communication plan for specific initiatives. However, the communications objectives, target audiences, and key messages developed in the overarching plan are to be incorporated into every local communication plan.

Strategic Objectives:

- To raise the profile and demonstrate the value of LHINs at a provincial level.
- To create a communications campaign that highlights LHIN initiatives and promotes the value LHINs across Ontarians.
- Campaign is focused on "Access to Care".

Audiences (in order of importance):

- Public (taxpayers, patients/clients and family members)
- Health Service Providers (funded and non-funded such as public health)
- Health Service Provider Governance representatives
- Physicians (specialists and general practitioners)
- Local government stakeholders (municipal and provincial)
- Premier
- Minister's Office
- MOHLTC
- Media
- MPPs
- Local Government

Communication Key Messages

Local Health Integration Networks bring together health care partners from the following sectors – hospitals, community care, CSS, community mental health and addictions, community health centres and LTC – to develop innovative, collaborative solutions leading to more timely access to high quality services for the residents of Ontario and the (name of) LHIN. By supporting these important partnerships, LHINs are ensuring that Ontarians have access to an effective and efficient health care system that delivers improved health care results and a better patient experience.

Key Messages:

- Because of LHINs, for the first time, providers in the local health care system are **working together** to improve **access to quality care** for Ontario residents.
- Because of LHINs, for the first time, the health care needs of **people in your community** are being identified, coordinated and addressed as a **truly integrated system**.
 - Local residents are receiving the right care at the right time in the right place, at the right cost.
 - Hospitals and community partners are working together to reduce Emergency Room (ER) wait

times and deliver greater access to care.

- Because of LHINs, for the first time, **local decisions** are being made to respond to local health care needs.
 - Every corner of this vast Province has different health care needs. Those needs are best met through local decision-making.
 - By talking and listening to local health care providers and community residents, LHINs identify and bring to life local initiatives.
 - Health care decisions are focused on quality and with an understanding of the diverse and unique needs of each community.
- Because of LHINs, for the first time, health service providers, such as hospitals, long-term care homes and community agencies, are being held **accountable for the taxpayer dollars** they are given.

On-going collaboration among the 14 LHINs will ensure that a consistent message is delivered across the Province for provincial priorities while the development of local communications plans to support specific projects or programs will ensure that local priorities are addressed.

