

Central East **LHIN**

2013/2014 Annual Business Plan

Implementing the 2013-16 Integrated Health Service Plan (IHSP)



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Harwood Plaza
314 Harwood Avenue South,
Suite 204A
Ajax, ON L1S 2J1
Tel: 905 427-5497
Fax: 905 427-9659
Toll Free: 1 866 804-5446
www.centraleasthin.on.ca

Harwood Plaza
314, avenue Harwood Sud
Bureau 204A
Ajax, ON L1S 2J1
Téléphone : 905 427-5497
Sans frais : 1 866 804-
5446
Télécopieur : 905 427-9659
www.centraleasthin.on.ca

March 31, 2013

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

Dear Ms. Brown,

The Central East Local Health Integration Network (LHIN) is pleased to share its 2013/2014 Annual Business Plan with the Ministry of Health and Long-Term Care (MOHLTC).

This document outlines the operational details in support of achieving the aims of the Central East LHIN's newly developed 2013-16 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 four IHSP Strategic Aims:

1. Reduce the demand for long-term care so that seniors spend 320,000 more days at home in their communities by 2016.
2. Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.
3. Strengthen the system of supports for people with mental health and addiction issues so they spend 15,000 more days at home in their communities by 2016.
4. Increase the number of palliative patients who die at home by choice and spend 12,000 more days in their communities by 2016.

The overarching theme of this IHSP is Community First. We know the sustainability of our health care system requires us to rethink how we keep people healthy and well in the community to prevent avoidable hospitalization and long-term care. It is now time we put our energy and resources behind our words.

This document was approved by the Central East LHIN Board of Directors at their February 27, 2013 meeting. If you have questions or comments, please contact my office at your earliest convenience.

Sincerely,

ORIGINAL SIGNED BY

Wayne Gladstone, Board Chair
Central East LHIN

C:
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 LHIN Mandate and Strategic Directions

Being a critical part of the evolution of health care in Ontario, LHINs are striving to make it a system that is patient focused, results-driven, integrated and sustainable. The mandate of LHINs is to improve access and quality of health services for residents of Ontario through strengthened integration and coordination of health services. The Central East LHIN will continue to realize this mandate through community engagement, local health system planning, funding and allocation, and accountability and performance management.

In operationalizing its mandate, the Central East LHIN will 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 person 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 momentum of change for health care in Ontario has never been greater. The Central East LHIN and the newly developed 2013-16 Integrated Health Service Plan (IHSP) will shape the evolution of the local health care system to promote better health, better care, and better value for our residents.

In fact, Ontario's LHINs have been a significant driver of health care improvements in Ontario since 2006. It is recognized that real change can be a slow process. The gains we are achieving now, and hope to gain in the future, are in part a result of the seeds LHINs sowed in their first two Integrated Health Service Plans.

The Central East LHIN 2013-16 IHSP sets out a bold, but realistic, road map for health care improvement for our region. In order to realize our Vision of "*Engaged Communities - Healthy Communities*" and fulfill our LHIN's mission and mandate, the 2013-16 IHSP lays out four new innovative strategic aims and common enablers that will serve as the aspiration of our health care community for the next three years.

These strategic aims and enablers take their cue from the Ministry of Health and Long-Term Care Action Plan for Health and the common objectives of Ontario's 14 LHINs. Most of all, they are rooted in our LHIN's commitment to lead the creation of an integrated local health care system that delivers on the "Triple Aim" of better health for our community, better patient experience, and better value-for-money from our health care system.

The overarching theme of this IHSP is Community First. We know the sustainability of our health care system requires us to rethink how we keep people healthy and well in the community to prevent avoidable hospitalization and long-term care. It is now time we put our energy and resources behind our words.

A Community First approach requires focused and disciplined actions to create an integrated community-based health system that is able to pro-actively respond to emerging health care trends in our communities. With dramatic changes ahead in the areas of health care finance, clinical practice, demographic shifts, and technology - these changes are too large and too important to leave to chance. 'Home First' (see page 17), taught us that we need to be less implicit and more explicit in the coordination of patient care across health care sectors. We need a plan. That is why we have dedicated the 2013-16 IHSP to "Community First."

The Central East LHIN 2013-16 IHSP strategic aims are rooted in this Community First approach:

- *Reduce the demand for long-term care so that **seniors** spend 320,000 more days at home in their communities by 2016.*
- *Continue to improve the **vascular health** of residents so they spend 25,000 more days at home in their communities by 2016.*
- *Strengthen the system of supports for people with **mental health and addiction** issues so they spend 15,000 more days at home in their communities by 2016.*
- *Increase the number of **palliative** patients who die at home by choice and spend 12,000 more days in their communities by 2016.*

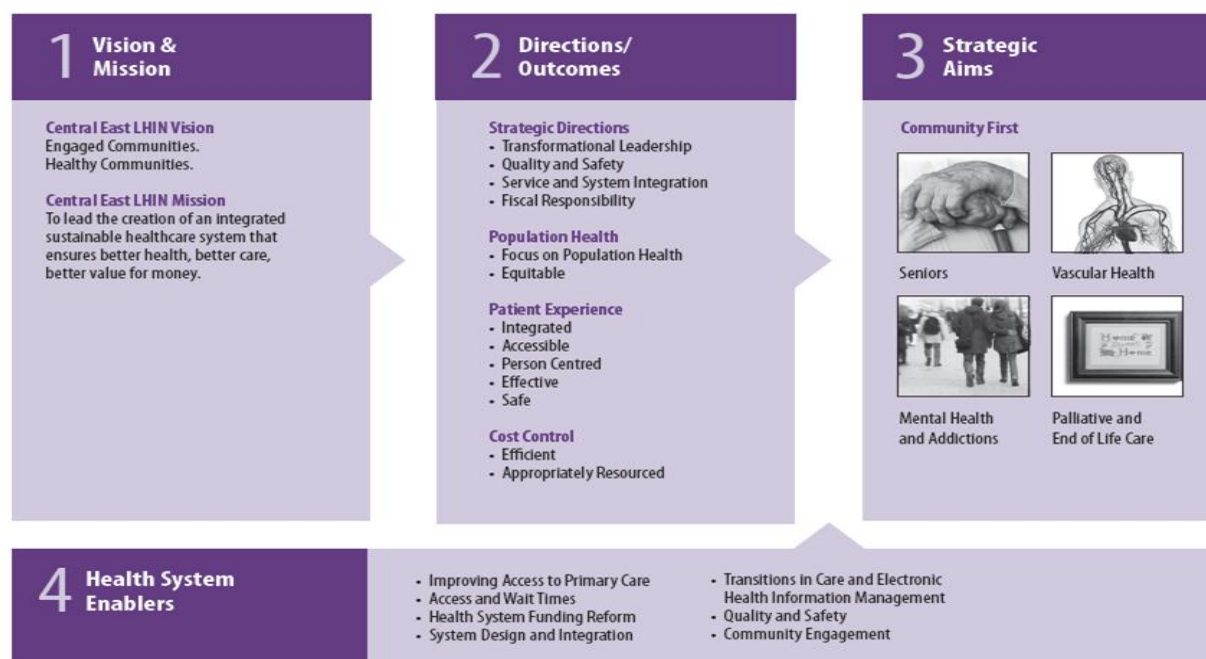
Achieving these aims requires a concerted effort of the LHIN, LHIN funded health care providers, other health and social service partners and, of course, our patients and their caregivers.

This IHSP identified a set of common enablers related to health system design and improvement that consistently weave between all of our strategic aims. Those common enablers are:

- Improving Access to Primary Care
- Access and Wait Times - Including Emergency Department, Surgical, and Diagnostic Services
- Health System Funding Reform
- System Design & Integration
- Transitions in Care & Electronic Health Information Management
- Quality & Safety



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.



Strategies and initiatives implemented in the Central East LHIN will be focused on the 2012-13 Ministry-LHIN Performance Agreement (MLPA) targets listed below.

MLPA Measure	Target
90 th Percentile Wait Times for Cancer Surgery	49 days
90 th Percentile Wait Times for Cataract Surgery	135 days
90 th Percentile Wait Times for Hip Replacement	179 days
90 th Percentile Wait Times for Knee Replacement	179 days
90 th Percentile Wait Times for Diagnostic Magnetic Resonance Imaging Scan	83 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	36 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	17.00%
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions	19.60%
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)	40 days
Readmission within 30 Days for Selected Case Mixed Groups	14.90%

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) including:

- Current health service provider funding as specified in the Ministry-LHIN Performance Agreement (MLPA)
- Emergency Department Pay for Results Program
- Central East LHIN Urgent Priority Funding
- Electronic Health Information Management (E-Health) Funding
- Other revenue provided by the MOHLTC

Community Engagement

The Central East LHIN is leading the creation of an integrated sustainable health care system that ensures better health, better care, better value for money. This mission can only be achieved through engagement and partnership with patients and their families, health care service providers, MOHLTC, 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 LHIN's 2006 inception, a new Community Engagement Framework was adopted by the Central East LHIN in 2010 (which is consistent among all Ontario LHINs). Details on specific community engagement activities to support the initiatives contained in this 2013/2014 Annual Business Plan (ABP), are outlined within *Integrated Communications Strategy* (pg 97) and *Community Engagement* (pg 104).

Central East Local Health Integration Network – Operations Overview

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.

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 Agreement (MLPA), 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.

The provincial budget announcement on March 27, 2012 included an addendum on "Agency Efficiency" which announced that for all classified agencies receiving more than \$5 million in ministry funding are under a 5% constraint to their administrative expense allocation beginning 2012-13.

The 5% constraint on administrative expenses is captured in the Central East LHIN operations budget as identified on the *Operations Spending Plan* (pg 96). As a result of this reduction to the annual operations budget the Central East LHIN annual symposium was cancelled as well as the governance retreat and other areas of the budget were reviewed for cost saving measures. The LHIN was expected to find efficiencies within the operations plan in order to meet this target while maintaining current service levels.

As of February 1, 2013, the LHINs received new funding as an amendment to the Ministry-LHIN Performance Agreement (MLPA) when the LHINs assumed the responsibility for the specific objectives and deliverables for the regional coordination of the diabetes services. The program's specific mandate and objectives include:

- Identifying regional and local services needs to support long term planning for diabetes care in alignment with LHIN and provincial priorities
- Engage primary care and other diabetes service providers across the region to facilitate the adoption and integration of consistent, evidence-based standards and best practices in diabetes management
- Coordinate regional services for adults with pre-diabetes and diabetes to support a more integrated, patient-centred, accessible, equitable and effective system that offers the best value for Ontarians

With the new funding to support the objectives of the program and to continue to support our Vascular Health Aim, the Central East LHIN recruited six new positions as identified in *LHIN Staffing Plan (pg 95)*. The positions include a Team Lead, Quality Improvement Facilitator, Health Planner, Outreach Facilitator, Administrative Assistant, and Decision Support Analyst.

Overview of Central East LHIN Current and Forthcoming Programs and Services

The Central East LHIN 2013-16 IHSP is a local road map to better health, better care and better value for the residents and health service providers in the Central East region. The strategies, projects and improvements presented in the IHSP are rooted in the common vision and priorities of the Ontario MOHLTC and the Central East LHIN, as well as in evidenced-based and leading-edge practice in the planning and delivery of health services.

Most importantly, the IHSP is informed by those people who directly deliver and receive health services each day in the Central East LHIN. Patients, clients, caregivers, allied health professionals, administrators, nurses, physicians and community leaders played a significant role in the creation of the IHSP, and will play an even bigger role in the achievement of the IHSP's objectives.

The IHSP is a three year strategic plan for the Central East health care system. Like all of the Ontario's 14 LHINs, the Central East LHIN has developed the IHSP to guide the activities and accountabilities of local health service providers. The Plan provides an overview of the current health care system, identifies areas for focused improvement, and sets standards for achievement. All of this is done to advance the Central East LHIN vision of *"Engaged Communities-Healthy Communities"*.

The general public and other stakeholders want to better understand what value integration and the Central East LHIN brings to the health care system, as well as what the Central East LHIN aims to achieve "by when" and "by how much." The single most important element of this IHSP is the identification of four system-level strategic aims for the Central East LHIN that are in keeping with provincial and local priorities. By "thinking" and "acting" Community First, we intend to help Central East LHIN residents spend more time in their homes and their communities, and fewer days in hospitals and long-term care homes. By emphasizing community-based health care services we will enhance the quality and sustainability of the Central East LHIN health care system, as well as improve the patient experience.

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

In 2011, the Central East LHIN had the second highest population within the Province accounting for 11.8% of the population of Ontario. Between 2006 and 2011, Central East LHIN's population has increased by 5.5% which is similar to the provincial growth rate. Between 2011 and 2016, the population is expected to increase by 8.2% and by 2021 the population will have increase by 17.0%. Ontario's expected population projection is expected to increase by 13.0% for the same time period. In 2011, over 14% of Central East LHIN's population were seniors aged 65 years and over. By 2016, seniors will account for 16% of the LHIN's population and by 2021, it will be 18%. Population projections from 2008/2013 (five year projection) indicate that there will be a six percent growth with year-to-year incremental increases of 1% 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. The Central East LHIN has conducted an extensive Environmental Scan for the IHSP which can be found here: [IHSP Environmental Scan](#)

Available Fiscal and Health Services Resources

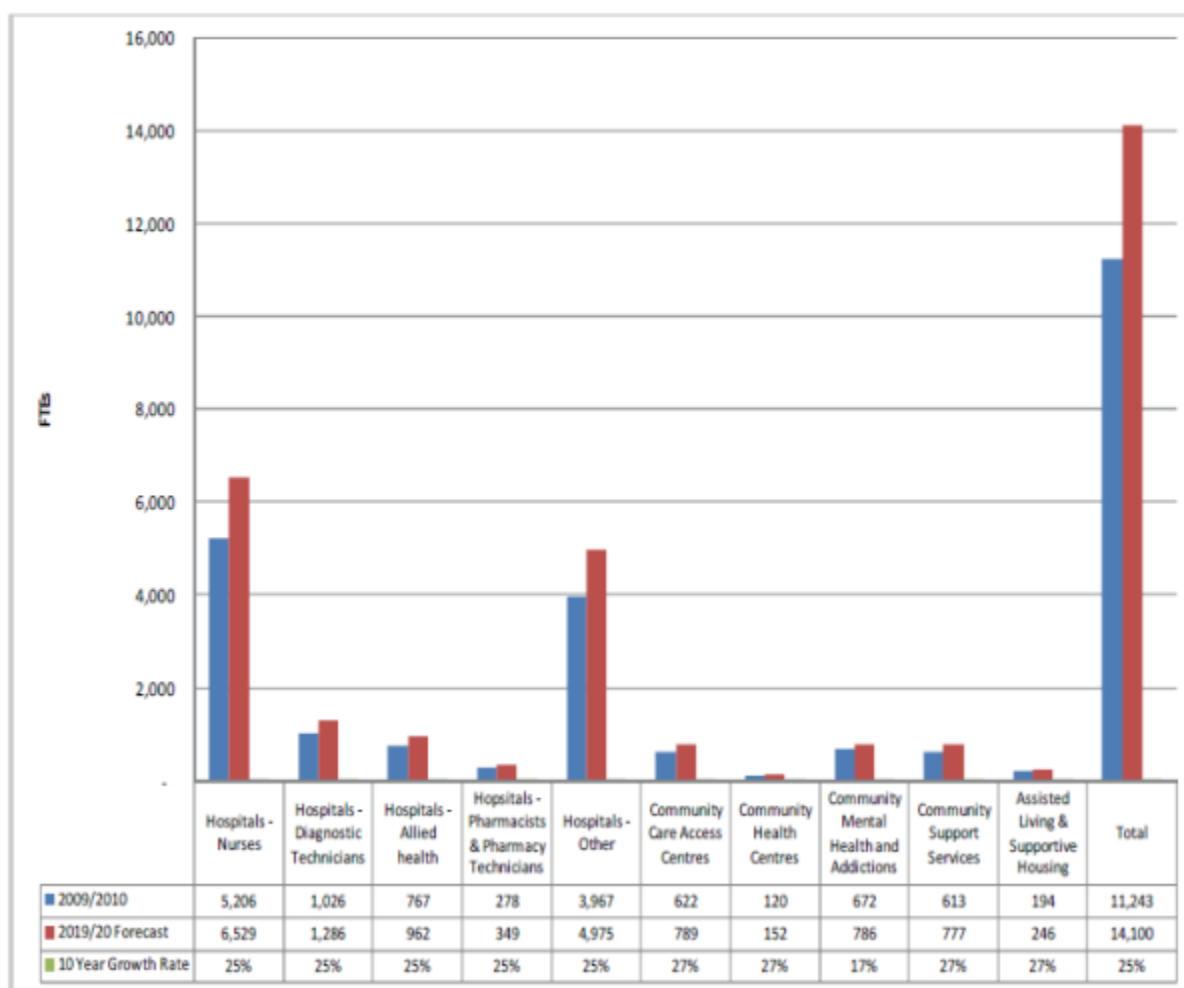
Central East LHIN Funding Summary: 2011/2012	
	Per Central East LHIN (\$)
Operation of Hospitals	1,248,266,221
Grants – Municipal Taxation – Public Hospitals	281,250
Grants – Municipal Taxation – Specialty Psychiatric Hospitals	25,425
Long-Term Care Homes	413,832,208
Community Care Access Centre	240,683,034
Community Support Services	34,510,686
Acquired Brain Injury	1,469,786
Assisted Living Services in Supportive Housing	13,871,585
Community Health Centres	22,343,541
Community Mental Health	49,306,425
Addictions Programs	10,793,284
Specialty Psychiatric Hospital	115,216,037
Community Investments unallocated including Addictions	1,585,028
TOTAL HSPs	2,152,184,510
LHIN Operations	4,534,130
E-Health	580,000
LHIN Initiatives	700,817
TOTAL Central East LHIN Allocations	2,157,999,457

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 forecast to increase by 3,000 full time equivalents over the next 10 years. Most of the growth resides in nursing and undesignated human resources in hospitals as shown by the graph below.

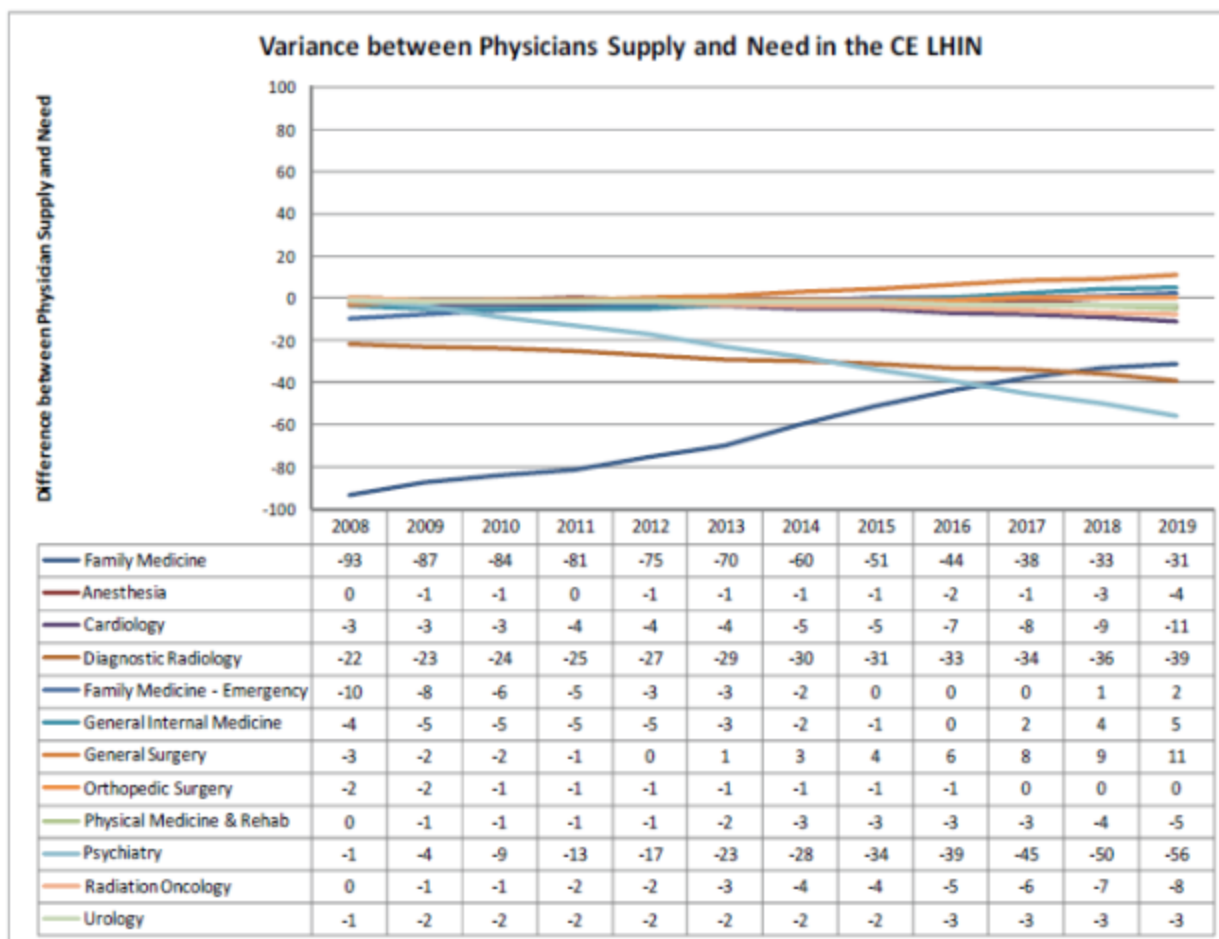
Human Resources 10 Year Forecast in the CE LHIN



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 Health Force Ontario 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 (5 networked); Fenelon Falls (1), and the City of Kawartha Lakes (1).
 - Satellite sites of these FHTs are currently in the following communities: Warkworth, Colborne, Apsley, Millbrook, 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:** Health Force Ontario 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 with 11 Regional Advisors located throughout Ontario. In addition, HFO MRA has agreements with all six of the medical schools in Ontario to provide transition to practice guidance and support to residents (doctors in training). Regional Advisors work with the residents one-on-one to find suitable practice opportunities based on their personal and professional needs with a focus on long term retention.

- The Central East LHIN now has two official Queen's Family Medicine training sites: Lakeridge Health Oshawa and Peterborough Regional Health Centre. The University of Toronto has established a Family Medicine training site through The Scarborough Hospital. Statistics show that the majority of residents tend to establish a practice in the same area where they trained. The increased number of local training sites in Central East will greatly assist with local physician supply.
- 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.

