

Central East **LHIN**

# 2014/2015 Annual Business Plan

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



# Table of Contents

|                                                                                                                                                                                                           |                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| <b>Context</b>                                                                                                                                                                                            | <b>5</b>       |
| Central East LHIN Mandate and Strategic Directions                                                                                                                                                        | 5              |
| Resources                                                                                                                                                                                                 | 8              |
| Community Engagement                                                                                                                                                                                      | 8              |
| Central East Local Health Integration Network – Operations Overview                                                                                                                                       | 8              |
| Overview of Central East LHIN Current and Forthcoming Programs and Services                                                                                                                               | 8              |
| Assessment of Issues Facing the Central East Local Health Integration Network                                                                                                                             | 9              |
| <br><b>Core Content</b>                                                                                                                                                                                   | <br><b>12</b>  |
| 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                                        | 12             |
| 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                                 | 25             |
| 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 | 34             |
| 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                               | 41             |
| Central East LHIN Common Enablers to Achieve IHSP Strategic Aims                                                                                                                                          | 48             |
| Improving Access to Primary Care                                                                                                                                                                          | 48             |
| Access and Wait Times                                                                                                                                                                                     | 54             |
| Health System Funding Reform                                                                                                                                                                              | 63             |
| Health System Design and Integration                                                                                                                                                                      | 65             |
| Transitions in Care & Electronic Health Information Management                                                                                                                                            | 83             |
| Quality and Performance Improvement                                                                                                                                                                       | 111            |
| <br><b>Central East LHIN Operations and Staffing</b>                                                                                                                                                      | <br><b>114</b> |
| <br><b>Integrated Communications Strategy</b>                                                                                                                                                             | <br><b>116</b> |
| <br><b>Community Engagement</b>                                                                                                                                                                           | <br><b>121</b> |

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SEP 24 2014

**Sent Electronically**

Ms. Nancy Naylor  
Assistant Deputy Minister (A)  
Ministry of Health and Long-Term Care  
Health System Accountability and Performance Division  
Hepburn Block  
5<sup>th</sup> Floor - 80 Grosvenor Street  
Toronto, ON M7A 1R3

Dear Ms. Naylor:

**Re: Central East LHIN 2014/15 Annual Business Plan**

The Central East Local Health Integration Network (Central East LHIN) is pleased to share its 2014/2015 Annual Business Plan with the Ministry of Health and Long-Term Care (MOHLTC).

This document outlines the operational details supporting the achievement of the Central East LHINs 2013-16 Integrated Health Service Plan (IHSP) Strategic Aims. 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 work towards achieving 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; and
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 the 2013-16 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

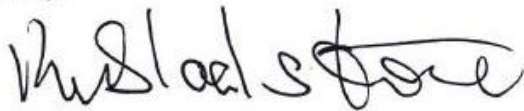
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Central East LHIN 2014/15 Annual Business Plan

prevent avoidable hospitalization and long-term care utilization. Since our inception in 2006 and now in 2014/15, we will continue to work diligently in the achievement of better outcomes for patients, caregivers and our communities.

This document has been approved by the Central East LHIN Board of Directors at their June 25<sup>th</sup>, 2014 meeting. If you have questions or comments, please contact my office at your earliest convenience.

Sincerely,



Wayne Gladstone  
Board Chair, Central East Local Health Integration Network

- c: Central East LHIN Board of Directors  
Deborah Hammons, Chief Executive Officer, Central East LHIN  
James Meloche, Senior Director - System Design & Implementation, Central East LHIN  
Paul Barker, Senior Director - System Finance & 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, allocation of public resources, 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 Central East LHIN's 2013-16 IHSP and the actions stated in this Annual Business Plan provide 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 continue to serve as the aspiration of our health care community for the next two years.

These strategic aims and enablers take their cue from the Ministry of Health and Long-Term Care's **Action Plan for Health, *The Excellent Care for All Act***, 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 placement.

A "Community First" approach requires focused and disciplined action 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 having occurred and expected to continue to take place in the areas of health care finance, clinical practice, demographic shifts, and technology – LHINs play an increasingly critical role in shaping the local health system and how it responds to needs of patients and communities.

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.*

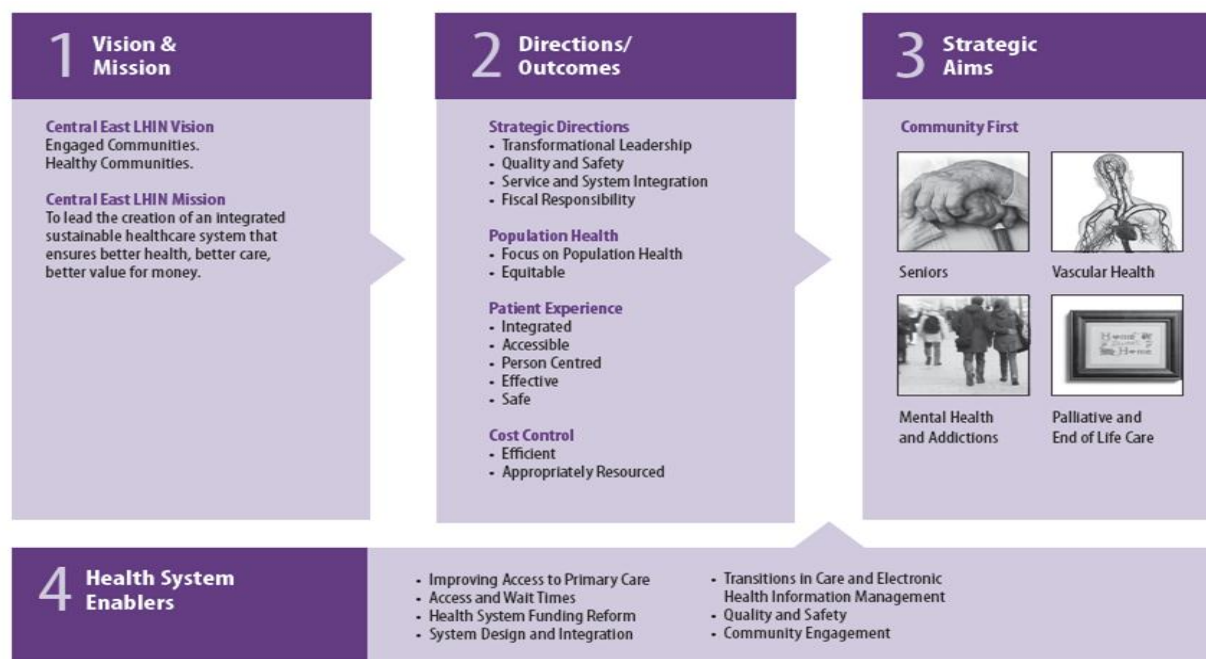
Achieving these aims requires a concerted effort by the Central East LHIN, LHIN funded health care providers, other health and social service partners and, of course, our patients and their caregivers.