Community Health Centres (CHC) Physician Recruitment and Retention Challenge:

Of the seven CHCs within the LHIN – four have vacancies for physicians (3.7 Full Time Employees (FTE) projected for March 31, 2013) and two CHCs (Port Hope and Oshawa) are requesting additional physician FTE allocation. CHCs with vacancies include City of Kawartha Lakes (0.6), Brock CHC (0.5), Scarborough CHC (0.4) and the developing Pickering Youth – Satellite site (2.2).

Actions in 2013/2014 will include:

- CHCs will be pursuing joint recruitment strategies – pending support by MOHLTC and LHIN.
- LHIN will continue to encourage CHCs to identify opportunities for integrating primary care and physician care across organizations/communities.
- The LHIN will continue to review and as appropriate support CHCs to apply one-time physician surplus' toward strategies to increase primary health care access through expansion of inter-professional teams; extended hours and advanced access initiatives.
- Province wide introduction of expanded accountability indicators and Quality Improvement Plans for CHCs starting in April 2013.

Culture and Change Management

Cultural 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 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: Reduce the Demand for Long-Term Care so that Seniors Spend 320,000 More Days At Home in Their Communities by 2016

Integrated Health Service Priority:

Reduce the demand for long-term care so that seniors spend 320,000 more days at home in their communities by 2016.

IHSP Priority Description:

We know the sustainability of our health care system requires us to rethink how we keep people healthy and well in the community to prevent avoidable hospitalization and admission to long-term care. This is highlighted in the Provincial Senior's Strategy. Improving health care for seniors is a top priority of the Central East LHIN. The population of seniors is growing, and this group often has complex health care needs. As a result, there will be increased pressure on caregivers, communities and our health care system. A focus on seniors will foster improvements in the health care experience of patients and their caregivers, as well as in the overall quality and sustainability of the health care system in the Central East LHIN.

Current Status:

The Central East LHIN will focus on seniors because of the large number of seniors in the Central East LHIN, and because frail seniors have complex health care needs typically requiring high resource utilization.

The Central East LHIN has the largest number of seniors (65+) in the province and the population is growing: Over 14% of Central East LHN's population is seniors 65+. Since 2006, this population has grown by 12.5%. By 2016, seniors will account for 16% of Central East LHIN's population; by 2021 they will account for 18%. Needs across the LHIN vary with 20.3% of the North East cluster's population being over the age of 65, while 11.4% of the Durham cluster is reaching the same age.

Age Group	Population
65 to 69 years	71,313
70 to 74 years	53,803
75 to 79 years	44,447
80 to 84 years	34,652
85 years +	30,881
Total	235,096

Source: Intellihealth, 2011 Census

Information in the IHSP Environmental Scan demonstrates the high health care needs that some seniors in Central East have including:

- 123 of every 1000 seniors aged 75+ require Long-Term Care, the third highest rate in Ontario
- Over 40% of the 85+ population live alone in the community

A small percentage of seniors use a disproportionate share of health care resources as evidenced by 177 of every 1000 people over the age of 80 years fall into the category of the top 10% of High Users (the proportion of patients with the highest combined expenses for all care types). Compare this rate to 8.4 persons per 1000 between the ages of 18-44.

In the Central East LHIN, Hospital Alternate Level of Care (ALC) days increased from 64,822 days in 2006/07 to 117,859 days in 2010/11 -- the third highest number of ALC days in the province. Alternate Level of Care days accrue when a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting. The seniors' cohort comprises the vast majority of the ALC population. A high-level of ALC is problematic because patients may not be receiving the care they need and resources are not being used to their full-capacity.

The urgency of improving health care for seniors was recognized by the Central East LHIN from the outset and a number of programs and services have been invested over the past six years directed towards improving the system and continuum of care for seniors and their caregivers.

Goal(s):

To achieve this strategic aim for seniors the Central East LHIN must reduce the current Long-Term Care demand rate from 123 persons per 1000 to the current provincial rate of 107.5 persons per 1000. Unlike the province where demand for Long-Term Care has steadily decreased since 2006, the Central East LHIN has remained stable.

Consistency with Government Priorities:

- Action Plan for Health
- Provincial Seniors Strategy
- Improving access to care at the right time, right place
- Enabling people to stay at home, in their community
- Enhancing coordination and transitions in care
- Promoting the achievement of provincial metrics related to Emergency Department (ED) wait times and ALC
- Supporting senior's access to culturally and linguistic appropriate services

Action Plans/Interventions:

Seniors are impacted everywhere in our health care system, and as such will benefit from the full range of initiatives of the IHSP related to vascular health, mental health and addiction, and end-of-life/palliative care. Seniors and their caregivers will also directly benefit from the integration and quality improvement initiatives being undertaken by the LHIN, including Health Links and the Community Health Services Integration.

The focus of activities specific to the seniors strategic aim, are centred on addressing – and where possible – reversing frailty. The key activities are:

- Central East Regional Specialized Geriatric Services Entity
- Home First approaches and Transitions In Care
- Increasing Capacity to Support Seniors in the Community
- Senior Friendly Hospitals and Restorative Care
- Behavioural Supports Ontario
- Identify and implement strategies to promote access for Francophone and Aboriginal seniors to culturally and linguistically appropriate services

System Design

a) Central East Regional Specialized Geriatric Services Entity (RSGS)

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 is providing 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.

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. 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.

Over the last year, the RSGS Entity has worked towards:

- Establishing a shared governance model
- Recruiting RSGS program staff and establishing office space/shared back office support
- Strategic Planning
- Signing of a Letter of Understanding between partnering organizations of the RSGS and the Central East LHIN Board, January 2013

Upcoming activities include:

- Aligning the following programs and initiatives under the mandate and auspices of the Central East Regional Specialized Geriatric Services (RSGS) Entity:
 - Geriatric Assessment and Intervention Network (GAIN)
 - Geriatric Emergency Management Nurses (GEM)
 - Behavioural Supports Ontario initiative (BSO)
 - Nurse Practitioner Outreach to Long-Term Care (LTC) Program [also known as Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)]

- Completion of a needs assessment and capacity analysis of Specialized Geriatric Services (SGS)
- Identification of performance standards for SGS providers for 2013/2014
- Development of an RSGS multi-year strategic plan
- Development and implementation of a communications, community engagement and branding strategy/plan

b) Ontario Senior's Strategy

The Central East LHIN was an active participant in enabling input to the recommendations put forth by Dr. Samir Sinha, Provincial Lead, Ontario Seniors Strategy, concerning the development of a Senior's Strategy for Ontario. While the final report has not yet been made public, on the basis of the summary document titled *"Living Longer, Living Well"* circulated late 2012, the Central East LHIN is well positioned to continue to build a better system of care for older adults and their caregivers. Specifically, efforts are already actively underway to improve the following key areas of the summary document:

- Strengthening primary care for older adults
- Enhancing home and community care
- Improving acute care for the elderly
- Addressing specialized care needs of older adults
- Supporting senior friendly communities (including hospitals and LTC Homes)

c) Community Health Services Integration

Please see page 72 of this document.

Access

a) Geriatric Assessment and Intervention Network (GAIN)

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 part of ongoing efforts by the Central East LHIN to build an improved system of care for seniors within a regional geriatric framework. 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. Referrals to the clinics originate from the community, inpatient discharges and/or directly from the Emergency Department (ED), thereby improving flow within the ED, reducing time spent in the ED as well as reducing ED demand by having direct community access.

The four GAIN clinics received a total of 2538 referrals from April 2012 to September 2012, with increasing referrals quarter over quarter. The majority of GAIN referrals come from the community (1069), followed by emergency department referrals (655) and those resulting from inpatient discharges (268).

Efforts continue in developing standardized practices, protocols and processes across all four teams. A new fellowship program has been instituted for January 2013 – March 2013 as a "test of change" to build specialized geriatric capacity in the Central East LHIN. Four individuals are participating in this inaugural endeavor.

Further efforts are expected in 2013 to better integrate specialized geriatric services across the LHIN as follows:

- Enhance access to geriatric assessment and intervention services across the LHIN
- Explore opportunities to collaborate interprofessionally and interorganizationally to reduce the need for patients/caregivers to re-tell their story
- Strengthen linkages with other specialized geriatric services/initiatives (e.g. GEM, NPSTAT, BSO) within the context of the Central East Regional Specialized Geriatric Services Entity (RSGS)

b) Expanded Role of Community Care Access Centres (CCAC)

The new legislation pertaining to CCACs will see an increased role for the CCAC in the determination of eligibility for rehabilitation, complex continuing care, supportive housing/assisted living and adult day services. Building on the successes of Home First that saw increasing collaboration between hospitals, community support services and the CCAC in assisting patient's access to home care from the ED or upon discharge, 2013/2014 will see further progress into other patient pathways through the **Transitions in Care Committee, Resource Matching and Referral project**, and the expansion of **Assisted Living Services for High Risk Seniors**.

Transitions in Care

a) Home First

A critical approach to improving hospital bed utilization in the Central East LHIN has been the intensive application of the Home First philosophy, one of several province-wide initiatives undertaken by LHINs. The Home First approach aids in avoiding admissions and, once an admission occurs, moves patients through the hospital to the most appropriate community care setting.

The intent of Home First is to facilitate, wherever possible, the timely and safe return home of every individual who enters the hospital. This philosophy was rolled out across all the LHIN's acute care hospitals between September 2010 and April 2011. Since then, all hospitals have remained engaged in regular sustainability activities, in conjunction with the CCAC and community service providers. Home First involves early engagement of the CCAC and 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. Extensive education and training is undertaken with staff and physicians to support a culture change that will realize a sustained reduction in ALC designations.

Late 2012 saw the roll out of Home First to Ontario Shores Centre for Mental Health Sciences. Sustaining the Home First approach will continue to be an on-going focus of the LHIN, the CCAC, hospitals and community support service agencies for 2013/2014.

b) Restorative Care

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, 7 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.

Through funding made available by the Ministry of Health and Long-Term Care (MOHLTC), the Central East LHIN looks to expand the Long-Term Care Convalescent Care Program. These programs have the same functional goals as hospital based restorative services, with an expected length-of-stay to be no more than 90 days. Access to these programs is through the Central East CCAC.

c) Rapid Response Nursing (RRN)

The Rapid Response Nursing Program (RRN Program) is a new CCAC program funded through the Central East LHIN as part of the MOHLTC's nursing commitment. Complimentary to the improved patient transition management brought about by Home First, the RRN Program will enhance the CCAC's role as care connector by helping to bridge those high-risk clients who will most benefit from seamless transitions between hospital and community. The RRN Program embraces a cross-continuum and interprofessional team-based approach to resettlement services and care delivery 24-hrs post discharge. The aim is to provide timely, accessible and supportive professional services to clients and their caregivers during the most vulnerable period between clinical hand-offs.

A key target client population of the RRN Program is medically-complex seniors and adults who are at risk for hospital readmission and ED visits. Initially the focus will be on clients with a primary diagnosis of Chronic Obstructive Pulmonary Disease (COPD) or Congestive Heart Failure (CHF), and have other co-morbidities such as history of dementia, diabetes, etc.

Rapid Response Nurses provide professional re-settlement services in the home within 24 hours post-acute discharge including:

- Medication reconciliation
- Focused health assessment including physical examination as needed
- By exception, the RRN may provide stop-gap treatments and minor procedures based on clinical judgment and/or when access to nursing/physician services is delayed
- Education about disease processes and recognizing signs of destabilization utilizing teach-back methods

d) Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)

Nurse Practitioners Supporting Teams Averting Transfer (NPSTAT) is a LHIN-wide initiative that consists of Nurse Practitioners, working in teams, supporting LTC Home staff to better serve the residents in over 40 Central East LHIN LTC Homes. Nurse Practitioners are assisting to provide timely and safe care to help avoid preventable transfers to hospital emergency departments. As well, they are supporting the transition of residents into (and out of) hospital when an acute stay is required. With the assistance of the Ministry, the Central East LHIN has been able to expand the number of Nurse Practitioners in this role to enable increased uptake in 2013/2014 to more of the 69 LTC Homes in the LHIN.

Primary Care

a) Health Links

Please see page 70 of this document.

b) Geriatric Assessment and Intervention Network (GAIN)

Aligned with Dr. Sinha's recommendations, an important component of the GAIN model (previously noted) is the linkage to and communication with primary care. The interprofessional teams of the GAIN clinics provide recommendations back to the primary care practitioner who then works with the client to determine how to achieve the best outcomes. CCAC Care Coordinators are also directly linked to the four respective GAIN clinics, enabling smooth transitions and connections to community services.

Capacity and Funding

a) Investing in the Community Sector

The Central East LHIN is committed to working with the community sector to enhance and strengthen its ability to meet the needs of a rapidly growing and aging population within the available resources. We aim to build a stronger foundation by providing better access and higher quality care and enable seniors to live reasonably independent lives in their homes. The Central East LHIN has made investments in a variety of initiatives that will provide a continuum of care through the development, expansion and coordination of multiple community based services to assist clients to reside in an environment that is least restrictive and most suitable to their needs.

In May 2011, the Central East LHIN Board received the Sustainable Access to Community Health Care Services report which identified the need to focus on enhancing capacity in the community. Included in the study was the finding that although the 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/supportive housing for seniors.

Following recent investments in Assisted Living Services for High Risk Seniors made in 2011/2012 (180 units) and 2012/2013 (120 units), the LHIN intends to invest in additional Assisted Living programs across the Central East LHIN in 2013/2014, pending new funding or efficiencies resulting from integration.

Keeping its commitment towards expanding community based services; the Central East LHIN has also expanded Adult Day Program (ADP) services for the frail elderly and/or those with cognitive impairments. An investment of \$295,000 has been made, from the community sector increase, to expand system capacity to help adults achieve and maintain their maximum level of functioning to avoid premature and inappropriate institutionalization, and to provide respite and support to caregivers.

These structured, comprehensive, non-residential programs will provide health, social and related support services in a safe setting. Expanding access to services that support senior's independence and functioning such as adult day programs and assisted living services will continue to be a priority. Expanded access will target Aboriginal communities where access may be limited due to language or cultural factors.

Quality and Safety

a) Behavioural Supports Ontario

The Central East Behavioural Supports Ontario (BSO) initiative, launched in Fall 2011, was created to enhance services for LHIN residents with behaviours associated with complex and challenging mental health, dementia or other neurological conditions wherever they live - at home, in long-term care, or elsewhere – and directly impacts two of the four *Priority Areas* of the LHIN's 2013-16 IHSP; *Seniors* and

Mental Health and Addictions.

Quality improvement methodology has been, and will continue to be, the central planning and implementation focus for BSO. A Value Stream Mapping process resulted in dividing the initiative into four distinct streams as follows:

1. Long-Term Care Home (LTCH) – Part 1: responsive behaviour supported by the Integrated Care Team within the LTCH
2. Long-Term Care Home (LTCH) – Part 2: LTCH requests external assistance or transfers resident out (e.g. Geriatric Mental Health Outreach Team; hospital) until resident can be returned to a baseline level manageable within the LTCH
3. Community – responsive behaviour care and support prior to and up to the point of admission to LTC
4. Hospital and Tertiary Care – client care throughout, including ED visit and/or admission up to the point of discharge

The following table outlines the applicability of each stream of activity to improved care for seniors:

BSO STREAM	Seniors
1. LTCH: Part 1 Action: Continue spread and sustainability throughout all 69 LTCHs	• Improved quality of life and safety in LTCH • Reductions in senior hospitalizations and ALC days • <i>Sustainability Plan</i> – in development to continue spread and hold senior care gains
2. LTCH: Part 2 Action: Continue spread and sustainability throughout all 69 LTCHs	• Achieve full standardization of Geriatric Mental Health Outreach Teams/hospital transfer tools and processes across the LHIN • Engagement of Integrated Care Team to reduce ED transfers and increase the number of days clients spend at home
3. Community Action: Complete value stream map and initiate implementation throughout community	• Reduce the demand for LTC by having seniors spend more days at home in their communities • Standardized tools, processes, and response times to help keep seniors in home (in development) • Achieve full standardization of transfer tools and processes across the LHIN • Home changes from community to LTC, but benefits in care, wait times, hospitalizations still prevail
4. Hospital and Tertiary Care Action: Complete value stream map and initiate implementation throughout community	• Enhance quality of care for seniors by standardizing care plans and pathways and support return to LTC – increasing number of days clients spend at home

b) Falls Prevention

Please see page 71 of this document.

c) Senior Friendly Hospitals

The Senior Friendly Hospital (SFH) Strategy was launched across the province in 2010/2011 and is focused on enhancing the care and reducing the risk of functional decline of seniors when in hospital. The SFH Indicator Working Group recently completed its work on indicator identification and has suggested four cross-LHIN outcome indicators related to functional decline and delirium at an organizational level. To date, involvement and uptake of the initiative by hospitals has been voluntary. In 2013/2014, the Central East Regional Specialized Geriatric Services (RSGS) entity will assume oversight for the Senior Friendly Hospital initiative and coordinate implementation of a LHIN-wide adoption of the SFH framework.

Action Plans						
	2013/14		2014/15		2015/16	
SYSTEM DESIGN	Status	%	Status	%	Status	%
• RSGS	In progress	30	Continue	50	Continue	75
• Provincial Senior's Strategy	In progress	25	Continue	50	Continue	75
• CHS Integration Strategy	In progress	50	Continue	100		
ACCESS						
• GAIN	In progress	40	Continue	80	Continue	100
• Expanded Role of CCAC	In progress	50	Continue	100	Sustain	
TRANSITIONS IN CARE						
• Home First	Sustain gains		Sustain gains		Sustain gains	
• Restorative Care	Sustain gains and expand if available resources		Sustain gains and expand if available resources		Sustain gains and expand if available resources	
• Rapid Response Nurses	In progress	100	Sustain gains		Sustain gains	
• NPSTAT – expansion to all LTCHs	In progress	90	Continue pending available resources and sustain gains	100	Sustain gains	
PRIMARY CARE						
• Health Links	In progress	90	Continue	100	Sustain gains	
CAPACITY AND FUNDING						
• Investing in the Community	Target community investments	100	Target community investments	100	Target community investments	100
QUALITY AND SAFETY						
• BSO	Continue spread in LTC and move into community	60	Complete community spread and move into hospital sector	90	Complete hospital sector and sustain gains	100
• Falls Prevention	Continue implementation and spread of Integrated	25	Continue	50	Continue	25

	Provincial Falls Prevention Framework activities					
Senior Friendly Hospitals	To bring under RSGS umbrella	100	Continue to embed practices and approaches		Continue to embed practices and approaches	
How will we measure success?						
- Quantifiable enhancements in community services to enable seniors to remain at home, in their communities - Wait time to home care services - Clients with MAPLe scores high and very high living in community supported by CCAC - Clients placed in LTC with MAPLe scores high and very high as a proportion of total clients placed - Incidence of falls; falls related ED visits - ALC days						
What are the risks/barriers to successful implementation?						
- Sustainability of Home First is placing significant financial strain on CCAC and Community Support Services (CSS) - Ongoing need to drive practice change in hospital related to ALC designation - Increasing complexity of care needs having to be met in the community - Leadership and change management support in the system - Equitable fiscal resources inter and intra-LHIN - Financial implications/pressure related to HSFR - Recruitment/retention of professionals with geriatric expertise						
For each risk/barrier, describe the plan to mitigate the risk?						
- Continued diligence in working with the CCAC and CSS throughout the year to understand and quantify pressures and respond accordingly - Continued efforts towards seeking and fostering champions of change in the system to align and achieve common goals - Proceed with Community Health Services Integration Strategy to build community capacity and ready for further system transformation - Seek opportunities, like the GAIN Fellowship program, to “build our own” expertise base - Learn from initiatives like the Change Foundation’s PATH program currently underway in the Central East LHIN and consider a spread strategy						

What are some of the key enablers that would allow us to achieve our goal?
• Adequate funding and/or redistribution of current funding • Leadership (LHIN and HSPs) • Alignment of goals (provincial, LHIN, HSPs) • Better levers of change in the system e.g. accountability of non-LHIN funded services • Recognition of the important role of sustainability to hold the gains made to date

Integrated Health Service Plan Strategic Aim #2: Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.

Integrated Health Service Priority:
Vascular Health Strategic Aim: Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016 Vascular Health Vision: Optimize the vascular health of our communities. Vascular Health Strategic Advisory Committee (VHSAC) Mission: To promote the transition to an integrated vascular health care system within the Central East LHIN.
IHSP Priority Description:
Vascular diseases are major causes of illness, disability, hospitalization and death in the Central East LHIN and across Canada. Despite reductions in the number of people who die each year from vascular diseases, it remains the number one threat to the health of Canadians. Vascular diseases are a broad group of health conditions that affect almost all parts of the body – from head to toe. 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. Vascular disease impacts our individual health and our health care system. 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. 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 and its risk factors are prevalent in the Central East LHIN and result in high numbers of hospital admissions and emergency department visits – being 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, 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%. This aim was chosen because it requires various stakeholders to work in an integrated way to deliver services and supports to patients and their families. Expanding or initiating collaborations, partnerships, transfer or mergers of services are necessary to achieve this aim.
Current Status:
Three years ago Central East LHIN set a strategic aim to reduce the impact of vascular disease by 10% (10,000 inpatient days). It's projected that by March 2013 17,430 inpatient days related to vascular

disease will be saved. In the Central East LHIN, through vascular health priority projects and investments, we have increased awareness of and access to:

- Client and caregiver chronic disease self-management training and clinician training in self-management support
- Acute stroke care
- Cardiovascular rehabilitation
- Inter-professional diabetic care
- Harmonization of practices across primary and specialty care settings for screening and treatment of vascular disease

Priority Population:

- Persons with established vascular disease including: cardiovascular and cerebrovascular conditions, vascular dementia and stroke, peripheral vascular disease and atherosclerosis
- Persons at higher risk of developing vascular disease namely: Seniors
- People with diabetes, reduced kidney function, heart disease, experienced a stroke
- First Nations, Metis, Aboriginals, and visible minorities
- Francophone populations

The Central East LHIN Vascular Health Strategy is focused on secondary prevention of disease and modification of risk factors for those with high needs.

Key issues facing this client group

High prevalence of vascular and related diseases and related risk factors continue to challenge both individual consumers and the Central East LHIN health system.

Vascular Health Risk Factors

The following risk factors are related to vascular health:

- Approximately 18% of Central East LHIN residents are smokers.
- Over half (53%) of LHIN residents are overweight or obese. Although the prevalence is similar to the provincial average, it has been increasing over time.
- The prevalence of physical inactivity (55%) is among the highest across LHINs and significantly higher than the provincial average of 49%. This is driven by the high rate of physical inactivity in the Scarborough cluster (66.6%). Physical inactivity rates are 42.3% and 48% in the North East and Durham clusters respectively.
- Smoking, being overweight/obese and physical inactivity is a risk factor for vascular diseases and many chronic conditions including diabetes.

Chronic Disease

- 37% of Central East residents (aged 12+) have a chronic condition and 17% have multiple conditions.
- Prevalence of multiple chronic conditions increases dramatically with age; 43% of LHIN residents aged 65-74 and 55% of those aged 75+ have two or more chronic conditions.
- Chronic conditions account for 6 out of 10 deaths, 1 out of 5 acute hospital separations, and 1 out of 4 acute hospital days for LHIN residents.
- The prevalence of chronic conditions in Central East is similar to provincial rates. There are upward trends in Central East for diabetes and hypertension (high blood pressure).
- Heart disease (including ischemic heart disease (IHD) and congestive heart failure (CHF) and stroke account for an additional 10% of all hospital days and 9% of all acute care separations.

- 15% of the population aged 65-74 has heart disease. The prevalence increases to 26% among those aged 75+. The prevalence rate of heart disease is slightly higher in the Central East LHIN than the province.
- The Central East and the South East LHINs have the highest rates of diabetes in Ontario at 7.9%. This was significantly higher than the provincial average of 6.9%.
- Hospitalization rates for most chronic conditions (except diabetes and hypertension) has been decreasing since 2005/06.
- Ischemic heart disease, cerebrovascular disease (stroke) are leading causes of death and potential years of life lost in the Central East LHIN – consistent with the provincial rates.

Condition	Hospital days rate per 100,000	Hospital days rate per 100,000
	Central East	Ontario
Congestive Heart Failure (CHF)	1310.4	1524.2
Diabetes	866.7	923.9
High Blood Pressure (Hypertension)	58.9	92.6
Ischemic Heart Disease (IHD)	1798.5	2103.7
Stroke	1452.4	1691.9

Source: *Cross LHIN Environmental Scan (IHSP 2013-16)*

Goal(s):

Achieving the vascular health aim will require inter-sectoral action between hospital, primary & specialty care, CCAC and community agencies in partnership with patients and their families. Priority areas for action span both community and hospital care settings. Regional coordination of vascular services, cardiac rehabilitation, stroke care and stroke rehabilitation are system design objectives.

Under the leadership of the Central East LHIN Vascular Health Coalition, a Vascular Health Strategy has been developed. The four overarching areas within the Vascular Health Strategy are:

1. Enhancing consumer/family supports & empowerments
2. Strengthening the design of vascular health and service delivery models
3. Enhancing community and primary care based services and supports
4. Developing supportive vascular health policies

The Vascular Health Strategic Aim Coalition (VHSAC) identified nine priorities on which to focus during the IHSP 2013-2016. This Vascular Health Strategy will guide Central East LHIN planning, integration activity and investments.

Priority initiatives include three **NEW** and six **CURRENT** or underway priority activities.

Consistency with Government Priorities:

The achievement of the vascular health aim supports many government priorities, including:

- Action Plan for Health
- 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 cardiovascular Case Mix Groups (CMGs) and Diabetes
 - 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
- Improving health outcomes and satisfaction for patients
- Supporting LHIN service providers through the implementation of the second phase of self-management of chronic disease workshops in French
- Strengthening the use by Francophones with chronic diseases conditions of services available from identified, designated HSPs or those who have ability to provide services in French in the Central East LHIN.
- Offering peer-leader workshops on self-management of chronic diseases in geographic areas with high concentration of Francophone populations. And, measure the results of these workshops.

Most notably the Central East LHIN vascular health aim directly actions the Ontario Integrated Vascular Health Strategy (OIVHS) - Blueprint (2012). The Central East LHIN has been identified as an Early Adopter LHIN for the implementation of the OIVHS Blueprint.

Action Plans/Interventions:

Action Plans						
	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
25,000 days spent at home in the community equates to 25,000 less days spent in hospital. As such, efforts to reduce avoidable hospitalizations will be a core focus namely: • Reducing readmissions to hospital, which could have been avoided if the care in hospital or the care after discharge was optimized;	Is a focus/ component of all vascular health initiatives	25	Continued uptake and spread	30	Continued progress	20

- Preventing initial hospitalizations which could have been prevented with comprehensive primary care focused on chronic disease management and prevention for patients with ambulatory-care sensitive conditions; - Reducing hospital days due to preventable adverse events in hospital.						
Development of Complex Diabetes Care system including centralized intake for diabetes education & management	In progress	50	Continued progress	50	Complete	0
Equitable access to best-practice Cardiovascular Secondary Prevention and Management across the LHIN (e.g. Cardiac Rehabilitation)	In progress	50	Continued progress	20	Complete	10
Identify hospital/community-based initiatives to support Congestive Heart Failure	Monitor	--	Monitor	--	Monitor	--
Self Management and Self Management support	In progress	75	Continued progress	10	Continued progress	10
Maintain in Durham/Scarborough and build new Primary Percutaneous Coronary Intervention (PCI) [coronary angioplasty] and Code STEMI capacity in the North East Cluster	Complete	25				
Hospital and Community smoking cessation partnership	Pre planning initiated	20	Initiate implementation	20	Continued progress	20
Equitable access to vascular surgical services across LHIN	In progress	70	Continued progress	20	Complete	10
Finalize Regional Vascular Surgery Service Level Agreement between Central East LHIN hospitals	Complete	20				
Early Chronic Kidney Disease (CKD) Management through Primary Care	Pilot sites identified by Ontario Renal Network (ORN)	20	Spread learnings	20	Continued spread of learnings	20

Ontario Telemedicine Network utilized for vascular clinical and education opportunities (e.g. diabetes and vascular health physician education “grand rounds”)	In progress – infrastructure and HR investments in place	25	Implement vascular focused initiatives	25	Continued spread and use	25
Continued development of a Central East Unified Stroke System including enhanced access to stroke acute and rehabilitation services and implementation of stroke care best practices	Pre planning with Ontario Stroke Network (OSN) initiated	20	Implement recommendations for service level and system improvements	25	Continued implementation	20
Transitions & E-Health initiatives to support achievement of vascular health aim including: • Pre-planning for hospital discharge • Improved communication between health professionals in different settings as well as between clinicians & patients • Medication reconciliation & management when the patient returns home • Patient & caregiver education • Timely primary care follow-up	Is a focus/ component of all vascular health initiatives	20	Continued uptake and spread	20	Continued progress	20
Assume accountability for selected Central East LHIN adult and paediatric diabetes education programs, and identify areas for quality improvement	Initiation	50	Implement Opportunities	25	Complete	25

How will we measure success?

The Vascular Health Coalition has developed a draft scorecard for vascular health priority initiatives*. This will continue to be developed and report back mechanisms identified during 2013/2014.

Overall Vascular Health Aim:

Metric:

Reporting Level:

Number of inpatient days saved

LHIN

Readmissions within 30 days for selected CMGs – CHF

Hospital

Readmissions within 30 days for selected CMGs - COPD/Pneumonia

Hospital

Readmissions within 30 days for selected CMGs – Diabetes

Hospital

Readmissions within 30 days for selected CMGs - Stroke (CVA)

Hospital

Reduction in readmission rates for cardiac patients

Hospital

CHC Diabetes Indicators:

Percentage of rostered clients with particular Chronic Disease (type 2 diabetes) receiving
Vacancy Rate (NPs and Doctors)

What are the risks/barriers to successful implementation?

- Implementation of Emergency Management Services protocols to support CODE STEMI in North East cluster
- Stakeholder resistance to change/confidence
- Variability in physician specialist (cardiology) 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
- Financial implications of the implementation of Quality Based Funding procedures for vascular conditions (CKD, Stroke, CHF, Coronary Artery Disease)
- Transition of accountability for Diabetes Education Programs to LHIN from MOHLTC

For each risk/barrier, describe the plan to mitigate the risk?

Risks identified will be mitigated through:

- Identification of LHIN level HSP leadership at administrative and clinical level who will champion high priority vascular initiatives
- Provincial collaboration with MOHLTC, other LHINs, OIVHS partners (Ontario Stroke Network, Heart and Stroke Foundation, Cardiac Care Network) and the Ontario Renal Network
- Continuation of the Central East LHIN Vascular Health Coalition to provide LHIN level leadership
- Supporting strong project management capacity within programs/initiatives during implementation
- Identification of opportunities for LHIN level re-investment toward achieving vascular priorities

- Development of LHIN level vascular and diabetes staff team
- Continued monitoring of impact of implementation of Quality Based Funding procedures

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

- Provincial support to joint implementation of the Ontario Integrated Vascular Health Blueprint by LHINs, Cardiac Care Network, Heart and Stroke Foundation and the Ontario Stroke System. The Ontario Renal Network should also be engaged in implementation of the Blueprint – 60% of dialysis patients have diabetes as well as other cardiovascular risk factors.
- Adequate funding for implementation of Central East LHIN North East PCI program
- Leadership by the Ontario Stroke Network in partnership with Central East LHIN to redesign stroke system in Central East

Integrated Health Service Plan Strategic Aim #3: Strengthen the system of supports for people with Mental Health and Addiction issues so they spend 15,000 more days at home in their communities by 2016.

Integrated Health Service Priority:

Strengthen the system of supports for people with mental health and addiction issue so they spend 15,000 more days at home in their communities by 2016.

IHSP Priority Description:

The strategy supporting this priority is to strengthen community supports for people with mental health and addiction issues so that they are able to remain in their home communities for an additional 15,000 more days from 2013-16.

This strategy will focus on five key areas:

- Access
- System Design
- Capacity and Funding
- Transitions and Electronic Health Information Management
- Quality and Safety

Progress will be measured using MOHLTC Systems Measures: the Rate of Unplanned, Unscheduled ED visits within 30 days, the Ontario Common Assessment of Need (OCAN), and measures specifically evolved to measure each initiative and the performance of the Central East LHIN's mental health and addiction system overall. Quality based system improvements in these key areas will result in an increase in the number of days people spend in their communities by providing mental health and addiction care more effectively and closer to home.

Within this aim, we will target those who are the most vulnerable. This will include First Nations, Métis and Non-Status Peoples, along with those who are frequent users of the Emergency/Crisis System, and who have multiple system involvement. We will also focus on providing services to those with Concurrent Disorders, as they make up the largest number of returning visitors to Central East LHIN Emergency Departments. We will not only ensure that the mental health and addiction system in the LHIN is Concurrent Disorder (CD) capable, we will work to improve the CD capacity of the health system overall. We will work with primary care providers to address the complex needs of people with mental health and addiction issues to ensure they are receiving the care they require. We will strengthen the network of community and peer supports to ensure those with mental health and addiction issues are able to access the services they need to reach and maintain stability in the most important spheres of their lives: home, job and friends.

The Central East LHIN will work with mental health and addictions and primary care providers in partnership to achieve this aim, which we believe will contribute to the eradication of the stigma often experienced by those with mental health and addiction issues in our health care system.

The following Strategies have been developed to support this aim:

- Hospital to Home Teams, (H2H Teams in the North East and Durham clusters): These integrated community/hospital teams are embedded in the most active Emergency Departments of the Central East LHIN. The Durham Team, based at Lakeridge Health Oshawa includes Intensive Case Management, Community Crisis Supports and Beds, Community Treatment Order Case Management, Substance Abuse Withdrawal Management, Addictions Treatment and Case Management, Concurrent Disorder Treatment Services and Consultation and links to Primary Care. The Central East LHIN will seek to further develop this strategy through quality improvement measures, and will determine a plan to further develop the H2H Team in the North

East cluster. An anti-stigma strategy is embedded in this Team, as is a specific accessibility strategy directed to Aboriginal Peoples.

- Reformatting of the Mental Health Support Unit (MHSU), Police/Mental Health Team that will firmly link these services with those of Lakeridge Oshawa and the H2H Team.
- Continued support of the “Elliott House” Community Crisis Bed Program located in Ajax and linked with the Rouge Valley Health System and with the H2H Team.
- Ontario Telemedicine Network (OTN) and Telepsychiatry will be used as strategic enablers to this aim. The installation of three new OTN machines in the North East cluster will make both direct treatment and consultation services more available to residents of this largely rural area. OTN will now enable links to the Pinewood Centre, which will provide improved access to specialized Addiction and Concurrent Disorder treatment and consultation services across the LHIN. OTN will be used to enable access to Psychiatric Treatment and Consultation Services for Primary Care Providers thus allowing them to support people with more complex needs. OTN will also support the use of Psychiatric Sessional Fees by connecting Health Service Providers with teaching facilities and consultation services for the purpose of staff development, training and case consultation. The Consumer Survivor Initiative Network of the Central East LHIN, (CSI) will use OTN services to build relationships between Peer Support Providers across the LHIN as they develop joint training, consultation and networking initiatives.
- Implementation of the Opiate Strategy throughout the Central East LHIN will ensure that Methadone Clinics located in each of the three clusters will be linked to both primary care and mental health and addiction service providers. The Opiate Strategy will target two key areas in the LHIN where the population of Methadone registrants is highest. It will expand existing Methadone Case Management in the Durham cluster and establish Methadone Case Management in the North East Cluster and will expand Pre and Perinatal services throughout the LHIN. The Opiate Strategy will build the capacity of the system to support those with Concurrent Disorders and will target the Opiate treatment capacity of the Aboriginal Communities throughout the LHIN via a specific Aboriginal Concurrent Disorder Capacity Building Project. This will further develop and solidify relationships between Aboriginal Service Providers and local Health Service Providers. The Opiate Strategy will provide specific training to the Health Units who will be able to provide Opiate reversal kits. This training is provided by the Toronto Public Health Unit.
- The Scarborough Cluster Integrated Addictions System Project was led and implemented by the Pinewood Centre in January of 2013. This project will continue to be refined through the quality improvement processes built into the implementation plan. This initiative will ensure local access to Scarborough residents to Withdrawal Management and Addictions Treatment services.
- Continued support of the Mental Health “Nurses in the Schools” program led by the CECCAC, which will focus on children who require hospitalization for a Mental Health and/or Addiction issue to return to school.
- Continue to work collaboratively with other Ministries, most notably Ministry of Children and Youth Services (MCYS) and Ministry of Community and Social Services (MCSS) around strategies to address the needs of Aboriginal Communities.
- Work collaboratively across sectors to determine a system of support for people with complex dual diagnoses.
- Support the inter-regional initiatives that promote optimal use of resources allocated to the Francophone school boards through the program of specialist nurses in mental health and addiction.
- Ensure that Mental Health and Addiction Services are available to Francophone residents residing in the LHIN within their preferred linguistic and cultural context.

- Facilitate the further development of positive relationships between Aboriginal Communities and Health Service Providers with Mental Health and Addiction Health Service Providers in the areas of capacity building and direct treatment.
- Complete the development of recommendations that will advise improvements to hospital based Child and Adolescent Psychiatric Services and determine a plan for moving these recommendations forward.
- Complete a Quality Improvement Process for Central East LHIN ACTT Teams and move forward with the process for implementing and evaluating these new processes.
- Determine a plan for improving services to people with neurological challenges and Acquired Brain Injury in the Central East LHIN.
- Determine a cross sectoral model that will maximize and potentially improve access to Child Developmental Assessment and Treatment Services
- Investigate and implement opportunities to integrate Primary Health Care with Mental Health and Addiction Treatment Services.
- Work with GTA LHINS to standardize access and processes connected to Police/Mental Health Intervention Teams.
- Continue to monitor and make adjustments to the ongoing operation of the Schedule 1 Bed Registry and Common Assessment tool and develop an Outcomes Evaluation strategy.
- Development of Client Centred housing models in partnership with Mental Health and Addiction Service Providers that meet the articulated needs of people with complex needs who are either homeless or at risk of homelessness.

Current Status:

Currently, the Central East LHIN has been working to consolidate and focus resources directed to reducing unscheduled ED visits within 30 days and, reducing In-Patient Psychiatric Bed Days. The LHIN has welcomed these systemic measures as an opportunity to improve the system, and views these repeat visits as an indication that more “upstream” solutions are required. The LHIN is currently using OCAN Data and specifically designed outcomes data in the form of “Project Scorecards” to measure the success of this aim. The LHIN is further strengthening the community crisis system and building on the initial success of the “Durham ED Avoidance Coalition”, (08/09) via the Hospital to Home Initiative and the implementation of the Integrated Scarborough Addictions System. Responses to these initiatives have been very positive from both service providers and users. Both are continuously measured via MLPA targets and scorecards specific to these projects. The scorecards include QI based measures that integrate both community and hospital based outcomes. Embedded in this is a focus on developing specific strategies that are focused on those with access issues related to their cultural context, such as Aboriginal Peoples, and those who frequently access the system and present with highly complex needs, such as, those with a dual diagnosis or concurrent disorder.

The LHIN is responsible for funding 27 community mental health and five addiction programs for a total of 32 programs that serve people with concurrent disorders. Improving concurrent disorder capacity and integration of programs and access is a key enabler of this strategy. The development of a strategy to improve the concurrent disorder capacity of primary care providers is being discussed. The project scorecard provides diagnostic information regarding the mental health or addiction visit, which has been instrumental to continuous quality improvement. Hospital to Home is aiming to reduce unscheduled repeat visits by 10%. The complexity of those who require and receive these services has made achieving this aim highly complex. The work to date on this aim has highlighted the importance of integration with the wider system in order to ensure access to primary health care supports and services.

The Central East LHIN has the third highest number of in-patient psychiatric days. House to Home and other community based strategies are seeking to reduce this amount by 10%. The achievement of this aim will ensure that “upstream solutions” have been successful in reducing the need for repeat ED visits and psychiatric in-patient bed days.

Goal(s):

- Reduce unscheduled return visits to Central East LHIN Emergency Departments by 10% by March 31, 2014.
- Reduce In-Patient Psychiatric Days by 10% by March 31, 2014.

Consistency with Government Priorities:

These goals are in alignment with the Minister’s Ten Year Mental Health and Addictions Strategy, as well as with the Opiate Strategy Framework.

Action Plans/Interventions:

- Hospital to Home Teams in the Durham and North East cluster
- Continued support of the Community Crisis System and a restructuring of the MHSU, (Mental Health Support Unit-Community/Police Team)
- Investigation of housing options with cross sectoral partners
- Increase concurrent disorder capacity in the mental health and addictions system as well as in the primary care system through specific capacity building activities
- Assertive Community Treatment Team (ACTT) Value Stream Mapping and Performance Improvement Project
- Hospital based Child and Adolescent Psychiatric Services Recommendations Report
- Central East LHIN Opiate Strategy
- Scarborough Integrated Addictions Treatment System
- Ongoing monitoring of Central East LHIN Common Assessment Tool and Schedule 1 Bed Registry

Action Plans						
	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Continue Hospital to Home Teams in Durham and North East Cluster	In progress	100	In progress	--	In progress	--
Implement Opioid Strategy in Durham and North East cluster, targeting areas of highest Methadone use. Opioid Strategy includes a strategy for building CD capacity throughout the MH and A, and Primary Care System. Implement Aboriginal capacity building project and determine ongoing Aboriginal Strategy. Implement Public Health Opioid Training Project	Implementation	70 100	In progress Completed	30	In progress	--
Establish Integrated Addiction Treatment system in the Scarborough Cluster. Includes CD capacity building strategy	Implemented and In progress	100	In progress	--	In progress	--
Monitor Quality and Safety through Accountability Agreements with Providers. This will be supported by Cluster Based Hospital to Home Teams working within quality improvement principles	Implemented and In progress	100	In progress	--	In progress	--
Continuous QI projects, such as the ACTT Value Stream Mapping work and the Schedule 1 Bed Registry	Implemented and In progress	100	In progress	--	In progress	--
How will we measure success?						
A 10% reduction in Unscheduled ED return visits at Lakeridge Health, Peterborough Regional Health Centre and Ross Memorial Hospital A 10% reduction in overall in-patient Psychiatric Bed Days throughout the Central East LHIN						
What are the risks/barriers to successful implementation?						
Lack of provider and/or system support for the initiatives Complexity in measuring system outcomes Complexity of this issue translates to slow and complex progress measures Complexity of the “upstream solutions” related to the aim Data collection at the ED is based on the most prevalent discharge diagnosis. Therefore it is difficult to						

measure overall system success related to concurrent disorders, or to obtain a more detailed understanding of what has precipitated an ED visit.
For each risk/barrier, describe the plan to mitigate the risk?
Close monitoring by the Central East LHIN and ongoing adjustment as necessary Quality improvement strategies Monitoring by Aboriginal Advisory Circles
What are some of the key enablers that would allow us to achieve our goal?
• Ongoing use of quality improvement principles and development of achievable indicators • Strong relationships with providers • Systemic measures of concurrent disorders and secondary diagnoses

Integrated Health Service Plan Strategic Aim #4: Increase the number of palliative patients who die at home by choice and spend 12,000 more days in their community by 2016.

Integrated Health Service Priority:

Increase the number of palliative patients who die at home by choice and spend 12,000 more days in their communities by 2016.