This IHSP identifies 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", Health Quality Ontario's "Attributes of a High Performing Health System", and performance indicators as established in the Ministry of Health and Long-Term Care / LHINs Performance Agreement (MLPA) and Service Accountability Agreements between the LHIN and local health service providers. 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 2013-14 Ministry-LHIN Performance Agreement (MLPA) targets listed below.

| MLPA Measure                                                                                                                                                                           | Target |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|
| Percent of Priority IV Cases within Access Target for Cancer Surgery (84 days)                                                                                                         | 90%    |
| Percent of Priority IV Cases within Access Target for Cataract Surgery (182 days)                                                                                                      | 90%    |
| Percent of Priority IV Cases within Access Target for Hip Replacement Surgery (182 days)                                                                                               | 90%    |
| Percent of Priority IV Cases within Access Target for Knee Replacement Surgery (182 days)                                                                                              | 90%    |
| Percent of Priority IV Cases within Access Target for Diagnostic MRI Scan (28 days)                                                                                                    | 50%    |
| Percent of Priority IV Cases within Access Target for Diagnostic CT Scan (28 days)                                                                                                     | 90%    |
| Percentage of Alternate Level of Care Days - by LHIN of Institution                                                                                                                    | 12.80% |
| 90 <sup>th</sup> Percentile Emergency Room Length of Stay for Admitted Patients                                                                                                        | 30.00  |
| 90 <sup>th</sup> Percentile ER Length of Stay for Non-Admitted Complex Patients                                                                                                        | 6.45   |
| 90 <sup>th</sup> Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated Patients                                                                                            | 4.00   |
| Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions                                                                                                        | 17.00% |
| Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions                                                                                                      | 22.50% |
| 90 <sup>th</sup> Percentile Wait Time for Community Care Access Centres (CCAC) In-Home Services - Application from Community Setting to first CCAC Service (excluding case management) | 29     |
| Readmission within 30 Days for Selected Case Mixed Groups                                                                                                                              | 14.80% |

## Resources

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

- Current health service provider funding as specified in the 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, including Community Sector funding increases

## Community Engagement

Details on specific community engagement activities to support the initiatives contained in this 2014/2015 Annual Business Plan are outlined within the *Integrated Communications Strategy* (see page 116) and *Community Engagement* (see page 121).

## 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 practices 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 Accountability Agreement, the Memorandum of Understanding with MOHLTC and all government directives applicable to the LHINs. The process involves the completion of a comprehensive checklist which demonstrates compliance to the policies, agreements and legislation in all LHIN activities.

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

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 five per cent constraint to their administrative expense allocation beginning 2012-13.

The 5 % constraint on administrative expenses was captured in the Central East LHIN operations budget as identified on the *Operations Spending Plan* (see page 114) starting fiscal year 2012-13 and continues to be reported in the actuals for fiscal year 2013/14. The LHIN was expected to find efficiencies within the operations plan in order to meet this target while maintaining current service levels.

## Overview of Current and Forthcoming Programs and Services

In addition to providing continuous oversight on the performance and integration of the local health system, 2014-15 will be a year in which the Central East LHIN will continue mature strategic initiatives, programs and services. Of particular importance are:

- *Health Links* – Health Links is a new model of coordinated care for highly complex patients that relies on participation from patients, providers and organizations across multiple sectors. Central East LHIN Board has approved the creation of seven Health Links covering the entire Central

East. By April 2015, it is expected that two Health Links will be approved – Peterborough and Durham North East - and five others will have submitted Readiness Assessments – Durham West, Northumberland, and Haliburton-Kawartha Lakes, Scarborough North, Scarborough South – and possibly be approved.

- *Community Health Services Integration and Small Rural Hospital Transformation Fund* – The Community Health Services Integration Strategy was developed 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. Integration planning and implementation initiatives are currently underway in the Durham Cluster, Haliburton County/Kawartha Lakes, Northumberland, Scarborough, and Peterborough.
- *Geriatric Assessment and Intervention Network (GAIN) Community Teams* – GAIN clinics, located in the four largest community hospitals in the Central East LHIN, offer comprehensive geriatric assessment and treatment. In FY 2014-15 GAIN clinics will be supporting the evolution of the GAIN community stream. GAIN Clinics are expanding from a primarily “treatment, assessment (and follow-up)” model to also include a comprehensive managed care model or philosophy for the most complex patients supporting Primary Care within a Health Link.
- *Health System Funding Reform (HSFR)* – The Central East LHIN Local Partnership was developed in 2013 to manage change in the HSFR environment and inform planning as funding models continue to evolve. Some areas of focus for FY 2014-15 include orthopaedics, stroke, CHF, COPD, and vision strategy.
- *Mental Health and Addictions Strategy* – The Mental Health and Addictions Strategy includes the implementation of a Physician Lead for mental health and addictions and the identification of projects that will be led by health service providers in partnership with their peers. These projects will be targeted to the achievement of the MLPA Targets and the Strategic Aims. The implementation of this strategy will be completed in early FY 2014-15.
- *Diabetes and Vascular Health Improvement Strategies* - A Vascular Health Strategy has been developed with four overarching areas; enhancing patient/family supports & empowerments, strengthening the design of vascular health and service delivery models, enhancing community and primary care based services and supports, and developing supportive vascular health policies. The LHIN is also an early adopter of Vascular Collaborative – an collaborative strategy led by the Ontario Stroke Network, Cardiac Care Network, and the Ontario Renal Network.

## Assessment of Issues Facing the Central East Local Health Integration Network

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

### Demographic Changes

According to the 2011 Census, 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: 2013/2014                  |                            |
|---------------------------------------------------------------|----------------------------|
|                                                               | Per Central East LHIN (\$) |
| Operation of Hospitals                                        | 1,245,127,094              |
| Grants – Municipal Taxation – Public Hospitals                | 279,675                    |
| Grants – Municipal Taxation – Specialty Psychiatric Hospitals | 25,425                     |
| Long-Term Care Homes                                          | 430,004,801                |
| Community Care Access Centre                                  | 259,364,231                |
| Community Support Services                                    | 36,946,902                 |
| Acquired Brain Injury                                         | 1,510,060                  |
| Assisted Living Services in Supportive Housing                | 13,880,255                 |
| Community Health Centres                                      | 28,518,714                 |
| Community Mental Health                                       | 49,425,551                 |
| Addictions Programs                                           | 12,484,729                 |
| Specialty Psychiatric Hospital                                | 116,355,537                |
| Community Investments unallocated                             | 827,063                    |
| <b>TOTAL HSPs</b>                                             | <b>2,194,750,037</b>       |
| LHIN Operations                                               | 4,534,130                  |
| E-Health                                                      | 0                          |
| LHIN Initiatives                                              | 1,322,301                  |
| <b>TOTAL Central East LHIN Allocations</b>                    | <b>2,200,606,468</b>       |

## Health Human Resources

- *Succession Planning, Recruitment and Training* - With a growing number of physicians approaching the age of retirement, having an effective succession planning strategy in place is more important than ever. 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. Health Force Ontario 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, FHTs, 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.

### **Community Health Centres (CHC) Physician Recruitment and Retention Challenge**

In the past year the CHCs within the LHIN – have been successful in recruiting for vacancies. Both Brock CHC, TAIBU and the City of Kawartha Lakes successfully recruited. The developing Pickering Youth – Satellite site (2.2) still maintains a vacancy however, the CHC is presently in integration discussions with the Oshawa CHC and it is anticipated that this vacancy will be deployed in the coming year. Pressures to access primary care remain at two CHCs (Port Hope and Oshawa). These CHCs are requesting additional physician full time equivalent (FTE) allocation. The Port Hope CHC is maintaining a waiting list of close to 1000 patients.

Actions in 2014/2015 will include:

- The 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 2014.

### **Culture and Change Management**

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 information 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.

## Core Content

Key initiatives and action plans supporting each aim and enabler of the 2013-2016 IHSP are detailed in the core content component of the 2014/2015 Annual Business Plan.

### 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 report developed by Dr. Samir Sinha, 'Living Longer, Living Well' (2012). 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, typically requiring high resource utilization. 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                |            |                |        |                |        |                |        |                |        |            |        |              |                |
| <p>The Central East LHIN is committed to building a network of services to meet the needs of its rapidly growing and aging population of seniors. The Central East LHIN has the largest number of seniors (65+) in the province and the population continues to increase. Over 14% of Central East LHN's population are seniors aged 65+. Since 2006, this population has increased by 12.5%. It is projected that by 2016, seniors will account for 16% of Central East LHIN's population; by 2021 they will account for 18%. The population distributions 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.</p> <table><tr><th>Age Group</th><th>Population</th></tr><tr><td>65 to 69 years</td><td>71,313</td></tr><tr><td>70 to 74 years</td><td>53,803</td></tr><tr><td>75 to 79 years</td><td>44,447</td></tr><tr><td>80 to 84 years</td><td>34,652</td></tr><tr><td>85 years +</td><td>30,881</td></tr><tr><td><b>Total</b></td><td><b>235,096</b></td></tr></table> <p>Source: Intellihealth, 2011 Census</p> | 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 | <b>Total</b> | <b>235,096</b> |
| 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         |            |                |        |                |        |                |        |                |        |            |        |              |                |
| <b>Total</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>235,096</b> |            |                |        |                |        |                |        |                |        |            |        |              |                |

Information contained in the IHSP Environmental Scan demonstrates the high health care needs of some seniors in Central East:

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

A small percentage of seniors use a disproportionate share of health care resources. 177 persons per 1000 seniors 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). Compared to 8.4 persons per 1000 people 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. The total number of ALC days in the Central East LHIN decreased from 13,965 days in November 2012 to 13,374 days in November 2013. Alternate Level of Care days occur 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.

- Since the adoption of Home First approaches, the LHIN saw marked improvements in ALC rates. Presently, the ALC rate for persons requiring supports in their own home is less than 1%.
- Performance has remained stable between 2012-13 and 2013-14. However, the face of the ALC problem has become increasingly complex.
- For post-acute care, the Central East LHIN (23%) had the third highest % of beds being occupied.
- The Central East LHIN had the highest % of CCC beds occupied by ALC patients (55%).
- In the Central East LHIN hospitals ALC patients represent 14% of mental health beds and 6% of rehab beds.