IHSP Priority Description:

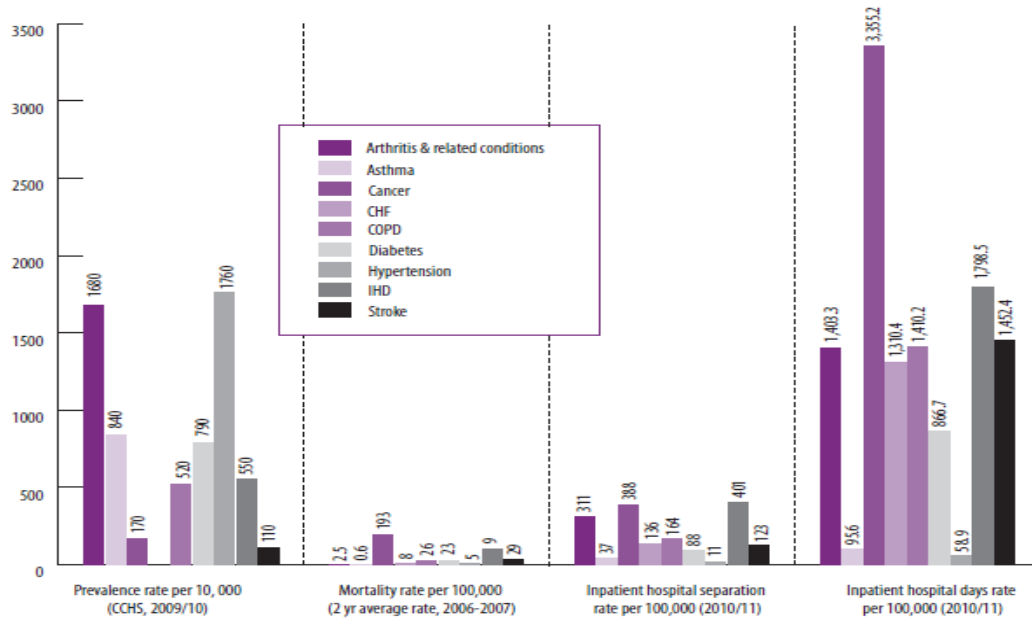
Palliative and end of life care is an approach to caring for people who are living with a life-threatening illness. It focuses on achieving comfort and ensuring respect for the person nearing death and maximizing quality of life for the patient, family and loved ones. Palliative and end of life care is holistic in nature and aims to:

- Address physical, psychological, social, spiritual and practical issues and their associated expectations, needs, hopes and fears
- Prepare for and manage self-determined life closure and the dying process
- Cope with loss and grief during the illness and bereavement

While many chronic diseases are life limiting, individuals with advanced chronic disease or end-of-life care needs require especially high quality palliative and end of life care services and supports. As the population continues to age, chronic illness and advanced co-morbid conditions are becoming increasingly common. In particular:

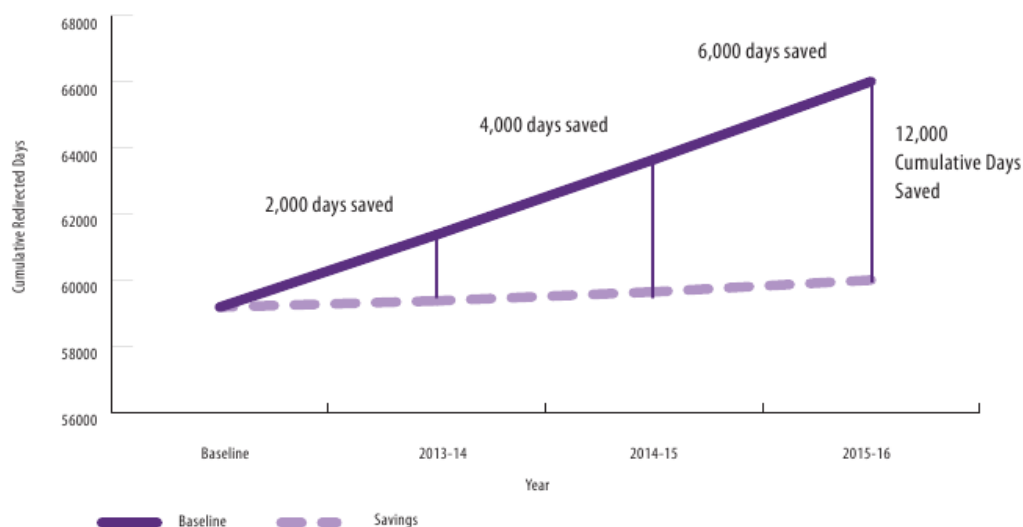
- Over 14% of the LHIN's population are seniors aged 65 years and over. By 2016, seniors will account for 16% of the LHIN; by 2021 they will account for 18%
- Chronic conditions account for 6 out of 10 deaths, 1 out of 5 acute hospital separations, and 1 out of 4 acute hospital days for LHIN residents
- Heart disease (including ischemic heart disease, congestive heart failure and stroke) accounts for an additional 10% of all hospital days and 9% of all acute care separations

CENTRAL EAST LHIN BURDEN OF CHRONIC CONDITIONS



By 2016, the Central East LHIN aims to increase the number of palliative patients who die at home by choice and spend 12,000 more days in the communities. The below graph highlights projected measures of change over the next three years. Specifically, 2,000 total palliative hospital days saved between 2013-2014, 4,000 days saved between 2014-2015 and another 6,000 days saved between 2015-2016 totaling 12,000 cumulative days redirected from acute to community based settings.

HOW WILL THE PALLIATIVE & END OF LIFE CARE AIM BE ACHIEVED?



Current Status:

Scope of Services Currently Provided

The Central East LHIN supports a variety of organizations offering hospice, palliative and end of life care services across the region including:

- Community based volunteer services and bereavement support
- Hospital based palliative programs offering specialty clinics and designated beds
- Community Outreach Nurse Practitioners and specialty care teams
- Interdisciplinary and physician education
- Palliative Pain and Symptom Management Consultation Services
- Community and Community Hospice Services including day programs, friendly visiting, grief and bereavement, respite and caregiver supports

Type of Providers Involved

The achievement of this aim requires active partnership and collaboration from a host of providers across the Central East LHIN including:

- Central East Hospice Palliative Care Network (CEHPCN)
- Provincial End of Life Care Networks
- Community Hospice Providers and their volunteers
- Central East Community Care Access Centre
- Interdisciplinary Care Teams
- Primary Care
- Community Palliative Nurse Practitioners
- Long-Term Care Homes

The Central East Hospice Palliative Care Network (CEHPCN) specifically, will play an integral role in the accomplishment of this aim through active engagement with key Central East LHIN stakeholders. Additionally, the Network will help establish and prioritize key deliverables including Ministry/LHIN action items and accountabilities as outlined in the Provincial document, *Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action*.

The CEHPCN is a voluntary affiliation of hospice palliative care and related organizations. Its mandate is to provide leadership for the development and evolution of a comprehensive, integrated and coordinated system of hospice palliative care for the Central East Region through:

- Development of standards and supports for delivery of care
- Support for implementation of best practices
- Education and knowledge transfer
- Support for building system capacity and access to hospice palliative care

Key Issues Facing this Client Group

There are a number of key issues currently facing our region's palliative clients. For example:

- Growing elderly populations and advanced co-morbid conditions have translated into an increased need for hospice, palliative and end of life services and supports

- Minimal palliative assessments and cultural awareness surrounding advanced care planning
- Limited capacity to support patient's choice to receive palliative and end of life care at home or in their communities
- Inconsistent support/respite care for families and caregivers
- Inconsistent coordination between hospitals, primary and specialty care, the CCAC and community agencies in partnership with their families

Successes of the Past Year

The Central East LHIN has begun putting programs in place that will enhance cultural awareness, expertise and service availability to support patients and families in need of palliative and end of life care. For example:

- **The Community Palliative Nurse Practitioners Program** has been rolled out across the Central East LHIN including the Scarborough, Durham and the North East clusters. The program supports individuals and their families in the community living with a terminal condition. It has helped fill a gap in community based palliative care management by enhancing the availability of Nurse Practitioners and their capacity to facilitate quality care to palliative clients in the home.
- **Palliative Pain and Symptom Management Consultation Services** have assisted service providers in home care agencies, long-term care homes, community support agencies and primary care settings by providing access to Palliative Pain and Symptom Management Consultants. These positions offer consultation, education, mentorship and linkages to palliative care resources across the continuum of care.
- **Standardization of Palliative Education Services** have offered a variety of streamlined programs and activities in an effort to better align resources resulting in improved equitability and accountability of educational services across the Central East LHIN regions.
- **Strengthened Community Hospice Services** have been supported through investments in innovative hospital-community partnerships in an effort to improve access to end of life care in all settings. This has reinforced the sustainability and value for money in Community Hospice Services across the Central East LHIN.

Goal(s):

The Central East LHIN aims to better support and inform patients and their choice to receive palliative and end of life care at home or in their communities. In achieving this aim, the LHIN intends to support a number of key enablers supporting the IHSP including:

- **Increased access and opportunity for patients** to receive palliative and end of life care within their homes and communities through enhanced interdisciplinary teams and outreach teams
- **Improved support in primary care settings** through advanced care planning
- **Enhanced system design and integration** through involvement with the Community Health Services Integration Strategy
- **Increased capacity and value for money** by redirecting services from acute care settings and into communities
- **Heightened quality and safety** through increased education and training opportunities
- **Transitions in care and e-Health opportunities** by promoting alternative options and care settings within the community

Consistency with Government Priorities:

In addition to the above highlighted IHSP enablers and related activities, increasing the number of palliative patients who die at home by choice and spend more time in their communities also aligns with the Ministry's proposed new model for hospice palliative care as outlined in the document, *Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action*. Specifically:

- Adults and children with advanced or end of life chronic disease(s) and their informal support network will receive care and support that is proactive, holistic, person and family-focused, centering on quality of life and symptom management issues, and delivered by a virtually integrated inter-professional team in a coordinated, continually-updated care plan, that encompasses all care settings in which the client receives care.

Action Plans/Interventions:

All Central East LHIN residents have the right to die with dignity, to have access to physical, psychological, bereavement, and spiritual care, and to be granted the respect consistent with other phases of life. Ensuring timely access to quality palliative and end of life care is not only an ethical imperative but a vital component of our health care system. This is why the focus of activities specific to the palliative and end of life aim are centred on supporting individual choice and the option to receive palliative and end of life care in their home and community settings. Planned activities are included in the following table:

Action Plans	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Education and leadership opportunities for primary care	In Progress	25	In Progress	50	In Progress	25
Expand and promote Advanced Care Planning in primary care settings	Not Yet Started (Will commence this year)	25	In Progress	25	In Progress	50
Establish outreach processes through the CCAC and primary care to identify individuals with advanced chronic disease and connect them with inter-professional care	Not Yet Started (Will commence this year)	25	In Progress	25	In Progress	50
Integrate community and hospital services to support a LHIN-wide Palliative Care Program coordinate at the local level	In Progress	25	In Progress	25	In Progress	50
Pursue opportunities for residential hospice	In Progress	25	In Progress	25	In Progress	50
Strengthen community hospice through the Community Health Services Integration Strategies	In Progress	25	In Progress	25	In Progress	50
Increase the number of community palliative nurse practitioners to support individuals, families and professional caregivers	In Progress	50	In Progress	25	In Progress	25
Utilize E-Health solutions to improve patient discharge and	Not Yet Started	0	In Progress	50	In Progress	50

help clients locate alternatives to care						
Support transitional care options outside of the hospital	In Progress	25	In Progress	25	In Progress	50
Expand and promote standardization of hospice, palliative and end of life care programs in Long-Term Care homes and hospitals.	Not Yet Started (Will commence this year)	25	In Progress	25	In Progress	50
How will we measure success?						
Achievement of this aim will result in improved access and support for community hospice, palliative end of life services, increased patient satisfaction and choice and service efficiency, while decreasing the burden on health care costs. Success will be measured according to a number of health service provider process and output indicators. These measures will include: • Number of patients with an advanced care plan • Number of patients receiving care in the hospice services community • Number of courses provided to volunteers and health care professionals • Number of patients supported by the Palliative Care Nurse Practitioner Program • Decrease in Alternate Level of Care for palliative care • Increase in hospital palliative discharges to home with support • Reduced hospital Length of Stay • Reduced hospital deaths • Decreased Emergency Department visits for palliative care Finalized palliative and end of life care Ministry LHIN Performance Accountability Agreement indicators are pending. These will be informed by senior level LHIN leadership representatives across Ontario.						
What are the risks/barriers to successful implementation?						
There are number of risks and barriers to the successful implementation of this aim. These include issues surrounding change management, resources and work, for example: • HSP and stakeholder resistance to change and lack of stakeholder commitment/confidence • Family and caregiver demands • Client perception of need (i.e. perception that only acute care settings are able to meet their needs) • Development of more effective working relationships and referral patterns between hospital and community providers • Limited human resources and lack of appropriately trained staff (i.e. increased demand for community nurse practitioners, physicians and personal support workers) •						
For each risk/barrier, describe the plan to mitigate the risk?						

Identified risk and barriers will be mitigated in the following ways:

- LHIN collaboration with MOHLTC, CEHPCN partners, Provincial End of Life Network Partners, Cancer Care Ontario and other LHINs
- Continuation of CEHPCN leadership to support and inform IHSP planning and implementation
- Ongoing quality improvement initiatives and activities
- Building strong project management capacity within programs and initiatives throughout implementation
- Identification of opportunities for LHIN level re-investment toward achieving palliative and end of life care priorities
- Continued data quality research and review to ensure complete and accurate information is reported (i.e. Assisted Health Research Question Proposal submission to the MOHLTC)

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

Key enablers that would allow the Central East LHIN to effectively and efficiently achieve this goal include:

- Ongoing engagement and collaborative with Hospice, Palliative and End of Life leadership from across the Central East LHIN to identify barriers and opportunities to improve access to community services
- Acknowledgment that substantial organizational change is accomplished over multiple years
- Clear alignment between desired outcomes and metrics

Central East LHIN Common Enablers to Achieve IHSP Strategic Aims

Achieving these aims requires a concerted effort of the Central East LHIN, LHIN funded health care providers, other health and social service partners and, of course, our patients and their caregivers.

The 2013-16 IHSP identified a set of common enablers related to health system design and improvement that consistently weave between all of our four strategic aims. Those common enablers are:

- Improving Access to Primary Care
- Access and Wait Times - Including Emergency Department, Surgical, and Diagnostic Services
- Health System Funding Reform
- Health System Design & Integration
- Transitions in Care & Electronic Health Information Management
- Quality & Safety

Improving Access to Primary Care

Integrated Health Service Plan Enabler:
Access: Improving primary care so that it provides the right care, at the right time, by the right provider
Integrated Health Service Plan Enabler Description:
• Primary Health Care is the first point of contact a person has with the health system – the point where people receive care for most of their everyday health needs. Primary care providers are integral in facilitating smooth transitions in care. • Guided by the Minister's Action Plan for Health proposal to bring the organization of primary care under the mandate of the LHINs, our initial focus is building and strengthening our partnership with primary care, and their partnerships with other parts of the health care system. • With the support of primary care leadership, efforts are underway to improve the care coordination between primary care and other health services, as well as improving timely access to primary care as an alternative to a hospital visit.
Current Status:
• 93% of Central East residents report that they have a regular family doctor however, only 70.3% of LHIN residents are satisfied with the availability of care in general. Data collected from public surveys suggests that access to family doctors may still be problematic for some Central East LHIN residents. • The lowest rate of enrollment in Patient Enrolled Models of primary care are the 90+ age cohort. • 7 Community Health Centres • 10 Family Health Teams • 3 Nurse Practitioner Led Clinics • Approximately 1100 family/general practitioners • Peterborough Health Links and planned roll-out across LHIN

Goal(s):

Primary care initiatives have been identified in each of our system aims. The following are additional areas of focused improvement:

- Raise profile of primary care through networking
- Creation of Health Links with primary care partners
- Support the adoption of Advance Access (same day appointments) to primary care
- Work with system partners to identify and support people at high risk of hospitalization or re-admission
- Leverage information technology (e.g., Electronic Medical Records) capacity to support informed, proactive care of patients within primary care and their transitions in care
- See below Action Plans for specific primary health care initiatives related to each of the strategic aims

Consistency with Government Priorities:

Minister's Action Plan Goal is "Faster Access and a Stronger Link to Family Health Care."

Action Plans/Interventions:

Action Plans						
	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Palliative Care Aim:	In Progress	25	In Progress	50	In Progress	25
• Education and leadership opportunities for primary care						
• Expand and promote Advanced Care Planning in primary care settings	Not Yet Started (Will commence this year)	25	In Progress	25	In Progress	25
Mental Health and Addiction Aim:	These processes have been initiated through Metabolic Initiatives, largely led by Ontario Shores. IHSP will develop further integration of the system, specifically through the	40	Initial process will continue to develop, ongoing evaluation will advise the development and implementation of additional strategies	30	All strategies are in place, MH and A Assessments are part of overall health assessment processes. Future initiatives are developed and planned that will ensure full system	30
• Support integration and capacity building between Primary Care and Mental Health and Substance Abuse Service providers						
• Develop access points between providers and systems that will ensure effective transitions from service to service for the client						

Explore and implement self-management options Mental Health and Substance Abuse patients	CHC OTN Initiative, Health Links, The Opiate Strategy and the implementation of the Scarborough Addictions Treatment Model				integration between Primary Care and the MH and A system, both in the community and at the hospital level.	
Vascular Health Aim: - Diabetes and vascular health physician education “grand rounds” using OTN - Self- management support training for clinicians. Collaborative shared care for people with chronic kidney disease - Ontario Integrated Vascular Health Strategy – Blueprint	Infrastructure and HR investments in place In progress through Choices and Changes In progress Provincial focus at present	25 40 20	Implement vascular focused initiatives Continue spread Early Adopter pilots	25 20 40	Continued spread and use Continued spread Provincial spread and local initiative implementation	25 20 20
Seniors Aim: - Improve linkages between Primary Health Care, CCAC and specialized geriatric services to either reverse and/or manage the effects of frailty - Earlier identification of risk factors by primary care	This is being addressed through projects like GAIN, Rapid Response Nurses, RSGS and Health Links This is being addressed through projects like GAIN, Rapid Response Nurses, RSGS and Health Links	25 25	In progress In progress	25 25	In progress In progress	25 25

How will we measure success?
• Number of people who are connected to care through Health Care Connects • Establishment of Health Links and accomplishments of identified metrics/outputs • Ambulatory care sensitive hospital admissions and re-admissions • Hospital Patient Discharge Information provided to primary care within 48hrs.
What are the risks/barriers to successful implementation?
• Lack of alignment between LHIN level primary health care initiatives and priorities and provincial primary care activities and directives • Lack of information sharing, collaboration and dialogue between LHIN and MOHLTC Primary Health Care branch/leadership • Fear and resistance from physician practices of increased accountabilities with MOHLTC or LHIN • Poor working relationships and collaboration between CHC sector and other Primary Health Care providers both on the ground and in communities • Disconnected operational planning and oversight within MOHLTC Primary Care branch between CHC and other Primary Enrollment Models (PEMs) • Influence /hindrance created by physician compensation issues (and provincial negotiations) on local level collaborations and partnerships (with LHIN, cross PEM or cross CHC-PEM)
For each risk/barrier, describe the plan to mitigate the risk?
Risks identified will be mitigated through: • Engagement of LHIN level primary health care leadership to champion system changes. • Provincial collaboration with MOHLTC and other LHINs regarding Health Links implementation. • Supporting strong project management and quality improvement focus within primary care programs/initiatives during implementation • Role of primary care lead
What are some of the key enablers that would allow us to achieve our goal?
• Central East LHIN Primary Care Leads in leading dialogue and change within the Central East LHIN primary health care sector • Re-constitution of the Central East Primary Care Working Group (2007-2012) to the Central East LHIN Primary Health Care Advisory Group (Feb/Mar 2013) • Engagement of both LHIN funded Community Health Centres (CHC) and other non-LHIN funded primary health care entities or enrolment models in the Central East LHIN strategic aim implementation; namely, Family Health Teams (FHT) and Nurse Practitioner Led Clinics (NPLC), Family Health Groups (FHGs), Family Health Organizations (FHO), Family Health Network (FHN) or other primary care providers/models.

Access and Wait Times

IHSP Enabler:
Access: Monitoring and improving MLPA wait time targets
IHSP Enabler Description:
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. These include cancer surgery, cataract surgery, hip and knee replacement and Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scans. The Central East 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. <u>How is success being measured?</u> Success is being measured according to the 2012/13 Ministry-LHIN Performance Agreement (MLPA) performance targets including: • 90th Percentile Wait Times for Cancer Surgery • 90th Percentile Wait Times for Cataract Surgery • 90th Percentile Wait Times for Hip Replacement Surgery • 90th Percentile Wait Times for Knee Replacement Surgery • 90th Percentile Wait Times for Diagnostic MRI Scan • 90th Percentile Wait Times for Diagnostic CT Scan
Current Status:
<u>Target Populations</u> Seven hospitals in the Central East LHIN provide wait times-related services: • Campbellford Memorial Hospital – CT and general surgery • Lakeridge Health – cancer, cataracts, hip/knee, CT and MRI • Northumberland Hills Hospital – cancer, cataracts, CT, MRI and general surgery • Peterborough Regional Health Centre – cancer, cataracts, hip/knee, CT, MRI and general surgery • Ross Memorial Hospital – cancer, cataracts, hip/knee, CT, MRI and general surgery • Rouge Valley Health System – cancer, cataracts, hip/knee, CT, MRI, general and pediatric surgery • The Scarborough Hospital – cancer, cataracts, hip/knee, CT, MRI, general and pediatric surgery

Community Engagement and Leadership

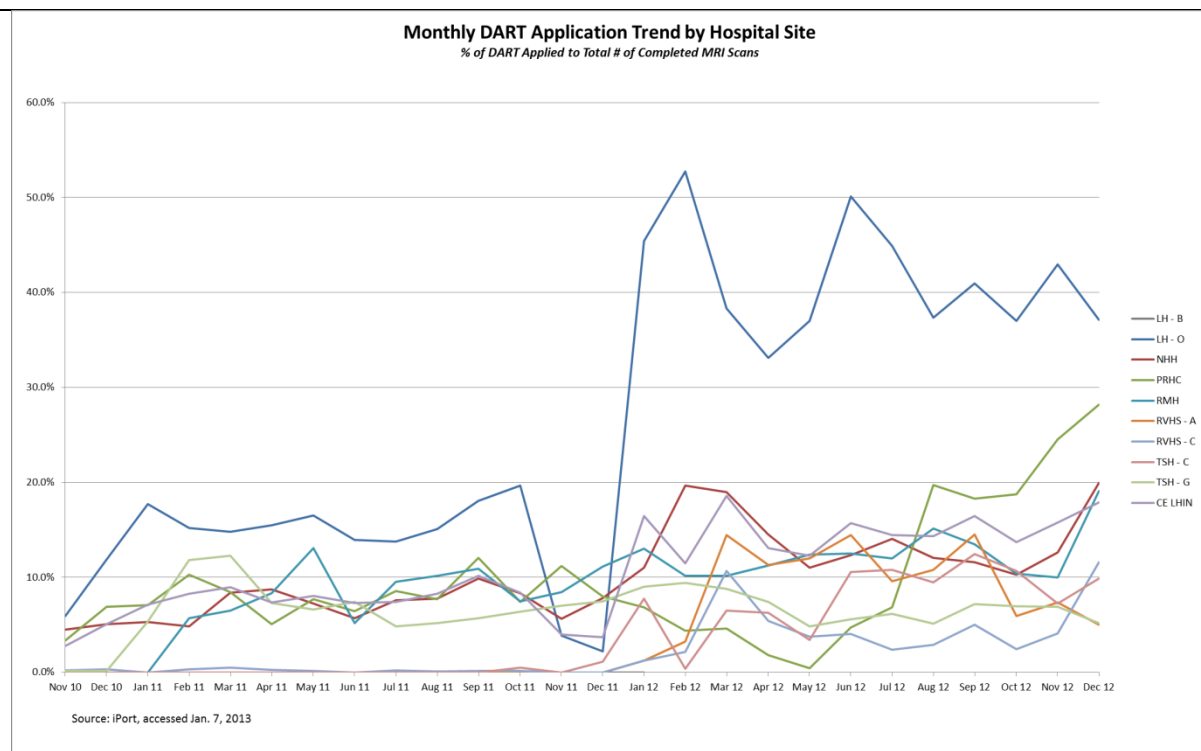
Wait Times Strategy Working Group

The Central East LHIN has established a Wait Times Strategy Working Group (WTSWG) that is comprised of representation from the above seven hospitals and meets monthly to discuss issues (e.g. aging machines, increases in referrals, etc.), risks, and mitigation strategies. The WTSWG also evaluates monthly performance at a system and hospital level, taking into account current year-to-date wait times above target for each hospital and volume management, including the identification of additional capacity. This is done in collaboration with other Central East LHIN working groups, such as the Hospital/Community Care Access Centre (CCAC) Financial Leadership Group (HCFLG), the Diagnostic Imaging (DI) Working Group, and the Central East Executive Council (CEEC) to enhance outcomes and meet MLPA targets.