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
- Excellent Care for All Act
- Improving access to care at the right time and right place
- Enabling people to stay at home, in their community
- Enhancing coordination and transitions in care

- Assess and Restore Policy (DRAFT)
- 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 Integrations. 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;
- Assess and Restore;
- Behavioural Supports Ontario;
- Identify and implement strategies to promote access for Francophone and Aboriginal seniors to culturally and linguistically appropriate services; and
- Geriatric Assessment and Intervention Network (GAIN).

## **System Design**

### **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. The final comprehensive report entitled "Living Longer, Living Well", was made public in March 2013 and includes recommendations intended to support seniors staying healthy and independent for as long as possible. 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; and
- Supporting senior friendly communities (including hospitals and LTC Homes).

### **Central East Regional Specialized Geriatric Services Entity (RSGS)**

With the looming demographic reality of an increasingly aging population 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 Regional Specialized Geriatric Services (RSGS) entity. This is providing a platform and structure to facilitate clinical and service delivery integration activity and build better health outcomes for frail seniors across the Central East LHIN. There are many developed and evolving specialized geriatric programs in the Central East LHIN, such as the expansion of the Geriatric Assessment and Intervention Network, Rapid Response Nursing and Behavioral Supports Ontario (BSO). The Regional Specialized Geriatric Services entity is positioned to improve the planning and coordination of these programs.

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. The number of seniors in the Central East LHIN is projected to double over the next 20 years and existing services needs to be increased proportionally to the senior population growth. Since almost 90% of Central East LHIN's seniors live in the community, focusing mainly on institution based services would under serve the population. There is potential for Specialized Geriatric Services (SGS) resources to expand in many settings outside long term care homes and hospitals, including seniors' own homes, retirement homes or Assisted Living in Supportive Housing. Early access to these interventions in the community is critical for delaying or avoiding frail seniors' need for institutional care.

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.

In 2014 RSGS will focus on leading and overseeing the Senior Friendly Hospital Strategy, the redesign of the GAIN clinics and the design and implementation of the GAIN Community Outreach Teams.

### **Physiotherapy Reform**

A major change has occurred in Ontario related to how physiotherapy services, previously funded under the Ontario Health Insurance Plan (OHIP) budget, are now being funded by the MOHLTC. The intent is to improve the availability of these services across the province and significantly boost access for seniors and others in need.

Previously, a small number of for-profit companies have had almost exclusive control over the delivery of publically funded physiotherapy. Starting August 1, 2013, there was a shift of funding for community-based physiotherapy from the OHIP budget to direct funding through the LHINs.

There are five streams of activity:

#### ***1. Exercise and Falls Prevention Classes***

The Central East LHIN has been working closely with the eight Community Support Service (CSS) Lead Agencies to ensure replacement of exercise and falls prevention classes that were previously funded through OHIP. To improve access to these services for more seniors in more communities across the Central East LHIN, extensive activity has been undertaken to identify locations for new and/or expansion sites for classes. These additional classes are expected to be operationalized over the last quarter of the fiscal year.

#### ***2. Physiotherapy and Exercise in Long-Term Care (LTC) Homes***

Providers previously billed OHIP for resident physiotherapy in LTC homes. With the new changes, homes receive direct funding through LHINs to provide physiotherapy. Residents who have an assessed need for physiotherapy in their plan of care will receive one-on-one, episodic physiotherapy in their LTC home to help them restore their mobility and function. All Long-Term Care Homes in the Central East LHIN have either hired physiotherapy staff directly or subcontracted for the service.

### **3. *In-Home Physiotherapy (CCAC)***

In addition to in home services provided by the CCACs including physiotherapy, OHIP previously funded physiotherapy services on a fee for service basis for anyone requiring physiotherapy in their home because of their condition or illness with a physician referral. CCACs are now the single point of access for in-home physiotherapy services. All clients receiving in-home CCAC physiotherapy will access service and be assessed for physiotherapy services in the same manner. The Central East CCAC is continuing its work with the Retirement Home sector and other congregate living sites to facilitate access to one-on-one physiotherapy.

### **4. *Physiotherapy Clinics in the Community***

The Ministry of Health and Long -Term Care released a Call for Applications for additional volumes of service in a clinic setting. The new funding model is \$312/episode of care (EOC). An episode of care relates to the assessment, diagnosis, treatment and then discharge/transition for a specific issue. The Ministry of Health and Long -Term Care requested the LHINs submit their recommendations on where additional volumes might best be placed within their geographies. This information, along with the 79 applications received, have been considered in the decision making process in which the LHINs were invited to participate in November. The Ministry of Health and Long- Term Care is proceeding through a process of due diligence to arrive at the final recommendations.

### **5. *Physiotherapy in Primary Care Settings (e.g. FHTs, CHCs and Nurse Practitioner Led Clinics)***

The intent of this stream is to enhance the quality and effectiveness of interdisciplinary primary health care programs through the integration of physiotherapists into primary health care settings. A Call for Applications process occurred in the spring for Community Health Centres (CHCs), Family Health Teams (FHTs), Nurse Practitioner Led Clinics (NPLCs) and Aboriginal Health Access Centres (AHACs) for approval of new physiotherapy positions and to fill existing vacancies. Proposals were evaluated based on ability to integrate physiotherapists into existing interdisciplinary primary health care programs, demonstrated need in community/patient population, address service gaps and avoid duplication of services being introduced through other reforms. The Central East LHIN has scored the nine proposals received for this stream and submitted this information to the Ministry of Health Long- Term Care.

## **Community Health Services Integration**

Please see page 66 of this document.

## **Access**

### **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, 2014/2015 will see further progress into other patient pathways through the Resource Matching and Referral project, and the expansion of Assisted Living Services for High Risk Seniors. Currently in the Central East LHIN the expanded role of the CCAC is being implemented for the following programs/projects:

- Assisted Living for High Risk Seniors; and
- Rehabilitation and Complex Continuing care in relation to the Resource Matching and Referral project.

## **Transitions in Care**

### **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 a risk of delayed discharge is 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.

Sustaining the Home First approach will continue to be an on-going focus of the Central East LHIN, the CCAC, hospitals and community support service agencies for 2014/2015.

### **Restorative Care**

In Ontario, there are 1.9M seniors who account for 14% of the population but utilize 45-50% of health care resources. Even when preventative programs are in place (e.g. community exercise and falls prevention classes, Senior Friendly Hospitals initiatives), frail seniors are vulnerable to stressors that can lead to hospitalization and rapid functional decline. Unaddressed, this functional decline can lead to permanent loss of self-care abilities in Activities of Daily Living (ADLs) (especially toileting, bathing, and ambulation) and this can result in the need for Long-Term Care Home (LTCH) placement.

The Central East LHIN is implementing an Assess & Restore (A&R) approach to care which:

- Complements other initiatives (e.g. Senior Friendly Hospitals, Rapid Response Nursing Programs, Nurse-Led Outreach Teams, Home First, Health Links) that are also focused on preserving the ability of seniors to live independently in their community;
- Targets community-dwelling, high-risk frail seniors with restorative potential who have experienced reversible functional loss and for whom home- and/or ambulatory-based rehabilitative care alone is not a safe and effective option; and
- Involves the use of standardized processes for assessment and system navigation for frail seniors to 'sub-acute' beds in hospitals and LTCHs to restore their strength and mobility and enable them to return home.

The Central East LHIN has recently made investments in eleven hospital based Assess and Restore projects for FY 2013-14. Eight projects representing an expenditure of \$377,940 are focused on expanding capacity in seven Central East LHIN hospitals. Three additional projects amounting to \$569,160 are focused on increasing access in two Central East LHIN hospitals. A written report on results will be submitted to the MOHLTC in June 2014.

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.

### **Rapid Response Nursing (RRN) Program**

The Rapid Response Nursing Program (RRN) is part of the Ontario Government's 9000 Nurses commitment, a key component of Ontario's Health Human Resources Strategy. The 14 CCAC's across Ontario are being funded to support a total of 126 Registered Nurses across the province.

The Central East RRN Program is a dedicated team of 10 full-time and 2 part-time Registered Nurses providing a variety of intensive in-home services to patients and their families. Patients with complex care needs and their families are professionally assisted to support smooth and safe transitions from hospital to home within 24 hours post-acute discharge.

The target population of the RRN Program is medically complex seniors and adults who are at risk for hospital readmission and ED visits. Initially, the focus of the program was on patients with a primary diagnosis of Chronic Obstructive Pulmonary Disease (COPD) or Congestive Heart Failure (CHF). The program now serves any patient who lives at home or in a retirement residence, who has multiple complex medical issues, has multiple medications or a change in medication routine post-discharge, and/or is having difficulty with disease management.

The RRN is responsible for: confirming the patient's hospital discharge care plan including follow-up appointments; initiating communication with the patient's primary care provider, ensuring everyone has the necessary information for follow-up and continuing care; reviewing the patient's medications and helping them to understand how to take their prescribed medications; helping the patient and their caregiver(s) to understand the care plan, treatments, how to manage symptoms and when/who to ask for help; and identifying individuals requiring accelerated assessment by the CECCAC Care Coordinator. These activities, combined, set the foundation for ongoing integrated home care provided through the CECCAC and service providers.

As of January, 2014, The CECCAC RRN Program will be live in all Central East hospital sites, with an increase in the number of referrals from each of the hospital sites since its launch in January, 2013. Extensive collaborative work has been undertaken to successfully develop standardized policies and procedures, business processes, clinical tools, and documentation tools across the 14 CCAC's, which were then customized to ensure that they fit with CECCAC business processes. Other key activities included capacity building for the RRN's, and the development of the necessary relationships and tool kits to support the RRN's to fulfill their role in the community.

In 2014, a focus will remain on increasing the number of referrals to the program, and on the refinement of the processes that support the program. A new focus will be on implementation of the program component for complex pediatric patients.

### **Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)**

Nurse Practitioners Supporting Teams Averting Transfer (NPSTAT) is a Central East LHIN-wide initiative that consists of Nurse Practitioners, working in teams, supporting LTC Home staff to better serve the residents in over 60 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. In 2014/15, NPSTAT will continue to advance their participation and leadership in LHIN-funded initiatives including Behavioural Supports Ontario (BSO) where NPs serve as critical members of the BSO Integrated Care Teams in LTCHs and participate in cluster-based BSO Implementation Teams and the LHIN-wide BSO Design Team. With the assistance of the Ministry of Health and Long-Term Care, 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

### Geriatric Assessment and Intervention Network (GAIN)

Aligned with Dr. Sinha's recommendations, an important component of the GAIN model (previously noted and described in more detail here) is the linkage to and communication with primary care. The inter-professional 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 GAIN clinics, enabling smooth transitions and connections to community services.

In 2011, the Central East LHIN established four Comprehensive Geriatric Assessment and Treatment Clinics located within the four largest community hospitals in the Central East LHIN (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 comprised of a specialized inter-professional geriatric team specially trained for assessing, diagnosing and treating the frail elderly to enable, wherever possible, their continued ability to remain independent in the community or in retirement residences. GAIN patients may be referred by their primary care provider, other community health professionals, emergency departments (ED) or inpatient units prior to discharge. This improves flow within the ED, reducing time spent in the ED as well as reducing ED demand by having direct community access.