Strategies and Programs

The Central East LHIN has undertaken the following approaches to achieve this goal:

1. Data quality improvement initiatives
2. Engagement with hospital physicians and surgeons, wait time coordinators, Diagnostic Imaging Directors, Decision Support and Performance Leads
3. Use of standardized best practices in hospitals, including participation in the Ministry MRI Performance Improvement Plan (PIP) initiative in 2011/2012 and again in 2013/2014
4. Hospital wait time performance by key services is posted on the Central East LHIN public website on a monthly basis, and issues and strategies/actions are highlighted for each key service
5. Continued application of Daily Access Reporting Tool (DART) in the Central East LHIN's hospitals. The application of DARTs assists with the reduction of the 90th percentile wait times by excluding wait times caused by the unavailability of patients



6. Wait time performance indicators have been incorporated into the Hospital Service Accountability Agreements (H-SAAs) with hospital-specific negotiated targets.
7. The Central East LHIN fully implemented the web-based Surgical Utilization Booking Management Integration Tool (SUBMIT) at the end of 2011/12 to assist with the management of wait times and patient wait lists, as well as reporting to the Wait Times Information System (WTIS). The 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

The LHIN is also exploring the expansion of SUBMIT to Diagnostic Imaging. The Central East LHIN submitted a business case in December 2012 to the Ministry to fund a Diagnostic Imaging module, called the Diagnostic Imaging Requisition and Entry Collaboration Tool (DIRECT).

8. The Central East LHIN, in collaboration with the clinical and financial leadership of hospitals and CCAC, completed a regional planning process in 2012 to determine the optimal model of service delivery for cataracts. In addition, a regional orthopaedic planning process is currently underway to determine the optimal model of service delivery for all orthopaedic Quality-Based Procedures (QBPs).

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, most hospitals now cap services to funded volumes only.

The Central East LHIN has seen wait times improving since 2007/08 as shown below. The LHIN will continue to work with health service providers (HSPs) and other key stakeholders to identify opportunities to improve wait times in 2013/14. As of November 2012, the Central East LHIN met all MLPA 90th percentile wait time targets.

Goal(s):

Central East LHIN IHSP AIM

MLPA Targets for Surgical and Diagnostic Imaging.

Indicator	2012/2013 Baseline	2012/2013 Final Central East LHIN Target
90 th Percentile Wait Times for Cancer Surgery	47 days	49 days
90 th Percentile Wait Times for Cataract Surgery	114 days	135 days
90 th Percentile Wait Times for Hip Replacement	163 days	179 days
90 th Percentile Wait Times for Knee Replacement	166 days	179 days
90 th Percentile Wait Times for Diagnostic MRI Scan	83 days	83 days
90 th Percentile Wait Times for Diagnostic CT Scan	23 days	28 days

Action Plans/Interventions:

The Central East LHIN's 2013-2016 IHSP is aligned with the Ministry's priorities and strategic directions. Wait times are an important component of the 2012/13 MLPA as well as legislated responsibilities concerning the dimensions of care involving:

- 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 impact on health conditions
- A sustainable health system framework

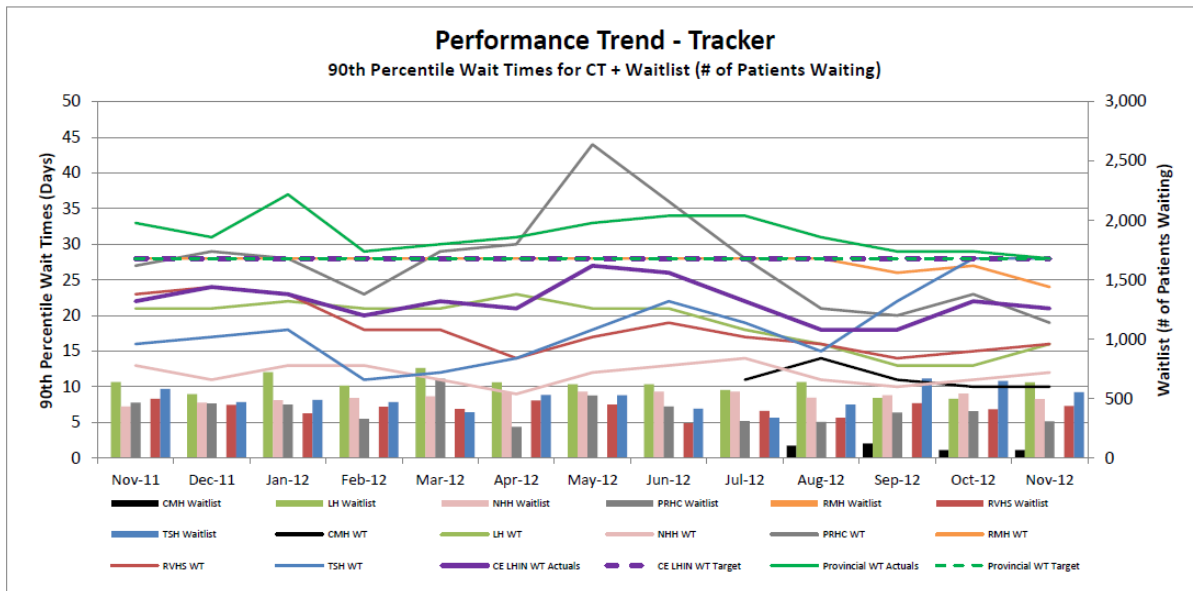
Action Plans						
	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Hospitals and the Central East LHIN implemented a Task Force for Data Quality Improvement . The Wait Time Coordinators group met for two years before disbanding in late 2012, due to the fact that it had achieved its stated objectives. Physician consultation, peer best practices, and standardization of processes are some of the areas that continue to be explored to improve outcomes. The WTSWG and the DI Directors Working Group continue to monitor DART usage and follow up on issues related to data quality.	Ongoing	-	Ongoing	-	Ongoing	-
Manage wait-time performance through the Central East LHIN's WTSWG and DI Working Group . 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 reallocations.	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 H-SAA negotiation process which is well underway for 2013/14 .	Ongoing	-	Ongoing	-	Ongoing	-
Implement the Surgical Utilization Booking Management Integration Tool (SUBMIT) system , which is a web-based project to improve	Completed	100%	Ongoing enhancements	-	Maintain	-

patient wait list management and wait times reporting for surgeons and hospitals in the Central East LHIN. For 2013/14 the following will be undertaken: • Reporting and usage of the data by hospitals and the LHIN. • Work to standardize criteria / data sets • Full use of the tools • Scanning data into system (consents etc.) • Template Management (using templated forms at offices to simplify documentation ○ Automated queries (ensuring that all automated uploads are working) ○ PSS templates (pre-op tests and rules) • Formalize the system support, updates and change requests and reporting on system use							
Reallocation of a portion of the Central East LHIN's surplus dollars from other sectors, targeting the improvement of key service areas for those hospitals that are able to demonstrate that this one-time funding will improve access to care.	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	10%	In Progress	30%	
DIRECT: A Business Case was submitted to the MOHLTC, regarding a proposed	10%		75%		95%		

Diagnostic Imaging solution, called "DIRECT (Diagnostic Imaging Requisition and Entry Collaboration Tool). Features of DIRECT include: Regional (i.e. LHIN) optimization of DI wait times: It will provide the ability to access real-time data on tests and the reporting ability to monitor hospital performance consistently. With this intelligence, the LHIN can identify any specific issues and trends that need improvement locally and regionally, and implement steps to ensure resolution. Integration with Primary Care: The ability to engage and connect the primary care providers (and others that are generally outside of the engagement environment of the LHIN and the hospital environments) will lead to increased knowledge transfer, sharing of information and ultimately, an improvement in the ability to support the delivery of care in the region. DIRECT can be an effective catalyst in the process to build stronger relationships between LHINs and Primary Care. Resource utilization: With the use of a central intake and triage system, cases will be routed to the most effective site, thereby							
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flattening wait time and maximizing the use of expensive DI resources (equipment, staff, etc.). Elimination of unnecessary or inappropriate, or repeated tests: With the eventual use of an appropriateness engine reinforced with artificial intelligence/learning capabilities, perhaps up to 8-9% of cases can be eliminated or routed to more appropriate (best practice), more effective, and less expensive tests. To set the stage for automated appropriateness, the new DI module will be constructed in such a way as to be able to incorporate appropriateness							
Engagement sessions at the hospital level with administrators and physicians, through the HSFR Local Partnership and previously, the QBP Working Group.	Ongoing	-	Ongoing	-	Ongoing	-	

How will we measure success?



Performance Commentary

In November 2012, CE LHIN CT 90th percentile wait times decreased slightly from 22 days in October to 21 days in November. This is below the 2012/13 negotiated target of 28 days.

Funding/Allocations: The LHIN has received and distributed final 2012/13 Wait Time Strategy allocations from the Ministry.

Hospital-Specific Issues/Best Practice:

CMH went live with WTIS reporting on July 16, 2012. All hospitals were at or below the CE LHIN target.

Action/Strategy:

- 1) The hospitals and CE LHIN implemented ongoing data quality improvement initiatives.
- 2) Engagement sessions with hospital physicians/surgeons are held as needed (e.g. Medical Advisory Councils, Chief of Staff/Surgery).
- 3) Wait time performance indicators have been incorporated into the H-SAAs with hospital-specific negotiated targets.
- 4) Volumes are allocated among hospitals to optimize wait time performance.
- 5) The CE LHIN will continue to closely monitor hospital performance and is exploring the expansion of SUBMIT to Diagnostic Imaging to assist with the management of wait times. With the current lack of LHIN investment opportunities, the LHIN submitted a business case in December 2012 to the Ministry to fund this Diagnostic Imaging module, called DIRECT.

What are the risks/barriers to successful implementation?

- The systemic underfunding of MRI volume has resulted in increasing wait times. Currently, the Ministry only funds 2,080 hours of operation for each new MRI machine, even though the Central East LHIN hospitals have additional capacity to perform more hours and are not fully utilizing the machines. The demand for MRIs has exceeded funded volumes and continues to increase. Additional volume is an important factor in reducing wait times, but this only produces short-term results; longer-term solutions are needed.
- The new Health System Funding Reform (HSFR) model, implemented in 2012/13 for cataracts, and hips and knees, has drastically impacted the planning of volume delivery in the LHIN. Multiple iterations of volume and funding announcements were made and then finalized quite late in the fiscal year. Further changes to the volume and funding levels will impact the hospitals' ability to plan accordingly.

For each risk/barrier, describe the plan to mitigate the risk?

- In 2012/2013, the Central East LHIN was able to identify one-time savings from reallocation dollars to supplement MRI volumes. This is not a sustainable strategy for managing volumes and wait times, since the amount of funding recovered from other sectors is variable from year-to-year and can only be done later in the year (late Q3). Hence, hospitals are unable to plan in advance. The LHIN also recommends that the Ministry approves funding for the DIRECT project. The benefits associated with this initiative will ensure an efficient use of existing resources.
- The Central East LHIN underwent a regional planning process to determine the optimal service delivery model for cataracts. Although the amount of funding and volumes are not known for future years, cataracts will be allocated by the hospital share determined during this process. A regional orthopaedic planning process is underway to determine the optimal model of service delivery for all orthopaedic QBPs as well.

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 is awaiting confirmation of funding related to the DIRECT business case to proceed with planning and implementation of these important longer-term and sustainable solutions to MRI and CT wait time management.

Health System Funding Reform

IHSP Enabler:
Capacity and Funding: Health System Funding Reform
IHSP Enabler Description:
The recently initiated Health System Funding Reform (HSFR) will evolve Ontario's health care system away from the current global funding system towards what is known as <i>Patient-Based Funding (PBF)</i>. Under Patient Based Funding, health care organizations will be compensated based on how many patients they look after, the services they deliver, the evidence-based quality of those services, and the specific needs of the broader population they serve. Starting with Hospitals and Community Care Access Centres in 2012, Patient Based Funding will be expanding in scope and is expected to reach maturity in 2015/16. It is also anticipated that PBF will spread to other health care sectors. There are two key components of Health System Funding Reform – Health Based Allocation Model (HBAM) and Quality-Based Procedures (QBP). Patient Based Funding is intended to serve as an equitable and sustainable funding model that will also standardize care, minimize practice variation and encourage investments in quality improvement and patient safety.
Current Status:
Going forward, hospitals' funding will be comprised of three different streams. Hospitals will still receive some <i>Global Funding</i>. The balance of hospital funding will be determined through two components: Health Based Allocation Model (HBAM) and Quality Based Procedures (QBP). HBAM will make-up roughly 40% of hospitals' funding, with the remaining 60% being divided evenly between QPBs and Global Funding. <i>Health Based Allocation Model (HBAM)</i> estimates expected health care expenses based on (i) population profiles and (ii) clinical complexity and type of care. Allocations are then adjusted according to differences between actual and expected health care expenses. <i>Quality Based Procedures (QBP)</i> provide reimbursement to health care providers based on the types and quantity of services they deliver. As part of Health System Funding Reform, the LHIN has established the Central East LHIN Local Partnership (LP). The Local Partnership will foster a change management environment for HSFR across Ontario by uniting health service providers across sectors and the LHIN to inform implementation planning, change management and future reform components. This will be achieved by acting as an advisory group, facilitating clinical, financial and decision support advice to and from the LHIN and the Ministry. The LP will: • Proactively discuss local implementation planning and change management imperatives related to all aspects of HSFR • Identify and discuss critical implementation issues and the associated strategies to ensure coordination across providers • Provide advice on volume management strategies and alignment to service accountability agreements • Proactively engage and communicate with local providers across sectors, with emphasis on implementation planning and the impact on the health care system as well as health service providers

Goal(s):						
Develop an effective volume management strategy for all Quality-Based Procedures. (Please see page 69 for the Integrated Orthopaedic Capacity Planning work related to HSFR).						
Consistency with Government Priorities:						
The Ministry of Health and Long-Term Care has asked the LHIN to develop and implement volume management strategies.						
Action Plans/Interventions:						
Action Plans	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Develop an accepted process for establishing volume management strategies	Complete	100	Monitor	--	Monitor	--
Group Quality-Based Procedures and prioritize and rank for creating volume management strategies.	Complete	100	In progress	50	In progress	25
Establish volume management strategies for grouped QBPs	In Progress	40	In progress	30	In progress	20
How will we measure success?						
Success will be measured by the development of volume management strategies through consensus building.						
What are the risks/barriers to successful implementation?						
Changing implementation of HSFR and QBPs and incomplete information can have negative impacts on the success of the LP						
For each risk/barrier, describe the plan to mitigate the risk?						
To develop a strong communication strategy with members of the Local Partnership and Health Service Providers.						
To continue data quality reviews to ensure complete and accurate information is reported.						

Health System Design and Integration

IHSP Enabler:
Health System Design and Integration
IHSP Enabler Description:
Health system design and integration activities will improve the quality of client care, performance of the local health system and system sustainability
Current Status:
<u>Access</u> The Ontario Telemedicine Network (OTN) A comprehensive province-wide telemedicine network, is an independent, not-for-profit organization funded by the Ontario Ministry of Health and Long-Term Care. The goal of OTN is “seamless integration of telemedicine into everyday health care delivery.” Telemedicine is a system solution that supports redesign of existing service delivery models, improved integration of health care delivery across the care continuum for clients and improved access to scarce, often highly specialized resources, across the dispersed communities. Central East LHIN OTN Objectives: • Build support and commitment across the LHIN to develop and grow priority programs and services through use of telemedicine • Improve access to clinical care for patients and caregivers through telemedicine • Increase the ability of health care providers to deliver clinical care through telemedicine (i.e. patient to provider consultation and provider to provider case conferencing/collaborative care) • Align the deployment of telemedicine nurses to address system pressures and achieve Central East LHIN priorities and strategic aims Current Status: Telemedicine Nursing Investment: In September 2012, the MOHLTC announced annualized telemedicine nursing investment of \$1,484,340 and approved a telemedicine nursing deployment plan within Central East LHIN which resulted in: • Hospitals: 5.75 FTE RN and 3.25 FTE RPN • Primary Care: Community Health Centres and FHTs: 3.25 FTE RN and 4.0 FTE RPN • LTC Homes: 0.75 FTE RN • Community Agencies: 3.0 FTE RPN • As of October 2012, of the 20 FTE (9.75 FTE RN and 10.25 FTE RPN) allocated across the Central East LHIN, 17.5 FTE new telemedicine nurses have been hired. Health service providers

that have not yet hired all staff have posted the positions. It is anticipated that all new staff will be in place in place before the end of the fiscal year.

OTN Equipment Investments:

- Central East LHIN invested \$479,000 in OTN equipment across eight hospital or agencies in 2011/2012.
- Additionally, as a component of the Behavioural Supports Ontario (BSO) project, the Central East LHIN provided equipment resources for the following 5 early adopter LTC Homes: OTN Clinical Units at Bendale Acres (Scarborough), Victoria Manor (Lindsay), Fairhaven (Peterborough) and OTN Educational Units for Seven Oaks (Scarborough) and Yee Hong (Scarborough).
- In response to the provincial request for OTN units to support addiction withdrawal, the Pinewood Centre's Withdrawal Management Unit, CMHA – North East, FourCast Addiction Services and the Haliburton Highlands Health system will be awarded funding to establish or upgrade OTN units to support clinical, education and administrative events.

Central East LHIN OTN Activity:

Current clinical utilization of the system is surpassing the established clinical target for 2011/2012. As new sites begin to deliver services and as human resourcing and clinical protocols are adapted we are confident that use at all sites will increase. It is anticipated that 2012/2013 targets will be re-negotiated.

Critical Care Capacity and Improvement

In 2013/2014 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:

- 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.
- 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
 - Better leverage technology, specifically Telehealth, to support rapid resuscitation of critically ill patients, and reduction in unnecessary transfers
- 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
- Work with local and provincial stakeholders to enhance a patient referral framework that will improve patient transfers in the LHIN
- 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 2013/2014 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 Health Care Advisory Group.

Maternal Neonatal and Child

The Central East LHIN is currently in the development of establishing the Central East LHIN Maternal, Newborn and Paediatric Advisory Committee. This Committee will function in an advisory capacity, providing leadership to all relevant health service providers, partners, key stakeholders, including the Provincial Council Maternal Newborn Health (PCMCH) and the Central East LHIN to support the adoption of evidence-based practice with the goal of improving the health of mothers and newborns. The overall role of the Advisory Committee will be to promote standardization, implementation of evidence and best practices within women's and children's programs.

French Language Services

With respect to an active offer of French Services, key enablers that help to implement the Annual Business Plan 2013/2014 include:

- Assessing French-speaking/bilingual health professionals to determine service capacities; and
- Ongoing communication by health care providers in both English and French through patient transitions between care providers (i.e. Hospital to Community Support Services).

The Central East LHIN and the French Language Health Planning Entity (FLHPE) will also obtain key results on French language services as required by the Ministry, such as:

- Knowledge and awareness to educate LHIN staff's, clients and general public on needs and concerns of Francophone communities as well as how the Central East LHIN is meeting its accountability under the French Language Service Act (FLSA).
- French Language Services (FLS) capacity by ensuring an active offer and delivering high-quality services in French, including services to the public delivered electronically and via partnerships.
- Francophone engagement - the Central East LHIN will hold and actively participate in Francophone public consultation and community engagement activities that address Francophone concerns, needs and equity.
- French Language Services Integration - as the Central East LHIN has embraced the FLSA by

incorporating its principles in its strategic planning and decision-making, it will continue implementing needs and concerns, as well as local health system transformation initiatives in the Annual Business Plan 2013/2014 in collaboration with the French Language Health Planning Entity #4, as partner in change.

The Central East LHIN continues its partnership with the South-West French Language Health Services Planning Entity (the Entity) to strengthen the engagement of, and health outcomes for the Francophone community within the Central East LHIN region by focusing on key Central East LHIN priorities such as Mental Health and Addictions, Creating a System of Care for Frail Seniors, Diabetes and Vascular Health. Based on this partnership, the Annual Business Plan 2013-2014 will be implemented to:

- Improve the quality of care and safety offered to Francophones by ensuring their satisfaction with the care they receive and reduce the negative impact of linguistic and cultural barriers they face in the health system
- Ensure planning of health services that takes into account the needs of Francophones as the Integrated Health Service Plan 2013-16 is implemented
- Improve access to health care services in French
- Improve access to services in French for Francophones with mental health conditions
- Improve access to primary care in French for the Francophone community
- Improve the quality of life of people living with chronic illness including diabetes and reduce complications associated with these diseases

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, Mississauga 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.

Both Aboriginal Health Advisory Circles have advised that they prefer to be included in the Strategic Aims as a Priority Population. Both Circles have identified Priority areas that they would like the Central East LHIN to focus on. These are:

- Palliative and End of Life Care
- Building Community Capacity to Care for Elders and other community members with responsive behaviors

- Supporting First Nation communities to care for Elders at Home
- Supporting First Nation communities in increasing the competencies of their PSW staff and in attracting people to the profession
- Ensuring that all HSP's in the LHIN provide services within an Aboriginal cultural context and that anti-stigma campaigns ensure services are safe and accessible for Aboriginal Peoples
- The LHIN will support relationships with mental health and addiction providers and with the CECCAC so that the services offered by these providers will be culturally accommodating

Members of both Aboriginal Health Advisory Circles were consulted in the development of the strategic aims for IHSP 2013-16. Aboriginal people will be a high priority population within all of the strategic aims of IHSP, 2013-16, and specific strategies to address their needs have been developed and will be implemented throughout Fiscal Year 2013/2014.

Emergency Department/Alternative Level of Care (ED/ALC)

Over the past years, the Central East LHIN has devoted much effort to investigating the source of Emergency Department (ED) Wait Times and developing solutions with hospital and community partners. There is widespread agreement and evidence that improving the flow of patients in the ED and throughout the hospital helps to address the issue around wait times. A number of hospitals in the LHIN have adopted and implemented patient flow improvement strategies that are playing an important role in collectively achieving and ultimately exceeding the targets established in relation to the Ministry LHIN Performance Agreement (MLPA) indicators.