In 2012/13, GAIN clinics received a total of 5434 referrals, an increase of 47% over the previous year. The community continues to represent the largest source of referrals (40%), although ED and inpatient unit referrals have steadily increased. Inpatient referrals (12%) present the opportunity to support frail seniors leaving hospital.

Guided by the Central East LHIN Integrated Health Service Plan (IHSP) and the *Community First* theme, the Central East LHIN continues to work towards improving quality of life, promoting health, independence and safety in order to help seniors and others with high or complex needs to remain in their own home surroundings as comfortably and as long as possible. Further, primary care is recognized by the Central East LHIN as a cornerstone and point of entry to the healthcare system and the place where the majority of health services are initiated and coordinated. Primary care encompasses services related to health promotion, illness and injury prevention, as well as the diagnosis, assessment, treatment and management of chronic conditions. Accordingly, the Central East LHIN is developing inter-professional team-based models to provide clinical outreach/community-based care to seniors and others with high or complex needs. This initiative will improve access to inter-professional team-based care in community and/or home settings within the Central East LHIN.

Going forward in FY 2014-15 GAIN clinics will be supporting the evolution of the GAIN community stream, as well as undergoing some change itself. GAIN Clinics are expanding from a primarily "treatment, assessment (and follow-up)" model to also include a comprehensive managed care model or philosophy for the most complex patients supporting Primary Care within a Health Link. The creation of GAIN Community Teams will support patients' at-home and in the community.

The following principles were identified by the Central East LHIN and adopted by the RSGS and are consistent with international evidence:

- Enrollment for high risk seniors within a defined population. Inter-professional clinical care model supported by gerontological best practices, standardized assessment and protocols;
- Patient Integrated Care Plans supported by enhanced system navigator role;
- 24 hour support availability and Rapid Team mobilization;

- Enrolled patients “tethered” to community health services, namely Adult Day Programs, Assisted Living, transportation, and home care supports;
- Patients remain with their primary care provider; and
- Mutual support/shared care between primary care and inter-professional GAIN teams including behavioural support providers.

Further efforts are expected in 2014 to better integrate specialized geriatric services across the Central East LHIN as follows:

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

### **Health Links**

Please see page 65 of this document.

## **Capacity and Funding**

### **Investing in the Community Sector**

The Central East LHIN is continuously working with the community sector to strengthen our ability to meet the needs of a rapidly growing and aging population.

Positive health impacts on patients and communities is made possible when health care organizations have effective and sustainable systems in place to deliver the right care at the right time, and at the right place. With an overarching aim of *Community First* – to enable Central East LHIN residents to spend more time in their homes and their communities – the Central East LHIN is making new investments in the following high-impact community programs:

- Assisted Living Services for High Risk Seniors (ALS-HRS);
- Adult Day Programming (ADP); and
- GAIN Community Teams to Support Seniors and Others with Complex Health Needs.

The intended target populations are clients with complex and long-term medical, physical, social and/or cognitive conditions that place the client at risk of avoidable hospital admission or readmission, premature institutionalization in Long-Term Care, or other health decline.

These investments will be in addition to enhanced funding directed to the Central East Community Care Access Centre (CCAC) in order to reduce wait times to personal support for patients in their home.

## **Quality and Safety**

### **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 [i.e. Psychogeriatric Resource Consultant (PRC), Nurse Practitioners Support Teams Avoiding Transfer (NPSTAT), Geriatric Mental Health Outreach Team (GMHOT); 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; fully integrated into the CE LHIN GAIN (Geriatric Assessment & Intervention Network) Strategy.
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                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1. LTCH: Part 1</b><br><br>Action: Continue spread and sustainability throughout all 69 LTCHs                               | <ul style="list-style-type: none"> <li>Improved quality of life and safety in LTCHs</li> <li>Reductions in senior hospitalizations and ALC days</li> <li>Sustainability Plan – in place to continue spread and hold senior care gains</li> </ul>                                                                                                                                                                                    |
| <b>2. LTCH: Part 2</b><br><br>Action: Continue spread and sustainability throughout all 69 LTCHs                               | <ul style="list-style-type: none"> <li>Achieve full standardization of Geriatric Mental Health Outreach Teams/hospital transfer tools and processes across the LHIN</li> <li>Engagement of Integrated Care Team to reduce ED transfers and increase the number of days clients spend at home</li> </ul>                                                                                                                             |
| <b>3. Community</b><br><br>Action: Complete BSO staffing in GAIN Clinics and GAIN Community Teams                              | <ul style="list-style-type: none"> <li>Reduce the demand for LTC by having seniors spend more days at home in their communities</li> <li>Standardized tools, processes, and response times to help keep seniors in home (in development)</li> <li>Achieve full standardization of transfer tools and processes across the LHIN</li> <li>Achieve service integration along a seamless continuum of care for frail seniors</li> </ul> |
| <b>4. Hospital and Tertiary Care</b><br><br>Action: Complete value stream map and initiate implementation throughout community | <ul style="list-style-type: none"> <li>Enhance quality of care for seniors by standardizing care plans and pathways and support return to LTC or community with appropriate supports – increasing number of days clients spend at home</li> </ul>                                                                                                                                                                                   |

## Senior Friendly Hospitals

The LHINs across Ontario identified the Senior Friendly Hospital (SFH) Strategy as a priority for implementation in 2010/2011. The provincial SFH Indicator Working Group recently completed its work on indicator identification and has suggested a process and outcome indicator for both functional decline and delirium at an organizational level. Involvement in the Delirium and Functional Decline Indicators Provincial Pilot Initiative has largely been a function of the decision of each hospital independently. Seven hospitals in the CE LHIN are currently participating in this pilot initiative: 3 in delirium and functional decline, 2 in delirium only and 2 in functional decline only.

In 2013/2014, the Regional Specialized Geriatric Services (RSGS) assumed a leadership role in promoting and coordinating SFH care within the Central East LHIN. The *Central East RSGS Senior Friendly Hospital Care in the Region of the Central East Local Health Integration Network*, July 2013 report included the following recommendations: 1) establish a Senior Friendly Working Group with representation from the nine Central East LHIN hospitals initially and then expand to include representation from other health care providers, and 2) RSGS to participate in the SFH Provincial LHIN Leads forum. Both of these recommendations have been implemented. The inaugural meeting of the RSGS Senior Friendly Hospital Working Group was held on October 2, 2013 with a subsequent meeting held on December 4, 2013. The group will continue to meet on a monthly basis. To date the working group has approved the terms of reference and is in the process of developing an At-A-Glance Catalogue of SFH initiatives throughout the Central East LHIN as well as a work plan for the upcoming year. It is anticipated that the work plan will establish the details of how to further embed SFH care across CE LHIN hospitals over the next three years.

| Action Plans                                                       |                                                 |    |                                                 |    |                                                 |    |
|--------------------------------------------------------------------|-------------------------------------------------|----|-------------------------------------------------|----|-------------------------------------------------|----|
|                                                                    | 2014/15                                         |    | 2015/16                                         |    | 2016/17                                         |    |
| SYSTEM DESIGN                                                      | Status                                          | %  | Status                                          | %  | Status                                          | %  |
| Provincial Senior's Strategy                                       | In progress                                     | 50 | Continue                                        | 25 | Continue                                        | 25 |
| Central East Regional Specialized Geriatric Services Entity (RSGS) | Complete implementation                         | 30 | Maintain                                        | -  | Maintain                                        | -  |
| <b>ACCESS</b>                                                      |                                                 |    |                                                 |    |                                                 |    |
|                                                                    |                                                 |    |                                                 |    |                                                 |    |
| Expanded Role of CCAC                                              | Complete                                        | 50 | Maintain                                        | -  | Sustain                                         | -  |
| <b>TRANSITIONS IN CARE</b>                                         |                                                 |    |                                                 |    |                                                 |    |
| Home First approaches and Transitions in Care                      | 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                                     | 90 | Sustain gains                                   | 10 | Sustain gains                                   | -  |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   |    |                                                                |    |                                                                |    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|----|----------------------------------------------------------------|----|----------------------------------------------------------------|----|
| Nurse Practitioners Supporting Teams Averting Transfers NPSTAT – expansion to all LTCHs                                                                                                                                                                                                                                                                                                                                                               | In progress                                                                                       | 90 | Continue pending available resources and sustain gains         | 10 | Sustain gains                                                  |    |
| <b>PRIMARY CARE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   |    |                                                                |    |                                                                |    |
| Geriatric Assessment and Intervention Network (GAIN)                                                                                                                                                                                                                                                                                                                                                                                                  | In progress                                                                                       | 80 | Continue                                                       | 20 | Continue                                                       | -  |
| <b>CAPACITY AND FUNDING</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                   |    |                                                                |    |                                                                |    |
| Investing in the Community                                                                                                                                                                                                                                                                                                                                                                                                                            | Target community investments, as available. Monitor Investments                                   | -  | Target community investments as available. Monitor Investments | -  | Target community investments as available. Monitor Investments | -  |
| <b>QUALITY AND SAFETY</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                   |    |                                                                |    |                                                                |    |
| Behavioral Supports Ontario (BSO)                                                                                                                                                                                                                                                                                                                                                                                                                     | Complete spread in LTC, move into community through GAIN Outreach and introduce hospital sector   | 60 | Continue BSO spread in community and hospital sector           | 30 | Complete hospital sector and sustain gains                     | 10 |
| Falls Prevention                                                                                                                                                                                                                                                                                                                                                                                                                                      | Continue implementation and spread of Integrated Provincial Falls Prevention Framework activities | 25 | Continue                                                       | 50 | Continue                                                       | 25 |
| Senior Friendly Hospitals                                                                                                                                                                                                                                                                                                                                                                                                                             | Test and spread SFH indicators                                                                    | 50 | Continue to embed practices and approaches                     | 25 | Continue to embed practices and approaches                     | 25 |
| <b>How will we measure success?</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   |    |                                                                |    |                                                                |    |
| <ul style="list-style-type: none"> <li>Quantifiable enhancements in community services to enable seniors to remain at home, in their communities</li> <li>Wait time from hospital discharge to service initiation (hospital clients)</li> <li>Wait time for home care services – application to first service (community setting)</li> <li>Clients with high and very high MAPLe (Method for Assigning Priority Levels) scores, indicating</li> </ul> |                                                                                                   |    |                                                                |    |                                                                |    |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>impaired functioning, living in community supported by CCAC</p> <ul style="list-style-type: none"> <li>• Clients placed in LTC with high and very high MAPLe scores as a proportion of total clients placed</li> <li>• Incidence of falls; falls related ED visits</li> <li>• ALC days</li> <li>• Median Wait time to Long-Term Placement</li> <li>• Ratio of Seniors 75years + requiring long-term care</li> <li>• Percent of LTCH residents that have been assessed using the Central East LHIN BSO Behavioural Assessment Tool</li> </ul>                                                                                                      |
| <p><b>What are the risks/barriers to successful implementation?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p>Risks/barriers to successful implementation include:</p> <ul style="list-style-type: none"> <li>• Increasing complexity of care, notably behavioural needs and needs having to be met in the community and hospital setting</li> <li>• Adaptation to HSFR</li> <li>• Recruitment/retention of professionals with geriatric expertise</li> </ul>                                                                                                                                                                                                                                                                                                   |
| <p><b>For each risk/barrier, describe the plan to mitigate the risk?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <ul style="list-style-type: none"> <li>• Continued diligence in working with the CCAC and CSS throughout the year to understand and quantify pressures and respond accordingly.</li> <li>• Continued efforts towards seeking and fostering champions of change in the system to align and achieve common goals.</li> <li>• Proceed with Community Health Services Integration Strategy to build community capacity and ready for further system transformation.</li> <li>• Learn from initiatives like Health Links, and the Change Foundation's PATH program currently underway in the Central East LHIN and consider a spread strategy.</li> </ul> |
| <p><b>What are some of the key enablers that would allow us to achieve our goal?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>Key enablers include:</p> <ul style="list-style-type: none"> <li>• Leadership (LHIN and HSPs);</li> <li>• Alignment of goals (provincial, LHIN, HSPs);</li> <li>• Better levers of change in the system e.g. accountability of non-LHIN funded services; and</li> <li>• Recognition of the important role of sustainability to hold the gains made to date.</li> </ul>                                                                                                                                                                                                                                                                            |