Target Populations

Focus is being placed on the targeted populations that have the highest risk for unscheduled visits to the Emergency Department. 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 section related to Reducing the Impact of Vascular Disease.

Strategies and Programs

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

- Approach #1: Reducing ED Demand, including Reducing Avoidable Hospital Readmission or Return Visits to the ED
- Approach #2: Improving ED Capacity and Performance; and
- Approach #3: Improving Hospital Bed Utilization, including Reducing Alternate Level of Care (ALC) Days.

Initiatives like Home First, Resource Matching and Referral (RM&R), and LHIN-wide information management projects (e.g. Community Care Information Management) are contributing towards reducing ED wait times and improving patient flow. Data consistently demonstrates that prolonged ED wait times is not only an ED problem but requires hospital wide solutions and interventions.

Approach #1: Reducing ED Demand

The total number of ED visits in the Central East LHIN between April 1, 2011 and March 31, 2012 was 519,216. This is an increase of approximately 25,627 visits or a 5% increase over 2010/2011. In comparison to 2009/2010 this is an increase of 45,571 visits or a 9% increase.

	Fiscal Year 2010				Fiscal Year 2011				Fiscal Year 2012 (YTD)	
Unscheduled Visits	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
High Acuity	73,423	75,954	78,126	77,698	78,760	80,821	81,199	83,665	83,867	84,123
Low Acuity	48,533	49,797	46,035	44,023	47,785	51,070	49,309	46,562	48,234	51,109
Quarterly Totals	121,956	125,751	124,161	121,721	126,545	131,891	130,508	130,227	132,101	135,232
Annual Totals	493,589				519,171					

The two main causes that contribute to increased ED wait times are a lack of beds and a lack of integration between community and hospital health care resources. As evidenced and in support of the outcomes of the Sustainable Access Report completed by the Central East LHIN, investments are being made in the community support services sector and specialized services/programs to enable people to live in their homes and their communities longer. These initiatives will support the ED from a variety of perspectives including ED diversion, admission avoidance and supporting individuals upon discharge (reducing readmissions).

Approach #2: Improving ED Capacity and Performance

ED ALC Scorecard April-September 2012

2012-13	Apr	May	Jun	Jul	Aug	Sep
ED Admitted	38.2	30.9	32.9	31	30.1	34.8
ED Low Acuity	4.2	4.2	4.2	4.2	4.3	4.1
ED High Acuity	6.8	6.7	6.6	6.7	6.7	6.6
PIA	2.9	3.1	2.8	3	3.3	3.1
ALC Throughput	1.11	1.00	0.90	0.97	0.92	0.98

The Central East LHIN is constantly evaluating the impact of the various interventions in order to improve access to care. The LHIN wide performance indicators shown above are monitored closely. These performance indicators measure the overall Length of Stay (LOS) as well as ED time to admission. The former provides us with a standardized measure of access to emergency care while the latter is closely linked to the availability or lack of acute care capacity and access to inpatient beds. Success in meeting these targets is assessed through incremental improvement.

Approach #3: Improving Hospital Bed Utilization, including reducing ALC 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:

- Ensure that patients are in the right beds, on the best care pathways, at the right time

- 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
- Assess and address capacity issues and the potential for conservable bed days
- Improve tracking and strategically target critical issues
- Strengthen day-to-day care team process and support multidisciplinary communications

Some patients are kept in acute care beds due to a lack of post-acute capacity to provide appropriate care to meet their clinical and social needs as well as meet patient and caregiver preferences. 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 plan also focuses on the frail and the elderly as they are particularly vulnerable in these situations as delays in matching services and a rapid deterioration in health status can result in unnecessary/preventable hospital admissions.

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.

A more integrated system of continuing care is being developed at the LHIN to improve quality and reduce inappropriate hospital utilization. The aim is that this integrated system will offer comprehensive solutions for improving patient flow between acute and post-acute settings and reduce ALC utilization. Reduction of ALC utilization is a high priority for the LHIN. We are focusing on two key strategies to reduce ALC days.

- Discharging patients from acute care earlier to the most appropriate setting
- Reducing demand for future hospital-based care.

Goals:

Indicator	2012/2013 Baseline	2012/2013 Final Central East LHIN Target
90 th Percentile ER length of stay for admitted patients	44.53	36.0
90 th Percentile ER length of stay for non-admitted complex patients	6.83	7.0
90 th Percentile ER length of stay for non-admitted minor/ uncomplicated patients	4.3	4.0
Percentage of ALC days	17.4%	15.2%
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions	18.7%	17.0%
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions	21.9%	19.6%
90 th Percentile Wait Time from Community for CCAC In-Home Services – Application from Community Setting to first CCAC Service (excluding case management)	56	46

To improve emergency department capacity and performance the Central East LHIN has focused on identifying best practices to reduce ED demand and improve quality thereby reducing health care utilization and costs and promoting patient centre care. Initiatives designed to decrease ED length of stay have been targeted mostly at hospitals participating in the Pay-for-Results Program (P4R), although some initiatives will have a LHIN-wide impact.

The P4R program has changed substantially for the 2012-2013 fiscal year. Overall, the Central East LHIN has benefited from the changes in this fiscal year. Funding has increased by 9% to \$10, 294,392. With this, the LHIN has funded shared projects that will benefit the LHIN system as a whole, as well as allocated the majority of the funding to projects focusing on establishing or continuing ED initiatives that improve patient flow, quality improvement initiatives and improving human resources practices/coverage.

Through the implementation of Home First across the Central East LHIN since 2010/2011, the Central East CCAC is constantly 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.

In terms of bed utilization, the Central East LHIN is seeking to establish technological tools to support effective patient management and flow throughout the system. This goal has been accomplished for the pathway from the surgeon's office to the OR, through the SUBMIT project, and regional or provincial implementation of a technological solution for the pathway from acute inpatient units to post-acute care will be forthcoming through the provincial Resource Matching and Referral project. The LHIN is also working with the hospitals on a LHIN-wide implementation of a Clinical Utilization and Bed Management solution to accomplish this goal for the pathway from the ED to the Inpatient units and within units. . The LHIN is prepared to fund the implementation/start-up costs associated with such a solution (via P4R), provided that the LHIN's objectives and desired outcomes are met. The hospitals engaged in the project are currently going through a readiness assessment.

LHIN Objectives:

- A single-instance, standardized solution to be implemented across all LHIN hospitals, to enable regional system optimization
- Tools that enable timely (live) hospital and regional information management and decision support capacity that can be put in the hands of decision makers from the front lines (patient flow), to senior management (resource allocation)
- Alignment with and reinforcement of standard LHIN-wide Home First business processes as developed and published by the CECCAC
- Admission to inpatient beds only of patients with an appropriate medical diagnosis (elimination of "failure to cope/failure to thrive" admissions)
- Consistent care maps and LOS determination LHIN-wide, such that the patient who is admitted to an inpatient bed at any Central East hospital can expect the same care pathway as the patient admitted to an inpatient bed at any other Central East hospital

- Consistent ALC designation LHIN-wide, consistent and compliant with CCO definitions
- Bed management system that shows all beds in the system with their current status, using the same methodology, definitions, and visual displays

System Design

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.

In 2013/2014 the LHIN will initiate a joint capital planning table amongst hospital corporations.

Clinical Service Plan (CSP) – Integrated Orthopaedic Capacity Plan (IOCP) and Musculoskeletal Rehabilitation Services

In response to a Ministry of Health and Long-Term Care request, the Central East LHIN has initiated a comprehensive orthopaedic and musculoskeletal planning initiative to plan and build a regional system for providing a continuum of orthopaedic care from pre-operative education and intake to community-based rehabilitation for all orthopaedic procedures.

The development of the IOCP and a Musculoskeletal Rehab Plan are being supported by two working groups that are made up of representatives from a variety of Central East LHIN Health Service Providers (HSPs). The Orthopaedic Surgical Task Group (OSTG) is currently planning siting and sizing of orthopaedic procedures in the Central East LHIN, fulfilling the requirements of the Integrated Orthopaedic Capacity Plan. The Rehabilitation Services Task Group (RSTG) will align its plan with the IOCP which is expected to be completed to start fiscal 2013/14 with implementation to begin in April. Comparable timelines are expected for the Musculoskeletal Rehabilitation Services plan a month later.

The IOCP will identify opportunities to maximize quality of care, while minimizing travel to receive service and preparing for future needs across each of the Central East LHIN's three clusters. The decision to include all orthopaedic services in the IOCP will position the system to take advantage of Health System Funding Reform and respond to implementation of Quality Based Procedures as they come online over the next few years. System improvements are intended to result in Orthopaedic patients spending more time at home in their communities when appropriate, aligning with the IHSPs Community First aim and improving patient experience and quality of care.

Key Action Steps being considered for inclusion in the IOCP include the following:

Key system change #1: Align surgical services using a regional/ district/ local framework which ensures optimal use of the Central East LHIN capacity and quality care while keeping the patient as close to home as possible

Key System change #2: Develop a systems approach to trauma access and repatriation

Key system change #3: Standardize care for orthopaedics including hip and knee replacement and hip fracture throughout the LHIN through coordinated care plans for inpatient care and rehabilitation

Key System change #4: Identify a performance measurement system which includes outcomes for orthopaedics

Key System change #5: Complete a review and develop a plan for a coordinated intake system that promotes access and standardization in care

Key System change #6: Align rehabilitation services to patients' need and within their local community

Key System change #7: Complete a review and develop a plan for supported physician integration including:

- LHIN-wide Credentialing
- LHIN-wide On-Call
- LHIN-wide Operating Room Efficiency and Scheduling

Health Links

The Central East LHIN is fully engaged in supporting our health care provider partners in the development of the Peterborough Health Link (PHL) in our North East cluster. The PHL is the first of several Health Links to be implemented in Central East which focus on high-users or high-risk populations in an attempt to:

- Understand the health care and non-health care needs of that population to better tailor services to improve patient outcomes
- Focus on interventions that will have more immediate impact on the target population so that resources can be re-directed to other population-based health initiatives that prevent illness.

With the identification of the following two priority patient cohorts, a facilitated patient engagement approach was launched to identify change opportunities, plan interventions and implement change:

Cohort I: Seniors with exacerbated congestive heart failure and at least one other co-morbidity with the possibility of other complicating factors (such as inadequate housing or transportation, isolation, palliation, responsive behaviours, finances).

Cohort II: Patients with serious mental health and/or addictions and at least one other co-morbidity with the possibility of other complicating factors (factors like inadequate housing or transportation, isolation, palliation, responsive behaviours, finances).

A business case was submitted to the Central East LHIN on February 15, 2013 and then forwarded to the Ministry of Health and Long-Term Care on February 22nd. Moving beyond the business case, Health Links will be taking an innovative approach of experienced-based co-design whereby patients will have an opportunity to tell their story, share their experience of navigating through the health care system, and actively participate in the planning and implementation of system redesign.

A substantial engagement with local providers in the PHL has resulted in a robust governance and organizational structure that can serve as a model for local engagement as new Health Links are structured to cover the entirety of Central East. The HL structure across the Central East LHIN will be primarily geographical based, will to a large extent follow the catchment areas of hospitals, and will be informed by several measures of physician and patient loyalty to hospital services. The context of local

health care service delivery, such as catchment areas of Family Health Teams and other providers and recent and ongoing community health care services integration strategies will also influence HL design. Population size and a manageable number of HLs are important features for LHINs and providers to consider. Municipal, LHIN and other jurisdictional boundaries will be considered in the design.

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 the 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 an effort to support framework implementation, the Central East LHIN in collaboration with its regions four Public Health Units (Toronto Public Health, Peterborough County-City Health Unit, Haliburton, Kawartha, Pine Ridge District Health Unit, and Durham Region Health Department) is organizing a Central East LHIN Falls Prevention Advisory Group. This group will function in a consultative capacity, providing leadership to all relevant health service providers, partners and key stakeholders. Key Advisory Group objectives will involve:

- Strengthening linkages across providers and sectors
- Highlighting current LHIN-wide falls prevention programs/initiatives
- Identifying gaps in the health continuum regarding falls prevention
- Providing direction to help leverage current activities and better support integrated falls prevention in the following key areas:
 - Governance
 - Assessment and intervention
 - Inclusive partnerships
 - Local performance measurement
- Guiding opportunities for consistent education and enhanced awareness surrounding falls prevention
- Prioritizing the *Integrated Provincial Falls Prevention Toolkit* components, coordinating care opportunities, implementation strategies and sustainability approaches

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 health care 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.

Central East LHIN Integration Strategy

The strategic aim for the Community Health Services Integration Strategy is:

Design and implement a cluster-based service delivery model for Community Support Services (CSS) and Community Health Centre (CHC) agencies by 2015 through integration of front-line services, back office functions, leadership and/or governance to:

- improve client access to high-quality services

- create readiness for future health system transformation
- make the best use of the public's investment

Community Health Services Integration Strategy (CHS) and Small Rural Hospital Transformation Fund

On February 22, 2012, the Central East LHIN Board of Directors approved a Community Health Services Integration Strategy to address demographic pressures, adjust to changing expectations of clients/patients and families and to meet provincial expectations on improving access, quality and value for money/investment.

This strategy resulted in the commencement of integration planning processes in Durham Region and Haliburton County in April 2012.

In late fall, given the announcement of a Health Links in Peterborough, along with an allocation under the "Small, Rural, Northern Hospital Transformation Initiative," it became evident a retooling of the strategy was required. At their Open Board Meeting on November 28, 2012, the Board of the Central East LHIN passed a series of motions that resulted in changes to the timing, sequencing and scope of the current Community Health Services Integration Strategy, first approved by the Board in February 2012.

Based on the motions passed by the Board, the following changes are being instituted to the CHS Integration Strategy:

- The North East cluster process will be initiated January 2013
- The North East cluster process will proceed as three distinct processes rather than one large grouping. The three areas are a) Haliburton County/City of Kawartha Lakes, b) Peterborough City and County, and c) Northumberland County
- Hospitals will now be included in the North East phase of the strategy
- There will be no change to the current CHS process in the Durham cluster
- The Scarborough process, which had been scheduled to start in November 2012, will be delayed until June 2013

Durham Cluster CHS Integration Process

The Durham CHS process initiated in April 2012 and will complete its planning phase by March 31, 2013. An integration plan has been developed and will be considered by the 10 participating Health Service Provider (HSP) Boards during February 2013. Implementation will commence in April 2013. The Central East LHIN Board will consider the plan March 2013.

Haliburton County/Kawartha Lakes Integration Process

Building on the work that transpired in Haliburton County between April and October 2012, the process will be re-initiated January 2012 with the addition of providers from the City of Kawartha Lakes. The process will culminate with an Integration Plan being presented to the Central East LHIN Board December 2012. This will be followed by more detailed implementation planning into Q4 2013/14.

Northumberland County Integration Process

This process will be initiated January 2012 with the process culminating with an Integration Plan being presented to the Central East LHIN Board December 2013. This will be followed by more detailed implementation planning into Q4 2013/2014. Wherever possible, the Haliburton County/City of Kawartha Lakes and Northumberland County processes will leverage synergies, inclusive of the use of the Small, Rural, Northern Hospital Transformation Funds.

Scarborough and Peterborough CHS Integration Processes Both of these processes will be initiated summer 2013 and continue into 2014/2015.
IHSP Enabler:
System Design and Implementation – Hospital Clinical Services Planning
IHSP Enabler Description:
As part of the overall enabler of Health System Design and Integration, the LHIN will continue to implement the recommendation of the 2009 Hospital Clinical Services Plan. The program focus of the 2009 Clinical Services Plan included: • Thoracic Cancer Surgery • Cardiac Care • Vascular Surgery • Maternal, Newborn and Pediatrics • Mental Health and Addictions The vision of the initial Hospital Clinical Services Plan continues today and is expanding to include new programs and services such as Orthopaedics and Critical Care (“Life or Limb” Policy). That vision is <i>“Improved and equitable patient access to an integrated hospital system that provides the highest quality of care across the Central East LHIN”</i>
Current Status:
The LHIN and its hospital health service providers have made significant progress since 2009. For example: • Consolidated Thoracic Cancer Surgery to one hospital site (Lakeridge Health Oshawa), thereby meeting Cancer Care Ontario standards for quality and access • Enhanced regional access to cancer treatment services (such as chemotherapy and radiation) through regional partnerships of hospitals and the regional Cancer Centre • Established and strengthened two regional Cardiac Centres (Rouge Valley Health System and Peterborough Regional Health Centre), and supported significant program expansion to acute cardiac care and rehabilitation services • Initiated regional solutions for Vascular surgical programs, cited at The Scarborough Hospital and Peterborough Regional Health Centre • Implementation of regional common assessment tool and in-patient Bed registry for mental health so health service providers can locate hospital capacity throughout the system based on patient needs • Completed a review of small hospitals maternal-newborn programs to ensure standards of quality and access are met and/or exceeded • Since 2007, employed a Central East LHIN Critical Care Lead to support on-going improvements in the capacity, quality and system-level coordination of hospital critical care resources
Goal(s):
• Finalize Hospital Regional Service Agreements for Thoracics, Vascular, and Cardiac Regional Programs • Confirm Central East LHIN Advanced Centre for Maternal Newborn and Pediatric Services • Receive, endorse and initiate a regional delivery model for In-Patient Child and Adolescent Mental Health services

- Develop a regional hospital repatriation agreement
- Implement the new “Life or Limb” Policy
 - The Life or Limb Policy is to facilitate timely access (i.e., hospital to hospital transfer) to acute care services within four hours in order to improve outcomes for patients who are life or limb threatened. The Life or Limb Policy was developed in response to recommendations from the Office of the Chief Coroner for a provincial “no refusal” policy when critical injuries or conditions of life or limb are involved.
- Explore technology solutions (e.g., telemedicine) that will improve access and quality of care for hospital patients, and reduce avoidable patient transfers
- Continue to plan for, maintain and manage local surge capacity management plans with a focus on system level moderate to major surge events.

Consistency with Government Priorities:

These goals are consistent with:

- Ontario’s Action Plan for Health
- Health System Funding Reform
- Ontario’s Critical Care Strategy and “Life and Limb” policy
- Cancer Care Ontario service standards
- Ontario’s Emergency Preparedness planning and policy

Action Plans/Interventions:

Action Plans						
	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Hospital Regional Program Service Agreements Finalize Service Agreements with respective hospitals, implement and monitor	Complete	100	Monitor	--	Monitor	--
Hospital Repatriation Agreements Develop LHIN-wide hospital repatriation agreements for patients requiring return back to home hospital	Complete	100	Monitor	--	Monitor	--
Implement Provincial Life and Limb Policy Policy implementation including (a.) ensuring compliance with hospital use of the Critical service; (b.) updating hospital mild and LHIN moderate surge plans.	Complete	100	Monitor	--	Monitor	--
Central East LHIN Advanced Centre for Maternal and Newborn Paediatric Services As per the recommendations of the Central East LHIN Clinical Services Plan, the LHIN will consider the above pending review and community	Report Submitted and considered	100	Pending Decision	--	Pending Decision	--

consultation.						
Regional Delivery Model for In-Patient Adolescent Mental Health and Addiction Services As per the recommendations of the Central East LHIN Clinical Services Plan, the LHIN will consider the above pending review and community consultation.	Report Submitted and considered	100	Pending Decision	--	Pending Decision	--
Explore Technology Solutions to Enable Better Patient Care Expand the spread of Ontario Telestroke model, and consider other technology solutions (e.g. Telemedicine) that will improve patient care and reduce avoidable patient transfers	In Progress	20	In Progress	30	In Progress	--
How will we measure success? • Wait times for Cardiac and Vascular Services • Program Specific Service and Quality Volumes (Cardiac, Vascular, Thoracic) • % ALC with another hospital as destination • Total number of inter- and intra- LHIN hospital transfers • Critical Care Occupancy Rate (%) • Total number of transferred Life or Limb cases • Total number of Life or Limb consults declined/accepted • Life or Limb acceptance rate • Time to referral/acceptance/transfer/treatment for Critical cases • # of Telestroke consults and administration of tPA • EMS Offload Times						
What are the risks/barriers to successful implementation? • Physician buy-in (e.g., support to regional on-call requirements) • Financial capacity to support required investments (e.g., funding for Vascular surgeries, enhancements of existing resources) • Health System Funding Reform – Hospital Budgets • Land and air transport systems • Availability of technology						
For each risk/barrier, describe the plan to mitigate the risk? • Extensive up-front engagement with hospital physicians in addressing challenges and opportunities, with support from LHIN Critical Care and Emergency Department Physician leads and other hospital physician leadership • Development of regional physician call protocols and schedule						

- Identify opportunities for consolidation and efficiencies between hospitals to create critical mass in clinical and health human resources.
- Engage local EMS and provincial transport services (ORNGE) in the design and implementation process

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

- Provincial “Life or Limb” policy
- Critical Care Services Ontario
- Criticall
- Central East LHIN physician leadership
- Health System Funding Reform
- Ontario Telemedicine Network and E-Health Ontario
- Resource Matching and Referral
- Hospital Governance and Senior Leadership

Transitions in Care & Electronic Health Information Management

IHSP Enabler:						
Electronic Health: Integrated Electronic Health Record Strategy						
IHSP Enabler Description:						
Electronic Health Record Strategy establishes the priority areas of Information Management focus for Central East LHIN for the next three years. The strategy is a key input to developing a detailed plan, taking into consideration alignment with the cluster and key activities that may be completed as shared initiatives.						
Current Status:						
The strategy has been completed and presented to LHIN CEO and LHIN E-Health Steering Committee. Projects being supported and aligned to the strategy are well underway including the projects that are highlighted in the following E-Health enablers. A LHIN and cluster wide communication Information Management plan is being finalized.						
Goal(s):						
Electronic health system strategy to inform at the LHIN level, the multitude of existing local and provincial initiatives and collaborations. A strategy that can ensure effective integration, avoid duplication, and leverage existing assets, processes and best practices to benefit the patients living in the region.						
Action Plans/Interventions:						
Action Plans	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Develop communications strategy including how to communicate the LHIN strategies (and the linkage to the cluster strategy)	In progress	100	Monitor	--	Monitor	--
Detailed planning: Work with the cluster and the Provincial agencies to develop the detailed plans for implementation within the LHINs	In progress	100	Monitor	--	Monitor	--
Detailed planning: Work with the cluster to define the approach for shared cluster	In progress	100	Monitor	--	Monitor	--

priorities (e.g. IM Strategy)						
Detailed planning: Identify any major initiatives that require new funding and develop business cases	In progress	40	Not yet started	40	Not yet started	20
Finalize governance 1. Finalize Terms of Reference for all governance bodies	In progress	100	Review and update if needed	--	Review and update if needed	--
Finalize governance 2. Work with the Cluster to finalize Decision Making Frameworks and Operating Principles	In progress	100	Monitor	--	Monitor	--
Finalize governance 3. Establish and report on key performance indicators using a balanced scorecard	In progress	60	Not yet started	40	Monitor	--

How will we measure success?

- Terms of Reference for groups supporting the work of the electronic health system strategy are well established.
- Completed decision making frameworks and Operating Principles.
- Completed communication plan and positive feedback from stakeholders on the communication output.
- Approved detailed plans that support and align to the strategy

What are the risks/barriers to successful implementation?

- Initiatives identified under the strategy fails
- Funding is not available
- Governance an issue with health service providers. Roles are unclear as to who are the decision makers and who has the authority
- Limited resources

For each risk/barrier, describe the plan to mitigate the risk?

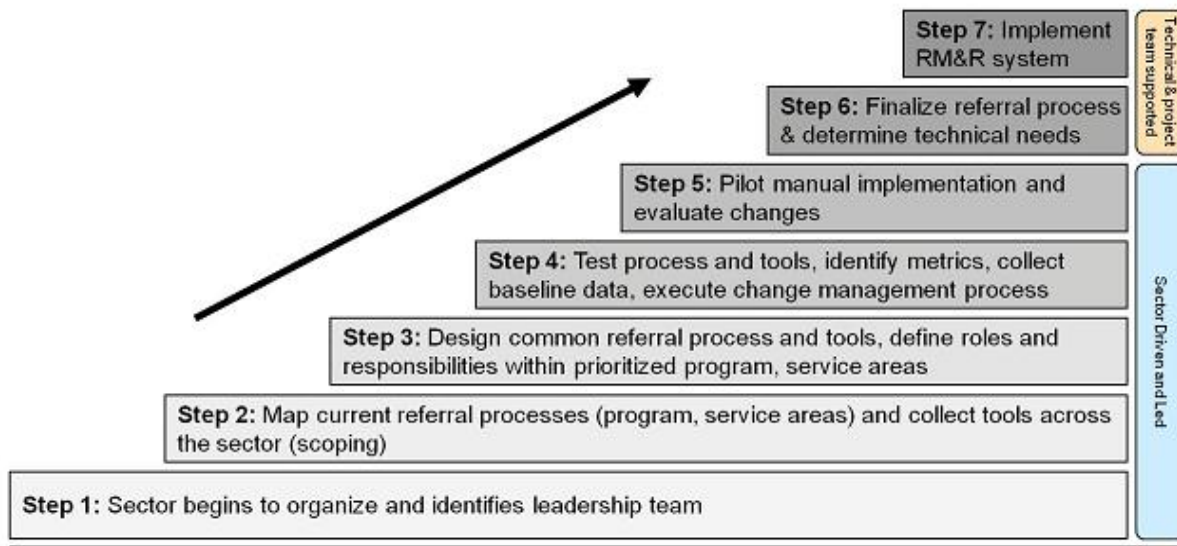
- Ensure dedicated and capable leadership is in place to drive each initiative
- Ensure early release of funds is coupled with multi-year funding; business cases must clearly identify the critical need for operating dollars to achieve the ongoing value proposition. Benefits realization as part of portfolio management is a priority
- Establish clear roles and responsibilities related to stakeholder engagement. Stakeholder identification is the basis for effective communication and will create stakeholder commitment and trust, increasing the likelihood of success
- Wherever possible, leverage existing resources (e.g. tools, templates, individuals/committees) and minimize redundancies; this increases the capacity available to all parties in the LHIN and cluster

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

- Key supporting processes that must be in place to ensure success in both implementation and adoption.
- Best practices can help to guide these supporting practices: Governance, Change Management, and Sustainability Models are closely related and have key points of overlap.

IHSP Enabler:
Transitions: Resource Matching and Referral (RM&R)
IHSP Enabler Description:
Technology enablers will be critical to support patient transitions between organizations and the required information flow. For example Resource Matching and Referral (RM&R) and various Assessment and Business tools are considered a critical technology enabler to manage patient flow. ALC RM&R stands for Alternate Level of Care Resource Matching and Referral and is a program that began as a way to help streamline the complex patient referral system across Ontario. Once fully implemented, it will benefit patients, health service providers and health planners. Through increased collaboration, standardized referrals and a shared commitment to project success, ALC RM&R will result in more efficient, equitable and client-centred care. Supported by the Ministry of Health and Long-Term Care, this initiative is considered a priority for all 14 Local Health Integration Networks. The in-scope care pathways have been defined as Acute to Rehab, Acute to Complex Continuing Care, Acute to Long-Term Care and Acute to CCAC in-home services. ALC RM&R supports the Ministry of Health and Long-Term Care ER/ALC Strategy, the Senior's Care Strategy, the Excellent Care for All Strategy, and the Ontario E-Health Strategy. The Community Care Information Management (CCIM) organization was given the mandate to provide standardized tools to the community sector and have worked with the Central East LHIN agencies to implement a number of the tools including: the Human Resources Information System (HRIS) - Human Resources application; the Ontario Healthcare Reporting Standards/Management Information Systems (OHRIS/MIS) – Information Systems and Reporting application, the Common Assessments (OCAN, inter RAI-CHA and the RAI Screener) and the implementation of the IAR – Integrated Assessment Record which includes a repository and a viewer to see all common assessments done per patient by providers. This automated process is a precursor to the link to
Current Status:
The Resource Matching and Referral (RM&R) solution is being implemented provincially and all the LHINs divided into clusters are working through a seven-step model developed by the Toronto Central LHIN.

Resource Matching & Referral 7-Step Model



RM&R is an electronic information and referral system that contributes to the provincial strategies of reducing Emergency Room wait times and Alternative Level of Care days and aims at improving health equity within the health care system. This is made possible by improving workflow and communication during the referral process, matching patients/clients to earliest available and most appropriate care/support setting, and delivering the right level of service at the right time.

The objective of the current phase (Phase 5) of the project is to standardize and streamline referrals in preparation for the implementation of electronic RM&R solutions.

The initial implementation of the Provincial RM&R is focused on the following four referral pathways which offer the greatest potential opportunities for improving ALC wait times, with the objective of having one provincial form per care pathway:

- Acute (Medical and Surgical Inpatient) sending referrals to Rehabilitation
- Acute (Medical and Surgical Inpatient) sending referrals to Complex Continuing Care (CCC)
- Acute (Medical and Surgical Inpatient) sending referrals to Long-Term Care
- Acute (Medical and Surgical Inpatient) sending referrals to CCAC In-Home Services

During the last phase of this initiative, a minimum data set (MDS) related to the four care pathways listed above was developed.

In the absence of clear provincial directions since early 2012 the Central East LHIN had engaged in the development of a streamlined post-acute referral processes for the Acute to Rehabilitation (Rehab) and Acute to Complex Continuing Care (CCC) referral pathways that can function in both the partial and full implementation states of a LHIN-and ultimately province-wide electronic RM&R solution. The Central East LHIN will continue to participate in cluster two activities while simultaneously developing pathways for Complex Continuing Care (CCC) first and then Rehab. Subsequently both of the aforementioned will be aligned with the standardized provincial pathways.

Each of the three clusters (GTA, SWO, NEO) is leading the work on a care pathway. All three clusters completed their work-flows and minimum data sets (MDSs), the Provincial Delivery Lead (PDL) amalgamated the work and presented the findings in April 2012 at a well-attended Subject Matter Expert

(SME) meeting with representation from across the province. At this meeting, SMEs, grouped by pathway, came to consensus on the MDS for each in-scope care pathway. They also reviewed any differences in workflows across the three clusters and provided feedback on Key Performance Indicators (KPIs) for the next step of the project. A Provincial Standards document was presented to the LHIN CEOs in April 2012, resulting in a provincially-approved minimum data set for each of the four pathways.

Next step of the ALC RM&R project will require a much broader level of stakeholder engagement –involving HSPs in the refinement, testing and implementation of standardized forms across all four pathways. The cluster delivery teams will begin the work of refining each of the draft standardized forms – The agreed upon pathway's by all clusters are as follows:

- Cluster 1: Acute to Home Care
- Cluster 2: Acute to Long Term Care (this cluster has already had significant development in the LTC pathway in existing RM&R solutions)
- Cluster 3: Acute to Rehab/CCC (this cluster has free-standing Rehab and CCC facilities)

The Central East LHIN has strongly supported CCIM initiatives and the implementation of these standardized tools in our region. As this is critical in our efforts to provide improved services, measure the improvements in the quality of care in our region, we have strongly encouraged agencies that qualify and where appropriate, to participate in the initiatives and take advantage of these resources and tools. The Shared Assessment Framework is currently being mapped and will be implemented for the Community Support Services (CSS) and Community Mental Health (CMH) sectors in the Central East LHIN. In its endeavor to support the implementation of the Shared Assessment Framework and ensure sustainability the Central East LHIN is establishing a Community Support Services Common Assessment Project (CSS CAP) Centre of Excellence. We see this centre as offering standardized training for assessors as well as developing a network of leaders in cross sector Shared Assessment. The Central East LHIN CSS CAP shared assessment project envisages that when accessing community health and support services, each client can expect one comprehensive health assessment conducted in his/her home by a mutually agreed upon assessor in collaboration with other health care providers and caregivers involved in the client's current episode of care.

Goal(s):

- Improved access and transparency
- Mandatory and standardized referral information
- Referral monitoring and tracking
- Reportable data
- Referral pathway specific needs

Action Plans/Interventions:

Action Plans						
	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Current State analysis	In Progress	100	Monitor	--	Monitor	--
Participate in Fusion to finalize the Future State consideration	In Progress	100	Monitor	--	Monitor	--

Consolidated referral workflows mapped for each pathway for each service at each HSP	In Progress	100	Monitor	--	Monitor	--
Undertake a procurement process to select prefer vendor solution for automation	In progress	100	Monitor	--	Monitor	--
Implement the future state process for Rehab/CCC in all CE LHIN hospitals	Note yet started					
Implement an automated system for resource matching and referral at CE LHIN	Not yet started					

How will we measure success?

Successful adoption of the standard referral future core data set across the hospitals:

- A reduction in total ALC days. This occurrence drives all other system measures that claim benefit from RM&R including number of patients on placement waitlists, average placement list wait times, reduced ALOS for the ALC population, % ALC beds and reduced acute bed waiting times.
- A secondary efficiency benefit from reducing the time and materials consumed in performing the tasks involved is processing a referral.

There are also benefits reported that are difficult to measure in real terms. These intangible benefits can be likened to the goodwill recognized in the balance sheets of private corporations, in that they are difficult to quantify but are real and do exist.

The discussion of these benefits that follow is categorized into three types of intangible benefits:

- Strategic benefits conferred to the administrators, integrators and planners of the health care system
- Tactical benefits conferred to clinicians for decision making and resource allocation.
- Patient benefits in terms of satisfaction with the transparency, timeliness and quality of care provided

What are the risks/barriers to successful implementation?

- Uncertainty regarding long-term funding and potential new government priorities may impact engagement and participation of health care system stakeholders and champions
- Limited resource capacity among participating HSPs
- Other competing provincial initiatives take precedent over the project

For each risk/barrier, describe the plan to mitigate the risk?

- LHIN to reinforce in stakeholder communications, the system stakeholders and health care dollars.
- LHIN explicitly link RM&R with Excellent Care for All strategy. This project will ultimately help identify gaps in the system and access barriers, thereby improving quality and equity.

- LHIN to conduct issues and risk analysis to understand competing priorities and align project plans
- Project Sponsor, Provincial, clusters and LHINs to garner support from credible health leaders to champion the project
- LHIN to work with primary audiences and stakeholder groups to build awareness, engagement, buy-in and participation
- Ensure frequent communications to maintain project momentum
- Ensure MOHLTC is updated on a regular basis
- LHIN and HSP CEOs, along with associated RMR committee members to seek commitment and ensure that the HSPs are supporting this priority

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

- Strong, focused participation by all stakeholders for all activities within the project
- LHIN to engage their local health service providers to participate in the development of standardized referral processes and tools, roles and responsibility definitions, and change management plans
- Agreement from participating LHINs to share in the costs for economy of scale
- Strong governance at the LHIN, cluster and Provincial levels
- Address privacy issues early in the planning to ensure PHIPA is followed

IHSP Enabler:							
Transitions and Electronic Health: Continue to drive delivery of Timely Discharge Information System (TDIS) , a tool that is used to exchange information within the Primary Care system.							
IHSP Enabler Description:							
TDIS enhances patient care delivery through the automatic generation of hospital admission, transfer and discharge summaries to a patient's primary care physician. It is a project of the Central East LHIN and works with all of the hospitals in the Central East LHIN. All transcribed hospital reports are sent electronically, via TDIS, to primary care physicians' electronic medical records (EMR) within 72 hours of transcription. A fax option has been implemented to serve physicians who do not have an EMR. Reports available through TDIS include diagnostic imaging, consults, emergency reports, discharge summaries, delivery notes, progress summaries, operative reports, etc.							
Current Status:							
Nine hospitals are connected to TDIS to provide hospitals reports. Nine physician EMRs can integrate with TDIS to automatically transfer hospital reports to registered physicians within the Central East LHIN. Approximately 300 physicians are connected, with another 150+ to come onboard in early 2013.							
Goal(s):							
• Enable patient care throughout the care provider continuum • Electronic patient information sharing - reduce paper, fewer repeat tests, faster access to patient information, less time involved with managing patient information, fewer delays in receiving information, enhanced decision-making and better care planning							
Action Plans/Interventions:							
Action Plans		2013/14		2014/15		2015/16	
		Status	%	Status	%	Status	%
Work with Ontario MD (OMD) and E-Health Ontario (eHO) to increase EMR adoption within the Central East LHIN		In progress	40	Not yet started	20	Not yet started	20
Expand physician membership on TDIS		In progress	40	Not yet	20	Not yet	20

			started		started	
Integrate TDIS with provincial assets to support integrated electronic health record	In progress	75	Not yet started	25	Monitor	--
How will we measure success?						
By the number of physicians adopting EMR and the number registered to connect to TDIS The volume of reports processed in the system						
What are the risks/barriers to successful implementation?						
Obtaining a comprehensive list of all physicians within the Central East LHIN that are eligible to participate in TDIS						
For each risk/barrier, describe the plan to mitigate the risk?						
Work closely with other groups such as the Ontario Laboratory Information Systems (OLIS) implementation to cross reference physician lists. Request the LHIN's Primary Care Lead to assist in communication to physicians.						
What are some of the key enablers that would allow us to achieve our goal?						
• Physician acceptance and buy in for project goals • Health Records/transcription acceptance and buy in of project goals • Appropriate funding for all project components including project management component • Implementation of a shared services agreement for technology components • An engaged and enthusiastic Physician Champion • Reputable experts for governance structures, Privacy Impact Assessments and Threat Risk Assessments • Availability of communications expert to engage clinical users						

IHSP Enabler:																																								
Electronic Health: Ontario Laboratory Information Systems (OLIS)																																								
IHSP Enabler Description:																																								
As a province-wide, integrated repository of tests and results, OLIS will contribute to fundamental improvements in patient care by providing practitioners with timely access to information that is needed at the time of clinical decision making. OLIS is one component of the overall provincial strategy to improve chronic disease management in Ontario.																																								
Current Status:																																								
Currently, OLIS has collected approximately 60 % of the provincial total test volumes through connections with eleven hospitals, four community labs and public health labs																																								
Of the Central East LHIN hospitals, one hospital has completed integration and is contributing to OLIS as part the early adopters.																																								
One hospital is slated for completion May 2013, with five more hospitals by November 2013.																																								
Some of the Central East LHIN physicians have registered to begin receiving lab results into their EMR.																																								
Goal(s):																																								
Enable physicians to receive Lab results directly into their EMRs.																																								
Update:																																								
<table border="1"> <tr> <th rowspan="2">Action Plans</th><th colspan="2">2013/14</th><th colspan="2">2014/15</th><th colspan="2">2015/16</th></tr> <tr> <th>Status</th><th>%</th><th>Status</th><th>%</th><th>Status</th><th>%</th></tr> <tr> <td>Work with Ontario MD (OMD) and E-Health Ontario (eHO) to increase EMR adoption within the Central East LHIN</td><td>In progress</td><td>40</td><td>Not yet started</td><td>20</td><td>Not yet started</td><td>20</td></tr> <tr> <td>Encourage physicians currently using a certified EMR to upgrade in order to receive Lab results from OLIS</td><td>In progress</td><td>75</td><td>Not yet started</td><td>25</td><td>Monitor</td><td>--</td></tr> <tr> <td>Assist eHO in getting hospital executives to sponsor the data contribution to OLIS</td><td>In progress</td><td>80</td><td>Not yet started</td><td>20</td><td>Monitor</td><td>--</td></tr> </table>							Action Plans	2013/14		2014/15		2015/16		Status	%	Status	%	Status	%	Work with Ontario MD (OMD) and E-Health Ontario (eHO) to increase EMR adoption within the Central East LHIN	In progress	40	Not yet started	20	Not yet started	20	Encourage physicians currently using a certified EMR to upgrade in order to receive Lab results from OLIS	In progress	75	Not yet started	25	Monitor	--	Assist eHO in getting hospital executives to sponsor the data contribution to OLIS	In progress	80	Not yet started	20	Monitor	--
Action Plans	2013/14		2014/15		2015/16																																			
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Encourage physicians currently using a certified EMR to upgrade in order to receive Lab results from OLIS	In progress	75	Not yet started	25	Monitor	--																																		
Assist eHO in getting hospital executives to sponsor the data contribution to OLIS	In progress	80	Not yet started	20	Monitor	--																																		

How will we measure success?
The number of physicians having access to lab results
What are the risks/barriers to successful implementation?
• Hospital having competing priorities • Physicians not ready to adopt EMR
For each risk/barrier, describe the plan to mitigate the risk?
• Work closely with eHO to provide hospital with project management, funding for planning and implementation of data contribution into OLIS • Direct Physicians to OMD and Physician Peers for support and to encourage adoption; and work closely with LHIN Physician Leads to promote adoption
What are some of the key enablers that would allow us to achieve our goal?
• Physician acceptance and buy in for project goals • Appropriate funding for all project components of planning and implementation • Engaged and enthusiastic Physician Champions

IHSP Enabler:							
Transitions and Electronic Health: Support the development of data definition standards and mapping tools such as the Standardized Discharge Summary Template project.							
IHSP Enabler Description:							
Participate and contribute at various levels of creating standardization to provide consistency in information sharing and discharge planning process. Standardized Discharge Summary Template project involves six GTA LHINS and it will align with other E-Health and LHIN initiatives: • Hospital Report Manager (Ontario MD) • Discharge Summary exchange projects in other LHINS • Referral and Resource Matching • E-Health Standards Discharge Summary Specification (2009) Organizations contributing towards creating the template include acute care, community care, specialty and complex continuing care to assist with the project.							
Current Status:							
Standardized Discharge Summary Template was approved by the GTA Health Information Custodian (HIC) CEOs. The project goal was to develop a minimal data set to improve communication between healthcare providers to support care transition. This has been achieved. The final template will now be used in a pilot where it may possibly undergo minor revisions before implementation more broadly later this year. St. Michael's Hospital has been appointed as the implementation lead for the pilot.							
Goal(s):							
Consistency of clinical definition of discharge data elements across the Central East LHIN hospitals							
Action Plans/Interventions:							
Action Plans	2013/14		2014/15		2015/16		
	Status	%	Status	%	Status	%	
	Engage an early adopter to participate in the pilot to help inform the final discharge standard template	In progress	100	Monitor	--	Monitor	--
	Conduct hospital readiness for implementation either	Not yet started	100	Monitor	--	Monitor	--

electronically or paper-based discharge summaries						
Plan sequential implementation for the remaining hospitals at the Central East LHIN	Not yet started	40	Not yet started	40	Not yet started	20
How will we measure success?						
Hospitals adoption of the final discharge summary standard template either manually or electronically.						
What are the risks/barriers to successful implementation?						
- Hospital having other competing priorities - Agreement of the standards						
For each risk/barrier, describe the plan to mitigate the risk?						
- LHIN to provide funding, if appropriate, to offset the potential burden it has on their current limited resources - LHIN CEO to endorse the standards within the Central East LHIN based on having gained approvals from the GTA Health Information Collaborative CEOs.						
What are some of the key enablers that would allow us to achieve our goal?						
- LHIN CEO advocating to hospital CEOs to adopt - Hospital CEOs understand the value of consistency in information sharing - Clinical staff to promote the value of standard data set to improve communications between providers						

Quality and Performance Improvement

IHSP Enabler:
Quality and Safety
IHSP Enabler Description:
Since 2007, the Central East LHIN Board and staff have been guided by four strategic directions: • <i>Fiscal responsibility and organizational health:</i> Resource investments in the Central East LHIN will be fiscally responsible and prudent • <i>Transformational leadership:</i> The LHIN Board will lead the transformation of the health care system into a culture of interdependence • <i>Health service and system integration:</i> Create an integrated system of care that is easily accessed, sustainable and achieves good outcomes • <i>Quality and safety:</i> Health care will be person-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. The Central East LHIN's focus on quality improvement has been proven to successfully implement and spread new pathways of care, facilitate engagement of inter-disciplinary teams, design tools and describe standard work. Emphasis on quality improvement methodology will continue as a critical enabler for the four current strategic aims. In addition, methodology to engage patients in planning and design processes, such as Experience-Based Design, will be developed and used to support activities to achieve the strategic aims.
Current Status:
Notable performance on key safety and quality indicators in the Central East LHIN are noted below: • Hospitalizations for falls among Long-Term Care Home (LTCH) resident (rate of hospitalizations for falls per 1,000 LTCH residents): Central East LHIN has been below the provincial rate for eight of the last nine Quarters up to and including Q1 2012/2013 (7.8 versus 8.3, respectively) • Hospital Associated Clostridium Difficile Infection (CDI) rate (per 1000 patient days): Central East LHIN rates have been consistently higher than the provincial average including in the latest reported Quarter – Q2 2012/2013 (0.45 versus 0.35, respectively) • Emergency visits for total adverse reaction to drugs (rate per 100,000 population): Central East LHIN rate was lower than the province in the latest Quarter – Q1 2012/2013 (78.3 versus 83.1, respectively) In support of improving health system performance and quality, the Central East LHIN will continue to build on its collaborative relationship with Health Quality Ontario and local health service providers to implement the provisions and objectives of the Excellent Care for All Act (ECFAA), 2010. Quality improvement methods have been used to design strategies for improving outcomes identified in hospital QIPs for 2013/2014 and outcome targets have been included in 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.

Behavioural Supports Ontario (BSO)

Quality improvement will continue to be the change methodology used to ensure spread and sustainability of the Behavioural Supports Ontario (BSO) initiative as it moves into its third year (2013/2014) and spreads into the community and hospitals. Both process and outcome measures, as well as anecdotal evidence from providers and family members, have shown improvement in a number of long-term care homes across a variety of issues.

Health Links

The Health Links initiative in Central East LHIN has started with the Peterborough Health Link where the Health Link Steering Committee has chosen to use patient engagement strategies such as Experience-Based Design to support planning and implementation of new care pathways and services for high user client cohorts. Additional quality improvement methods such as PDSA cycles (Plan, Do, Study, Act), small tests of change and the 5x spread strategy will be used to test and spread innovative client care solutions and to spread in other Central East LHIN Health Links as they are identified and come on stream.

Residents First

The Residents First quality improvement initiative in long-term care homes that is being led by Health Quality Ontario (HQO) in partnership with the LHIN, has moved into a sustainability phase. Central East LHIN continues to support the Residents First quality improvement philosophy and will contribute to operationalizing the program at every opportunity. For example, recently a 3-day improvement facilitator training between Residents First and Behavioural Supports Ontario (BSO) was jointly sponsored and co-led by the Central East LHIN BSO initiative and Health Quality Ontario.

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 SFH Indicator Working Group recently completed its work on indicator identification and has suggested four cross-LHIN outcome indicators related to functional decline and delirium at an organizational level, 1234 to date. Involvement has largely been a function of the decision of each hospital independently. In 2013/2014, the Regional Specialized Geriatric Services (RSGS) entity will assume oversight for the Senior Friendly Hospital initiative and coordinate implementation of a LHIN-wide adoption of the SFH framework.

Goal(s):

- Continue spreading Behavioural Supports Ontario to all long-term care homes and then into the community
- Develop and implement a shared falls prevention strategy
- Senior friendly hospitals
- Patient self-management training
- Implement evidenced based care pathways for stroke, Chronic Kidney Disease (CKD), and other quality based procedures
- Coordinated equitable access to vascular surgical services
- Monitor quality and safety through accountability agreements with providers
- Support cluster-based Hospital to Home teams working within quality improvement principles
- Ongoing quality improvement initiatives such as Assertive Community Treatment Team (ACTT)

- quality improvement initiative and Schedule 1 Bed Registry
- Expand and promote standardization of hospice, palliative and end of life care programs in long-term care homes and hospitals

To ensure quality improvement and engagement of patients is embedded within system design initiatives.

Action Plans/Interventions:

Action Plans						
	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Introductory and intermediate level training for the Central East LHIN staff in QI and patient engagement methods.	In progress	40	Monitor	40	Monitor	20
Integration of QI tools and methods in HSP initiatives for all sectors.	In progress	40	Monitor	30	Monitor	30
Standardize and develop a repository of CE LHIN quality improvement toolkits and protocols	In progress	90	Monitor	5	Monitor	5

How will we measure success?

- Number of staff training sessions and staff trained
- Degree to which quality improvement methodology is used in system redesign initiatives
- Degree to which patient experience is embedded within Health Links planning and implementation
- Availability of standard QI tools and protocols centrally through the Central East LHIN

What are the risks/barriers to successful implementation?

- Staff availability for training
- Ability to fund training costs as needed
- Participation in surveys or other data collection methods to identify QI and patient engagement uptake
- Agreement on standard tools and protocols

For each risk/barrier, describe the plan to mitigate the risk?

- Provide training in smaller parcels (theory bursts) and online and at convenient times
- Provide in-house training whenever possible

What are some of the key enablers that would allow us to achieve our goal?
• Leadership support • Staff expertise • Facility with Prezi and other presentation software

Central East LHIN Staffing Plan

Central East LHIN Staffing Plan (Full-Time Equivalents)				
Position Title	2012/2013 Actuals as of March 31/2012 FTEs	2013/2014 Forecast FTEs	*2014/2015 Forecast FTEs	2015/2016 Forecast FTEs
CEO	1	1	1	1
Senior Director	2	2	2	2
Manager/Controller	1	1	1	1
Team Lead/Lead	6	5	6	6
Consultant	5	6	6	6
Planner	3	3	6	6
Public Affairs	1	1	1	1
Coordinator	5	5	5	5
Analyst	4	4	5	5
Assistants	4	4	6	6
Receptionist	1	1	1	1
Total FTEs	33	33	40	40

*Note: From 2014/15 includes the Regional Coordinating Centres FTEs, transition to the LHINs.

Central East Local Health Integration Network Operations

LHIN Operations (\$)	2011/12 Actuals	2012/13 Allocations	2013/14 Planned Expenses	2014/15 Planned Expenses	2015/16 Planned Expenses
Operating Funding (excluding initiatives)	4,850,494	4,534,130	4,534,130	4,534,130	4,534,130
Initiatives Funding (e.g. E-Health, A@H, ED, Wait Time, etc.)	1,769,750	1,847,301	1,847,301	1,847,301	1,847,301
Salaries and Wages	2,779,921	2,785,836	2,785,836	2,785,836	2,785,836
Employee Benefits					
HOOPP	267,520	278,584	278,584	278,584	278,584
Other Benefits	393,949	334,300	334,300	334,300	334,300
Total Employee Benefits	661,469	612,884	612,884	612,884	612,884
Transportation and Communication					
Staff Travel	44,326	48,400	48,400	48,400	48,400
Governance Travel	16,796	30,000	30,000	30,000	30,000
Communications	53,706	40,000	40,000	40,000	40,000
Others					
Total Transportation and Communication	114,828	118,400	118,400	118,400	118,400
Services					
Accommodation	182,949	260,584	260,584	260,584	260,584
Community Engagement	86,293	24,000	24,000	24,000	24,000
Consulting Fees	42,759	20,075	20,075	20,075	20,075
Governance Per Diems	76,376	124,000	124,000	124,000	124,000
LSSO Shared Costs	501,995	390,000	390,000	390,000	390,000
Other Meeting Expenses	28,134	35,000	35,000	35,000	35,000
Other Governance Costs	10,074	20,000	20,000	20,000	20,000
Staff Development	33,025	43,000	43,000	43,000	43,000
Other Services	-	43,351	43,351	43,351	43,351
Total Services	961,605	960,010	960,010	960,010	960,010
Supplies and Equipment					
IT Equipment	12,999	10,000	10,000	10,000	10,000
Office Supplies & Purchased Equipment	133,513	37,000	37,000	37,000	37,000
Other S & E				-	-
Total Supplies and Equipment	146,512	47,000	47,000	47,000	47,000
Capital Expenditures	156,794	10,000	10,000	10,000	10,000
LHIN Operations: Total Planned Expense	4,821,128	4,534,130	4,534,130	4,534,130	4,534,130
Annual Funding Target		6,381,431	6,381,431	6,381,431	6,381,431
Operating Surplus (Shortfall)	29,366	-	-	-	-
Amortization of Tangible Capital Assets					

Integrated Communications Strategy

Objectives

Business Objective:

The Central East LHIN's 2013/2014 Annual Business Plan operationalizes the goals contained in the LHIN's 2013-16 IHSP, specifically:

- Help Central East LHIN residents spend more time in their homes and communities.
 - Reduce the demand for long-term care so that seniors spend 320,000 more days at home in their communities by 2016.
 - Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.
 - Strengthen the system of supports for people with Mental Health and Addictions issues so they spend 15,000 more days at home in their communities by 2016.
 - Increase the number of palliative patients who die at home by choice and spend 12,000 more days in their communities by 2016.

Communications Objective:

Given the magnitude of change contemplated by the Central East LHIN's 2013-16 Integrated Health Service Plan and the initiatives contained in this Annual Business Plan, the Central East LHIN and its Board will require a very deliberate approach to communication and engagement.

A strong communications strategy and plan are critical to support execution of the "Community First" transformation agenda.

This communication strategy and plan has been developed to guide the communications and engagement activities of the Central East LHIN (Board and staff) and health service provider partners involved in initiatives contained in the 2013/2014 Annual Business Plan and to ensure that all stakeholders understand the role of the respective organizations to identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services based on funding available and tracking performance against signed accountability agreements.

Context

- Ontario's Action Plan for Health Care, announced by the Minister in January 2012, which is consistent with the principles of the Excellent Care for All Act (2010), puts LHINs at the centre of health system transformation.
- As such LHINs have a critical role to play in key provincial initiatives recently introduced such as Health System Funding Reform, Health Links, Seniors Strategy and the expansion of Quality Improvement Plans into the primary and community care sectors.
- The Central East LHIN's "Community First" 2013-16 IHSP and the initiatives laid out in this Annual Business Plan are strategically aligned with government direction and priorities and recognize the joint accountability of the ministry and LHINs to serve the public interest and effectively oversee the use of public funds.
- The health care system has evolved to the point where LHINs are being recognized as the local system managers who play a central leadership role in driving health system transformation.

Target Audience

Depending on the situation, primary and secondary audiences will include:

- Health Service Providers/Stakeholders (in Central East and surrounding LHINs)
 - Health Service Providers Leadership and Front Line staff (including union leadership)
 - Central East Health Service Provider Boards
 - Physicians
 - Patients/Clients/Consumers/Residents/Caregivers
 - Consumer/Patient Support Groups
 - Healthcare Associations (OHA, ONA, OMA, etc)
- Government
 - Municipal
 - Regional
 - Provincial – including MOHLTC stakeholders
 - Federal
- CE LHIN Planning Partners
- General Public
 - Residents
 - Community Organizations
- Local media
- Other LHINs
- Ministry of Health and Long-Term Care and other ministries as appropriate

Strategic Approach

- Position the Central East LHIN as a valued key player within the transformation of Ontario's health care system and as the lead in health system transformation in the Central East region.
- Develop and leverage opportunities to build our reputation and establish credibility.
- Provide accurate and timely information to all audiences
- Be transparent and accountable to our shared audiences re: timelines, outcomes and opportunity for participation/feedback
- Foster an understanding of the need for health system transformation both internally and externally.
- Build support for the health system model by focusing on the benefits of the health system

transformation that creates an integrated sustainable healthcare system that ensures better health, better care, better value for money.

- Align the health service providers to the shared vision, mission, values and common “Community First” direction of helping Central East LHIN residents spend more time in their homes and their communities.
- Demonstrate how organizations and individuals can participate in the success of the health system transformation.
- Mitigate communications risks of negative publicity by proactive planning of risk reduction.
- Provide information on performance and progress on the implementation – document successes and share it.
- Each initiative contained in the Annual Business Plan will have its own “Communications and Community Engagement Plan” (as required) documenting the context for each initiative, timelines, audiences, tools/tactics, specific key messages and a deliverables tracking chart.
- In many cases, this will be a document that will be developed and rolled out in partnership with the appropriate health care partners.
- Common to all communications plan is an understanding of the following message matrix:

Audience	Principle Interests	Risks to Transformation Agenda	Key Messages	Mitigation Strategies
Hospital Leadership – administration/ physician	Success of the project	Failure to participate in collaborative solutions	Collaboration throughout the project	Involvement/ Representation in planning structures ie. Steering Committees/ Advisory Groups; web based collaboration workspaces
Front Line staff (including union leadership)	Job Security	Public campaigning against projects	Health Human Resources vital to the success of the projects	Ensure that front line staff have ongoing access to information through the Central East LHIN and HSP communication vehicles; targeted communication to union leadership at key milestones

Central East Health Service Provider Boards	Protecting the interests of their communities	Failure to participate in collaborative solutions	Collaboration throughout the project Focus on access and quality Other projects that are supporting transportation and patient flow	Ensure that HSP CEOs/EDs are providing ongoing updates to their board; targeted communication prior to public consultation on any transformation projects that involve change/integration ; involvement in change management sessions
Physicians	Ability to practice based on their skills	Public campaigning against project based on personal/patient interests	Plan developed by their physician peers; intensive involvement by physicians both within HSPs and CE LHIN planning partners	Physicians talking to physicians
Patients/Clients/ Consumers/ Residents/ Consumer/Patient Support Groups	Access	Public campaigning against projects based on perceived loss of access	Quality and access and fiscal responsibility	Transparent disclosure related to projects and timelines; direct involvement of these stakeholders in any HSP consultation/ Community engagement
Healthcare Associations (OHA, ONA, OMA, etc)	Protecting interests of their membership	Public campaigning	Collaboration by hospitals/ memberships throughout the project	Targeted communication to the leadership of these organizations at appropriate milestone
Local Government Stakeholders	Access/ protecting the interests of their	Public campaigning against project	Quality and access and fiscal	Targeted communication and engagement

	constituents		responsibility	with these stakeholders at appropriate milestone; ensure that message comes from their local HSPs/physicians on the gains to be made projects
CE LHIN Planning Partner volunteers	Involvement in the process and the outcome	Public campaigning re: perceived lack of involvement/consultation in the plan	Involvement throughout; link to other sectors	Ongoing updates at all of their meetings; link to public website and communication vehicles
General Public	Access	Support any organizing and individual campaigning against the project	Quality and access and fiscal responsibility	website; speakers' bureau; enewsletter; news releases; HSP communication vehicles
Media	HSP/Community reaction to the process – implementation and outcome	Will report on any and all public campaigning against project	Quality and Access and Responsibility	website; speakers' bureau; enewsletter; news releases; HSP communication vehicles; targeted communication at key milestones
Other LHINS	Seeing if project is applicable to their LHINS	No risk	Applicability in other LHINS	website; speakers' bureau; enewsletter; news releases; HSP communication vehicles; knowledge sharing with applicable staff
MOH	Success of the project related to access, financial stability, quality and MOH Action Plan	Lack of public support for the projects – implementation and outcomes	Collaborative consultation with HSPs and planning partners; communication and community engagement plan with key	Ongoing briefings with appropriate ministry staff at all key milestones

			stakeholders	
Key Messages				
• The CE LHIN is a key partner in transforming the health system to provide quality care that meets the needs of Ontarians today and into the future. • We are working with our partners to change from an old system designed to treat people once they are sick to a more coordinated, value-driven model that promotes wellness. • Populations are growing and aging. The rates of chronic conditions are rising. • Current fiscal realities and demographic trends have created a need for transformation. • LHINs have already brought about significant and positive change in the way health services are delivered, and we must continue that work. In fact, we must aggressively build upon that work, because the status quo is neither acceptable nor sustainable. • Transformation requires a collective call to action. Everyone has an important role to play in making healthy change happen, including health-service providers, the LHINs, community leaders and the public.				
Tactics – high level, if available				
The Communication team leverages a variety of communication vehicles tailored to various stakeholder groups. Specific tactics will be referenced in each plan but will include: ○ News releases/Blast Emails/Newsletters/Bulletins ○ Website postings/alerts/social media ○ Stakeholder events ○ Outreach to local government stakeholders Engagement with specific stakeholders – unions, provincial associations, community groups				
Evaluation				
Identifying and tracking critical communication success factors will enable the Central East LHIN to more effectively identify whether communication activities have been successful. • Visible senior leadership engagement and support of the ABP initiatives and related communications. • Senior leadership and LHIN-wide committees take visible, active roles in supporting communications and change with their teams as tracked in shared communication and community engagement plans. • Poll key stakeholders to measure their understanding of the “Community First” transformation agenda and how they will be impacted by the implementation of any related initiatives • Evaluate engagement of health care providers across the Central East LHIN – are they engaged early and frequently and how is their participation impacting the implementation of the Future State? • Evaluate Central East LHIN citizens’ engagement by monitoring and measuring tone and volume of traditional media, online/social media (e.g., websites, Twitter) and LHIN communication vehicles (blast emails, bulletins).				

Feedback mechanisms and ongoing assessment are in place to monitor the effectiveness of communication vehicles and messages, and the LHIN has the ability to make quick modifications based on shifts and lessons learned as activities are carried out.

Community Engagement

Community Engagement

In accordance with Community Engagement Guidelines (April 2011) and in keeping with the expectations of the Local Health System Integration Act (LHISA 2006), all LHINs are required to develop and publish their Community Engagement plan. Plans are updated annually to reflect specific priorities and objectives in the current/upcoming year.

The Central East LHIN's Community Engagement Plan provides an overview of the priority activities and associated community engagement mechanisms or strategies that will support achievement of the initiatives contained within this Annual Business Plan.

Guided by the organization's vision "Engaged Communities – Healthy Communities" and focused on achieving its identified priorities in 2013/2014, the Central East LHIN will fulfill its commitment to community engagement in the following ways:

Engagement Strategies and Best Practices

A variety of best practice strategies, appropriate to the desired objectives and identified level of engagement will be employed. The objectives of community engagement will be identified in advance for priority initiatives and will vary across the following engagement continuum.

Inform and Educate: To provide accurate, timely, relevant and easy to understand information to the community. This level of engagement will provide information about the LHIN, and offers opportunities for community members to understand the problems, alternatives and/or solutions. There is no potential to influence final outcome as this is one-way communication.

Gather Input: To obtain feedback on analysis and proposed changes. This level of engagement provides opportunities for community to voice their opinions, express their concerns and identify modifications. There may be potential to influence the final outcome.

Consult: To seek out and receive the views of community stakeholders on policies, programs or services that affect them directly or in which they may have a significant interest. This level provides opportunities for dialogue between community and the LHIN. Consultation may result in changes to the final outcome.

Involve: To work directly with stakeholders to ensure that their issues and concerns are consistently understood and considered, and to enable residents and communities to raise their own issues. In this level, community stakeholders may provide direct advice as this is a two-way communication process. This level will influence the final outcome and encourage participants to take responsibility for solutions.

Collaborate: To work with and enable stakeholders to work through options/solutions to find common ground or agreement.

Empower: Delegated stakeholder decision-making where final decision-making authority, leading to action is assigned to a committee (ad hoc, standing) or other organized body (project-related work group or task).

Identification of Stakeholders & Assessment of Impact and Outcomes

The Central East LHIN's is committed to leverage the knowledge, experience and expertise that currently exists within Central East LHIN communities to achieve its objectives. Accordingly, a core principle of engagement in Central East LHIN is to identify existing stakeholder groups or entities, individuals or organizations which have interest in the outcomes of the initiative/project.

Stakeholders are individuals, communities, political entities or organizations that have a vested interest in the outcomes of the initiative. They are either affected by, or can have an effect on, the project. Anyone whose interests may be positively or negatively impacted by an initiative, or anyone that may exert influence over the initiative or its results is considered a project stakeholder. All stakeholders must be identified and managed/involved appropriately. For the purpose of stakeholder identification, "communities" can be interpreted to mean geographic locations (i.e. a municipality in the Central East LHIN region), communities of interest or communities of practice.

Community of interest (COI) - an informal, self-organized, network of individuals brought together around a common interest, issue, concern or opportunity. They need not meet physically and may only ever connect with one another on an ad hoc basis, around that common element.

Community of practice (CoP) - an Informal, self-organized, network of peers with a common area of practice or profession. Such groups are held together by the members' desire to help others (by sharing information) and the need to advance their own knowledge (by learning from others).

Political Entity - For the purpose of stakeholder identification, "political entity" is an individual, organization or group with known political interests or public responsibility. This may include officials in public office, or organized labour or citizens groups.

Planning Partners – for the Central East LHIN, Planning Partners is defined as a group that has been formally constituted and/or is supported by the LHIN in order to facilitate engagement related to LHIN MLPA deliverables.

To further support the identification of stakeholders entities/groups the Central East LHIN maintains and updates a stakeholder engagement matrix, which at the present time includes, but is not limited to the following Planning Partners:

- First Nations Health Advisory Circle
- Métis, Inuit, Non-Status People's Advisory Committee
- Durham Governance Advisory Council
- North East Governance Advisory Council
- Scarborough Governance Advisory Council
- Central East Hospice Palliative Care Network
- CE LHIN Self-Management Program Advisory Council
- E-health Steering Committee
- Hospital/CCAC Financial Leadership Group
- HSFR Local Leadership Table
- Primary Care Health Care Advisory Group
- Wait Time Strategy Working Group

- Central East Executive Council
- CE LHIN Diagnostic Imaging Working Group
- CE LHIN Regional Decision Support Group
- CE LHIN Wait Time Strategy Working Group
- Clinical Vice Presidents and Chief Nursing Officers from CE LHIN Hospitals
- Medical Leadership Group - Chiefs of Staff from CE LHIN Hospitals
- Vascular Health Strategic Aim Coalition
- CE LHIN Communications Sub-Committee
- CE LHIN Communications Network
- BSO Advisory and Design Teams
- BSO Education Committee
- CCDC Diabetes Committee
- CE LHIN RSGS Governance Authority
- Central East Diabetes Network
- HPAC – Health Professionals Advisory Committee
- LEAN Community of Practice
- NPSTAT
- Pay for Results Working Group
- RM&R – Resource Matching and Referral
- System Surge Management
- Transitions in Care
- Home First Sustainability Steering Committee
- Orthopedic Surgical Task Group
- Rehabilitation Task Group
- Child and Adolescent Mental Health Advisory Group
- Community Health Services – Integration Planning Teams
- Health Links Peterborough

The assembly of new Central East LHIN Planning Partner tables, project teams and work or task groups and ongoing support for existing tables, project teams, work or task groups involves the identification of key stakeholder perspectives such as community, hospital, consumer/caregiver, clinical or administrative/leadership.

As appropriate, the engagement of providers or persons with expertise and experience in the delivery of services from across the three service clusters within the Central East LHIN is also obtained namely, the North East (Northumberland, City of Kawartha Lakes, Peterborough and Haliburton Highlands), Durham (Durham Region) and Scarborough.

Engagement of Aboriginal Peoples

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 continue 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 groups - the First Nations Health Advisory Circle and the Métis, Inuit, Non-Status People's Advisory Committee, the Central East LHIN receives advice on a variety of topics reflecting on provincial and Central East LHIN priorities pertaining to the First Nations people represented.

Engagement of Central East Francophone community

The Central East LHIN has a French-speaking population is approximately 32,400 or 2.3% of the population (2006). Almost 80% of the LHIN's Francophone population lives in Scarborough and Durham West/East. In the Central East LHIN, only Scarborough is officially designated under the FLSA. However, a request has been submitted to the Office of Francophone Affairs to have the regional Municipality of Durham designated under the Act.

The Central East LHIN's commitment to equity and respect for diversity recognizes the requirements of the FLSA and the legislation pertaining to the Engagement with the Francophone Community (January 2010) in serving Ontario's French-speaking community.

To do so, the Central East LHIN engages with its Francophone community in partnership with the French Language Planning Entities (April 2011). French Language Service Entity #4 for Central East LHIN provides advice and support to the Central East LHIN with respect to: engaging the local Francophone community; identification and planning for health needs and priorities; the needs and priorities of diverse groups within the Francophone community; health services available to the Francophone community; the identification and designation of health service providers for the provision of French language health services; strategies to improve access to, accessibility of and integration of French language health services in the local health system; the integration of French language health services.