## 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| <p>Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.</p> <p><b>Vascular Health Vision:</b> Optimize the vascular health of our communities.</p> <p><b>Vascular Health Strategic Aim Coalition (VHSAC) Mission:</b> To promote the transition to an integrated vascular health care system within the Central East LHIN.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| IHSP Priority Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p>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.</p> <p>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.</p> <p>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. Furthermore, diabetes significantly promotes both the development and adverse impact of vascular diseases and their associated risk factors and due to its prevalence in the Central East LHIN is main parallel focus under this priority.</p> <p>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.</p> <p>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%.</p> <p>This aim was chosen primarily because it requires various stakeholders to work in an integrated way to deliver services and supports to patients and their families; to bring the same stakeholders together; expands or initiate collaborations, partnerships, transfer or mergers of services necessary to achieve the aim.</p> |
| Current Status                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>Four years ago Central East LHIN set a strategic aim to reduce the impact of vascular disease by 10% (10,000 inpatient days). The IHSP for 2010-2013, we saved 37,870 hospital in-patient days. In the Central East LHIN, through vascular health priority projects and investments, we have increased</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

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 complex diabetes care;
- Diabetes Education Programs; and
- Harmonization of practices across primary and specialty care settings for screening and treatment of vascular disease.

**Priority Population:**

- Persons with established vascular disease or diabetes including: cardiovascular and cerebrovascular conditions, vascular dementia and stroke, peripheral vascular disease and atherosclerosis;
- Persons at higher risk of developing vascular disease and diabetes namely: Seniors;
- People with diabetes, reduced kidney function, heart disease, experienced a stroke;
- First Nations, Metis, Aboriginals, and visible minorities; and
- 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, alongside improvements in knowledge translation and self-management of high-risk populations.

**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 (52%) of Central East LHIN residents are overweight or obese;
- The prevalence of physical inactivity (53%) is among the highest across LHINs and significantly higher than the provincial average of 48.2%; and
- Smoking, being overweight/obese and physical inactivity are all risk factors 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 the Central East 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 the Central East LHIN 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 LHIN has one of the highest rates of diabetes in Ontario in 2012 at 10.9%. This was higher than the provincial average of 10.2%.
- Hospitalization rates for most chronic conditions (except diabetes and hypertension) have been decreasing since 2005/06.
- The Central East LHIN has the second highest rates of diabetic-related foot amputations in the province.
- 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<br>rate per 100,000 | Hospital days<br>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: Environmental Scan (IHSP 2013-16)

## Goal(s)

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

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

1. Enhancing patient/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

Since the transfer of Diabetes Education Programs (DEPs) to the Central East LHIN, the Vascular Health Strategic Aim Coalition (VHSAC) realigned the priorities previously identified on which to focus during the IHSP 2013-2016. This Vascular Health Strategy will guide Central East LHIN planning, integration activity and investments.

## **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)
- Implementation of Health System Funding Reform, specifically vascular related (e.g., Stroke, Congestive Heart Failure) Quality Based Procedures
- Reducing 30-day hospital readmissions for selected cardiovascular Case Mix Groups (CMGs) and Diabetes by:
  - 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
- Improve vascular health outcomes with the aboriginal population through engagement, support and service alignment with existing regional, provincial and federal health planning
- 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                        |    |           |     |           |    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----|-----------|-----|-----------|----|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 2014/2015              |    | 2015/2016 |     | 2016/2017 |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Status                 | %  | Status    | %   | Status    | %  |
| <p>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:</p> <ul style="list-style-type: none"> <li>Reducing readmissions to hospital, which could have been avoided if the care in hospital or the care after discharge was optimized;</li> <li>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;</li> <li>Reducing hospital days due to preventable adverse events in hospital.</li> </ul> | In progress            |    | Complete  | 100 |           |    |
| Development of Complex Diabetes Care system including centralized intake for diabetes education & management                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | In Progress            | 90 | Monitor   | 10  |           | -  |
| Diabetes Education Program Quality Improvements and monitoring                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | In Progress            | 40 | Implement | 40  | Monitor   | 20 |
| Self-Management and Self-Management support (enabler)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Ongoing                | -  | Ongoing   | -   |           | -  |
| Finalize Regional Vascular Surgery Service Level Agreement between Central East LHIN hospitals                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Complete / In progress | 50 | Ongoing   | -   | Ongoing   | -  |
| Early Chronic Kidney Disease (CKD) Management through Primary Care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Ongoing                | -  | Ongoing   | -   | Ongoing   | -  |

|                                                                                                                                                                                                        |             |    |             |    |         |    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|----|-------------|----|---------|----|
| Ontario Telemedicine Network utilized for vascular clinical and education opportunities (e.g. diabetes and vascular health physician education “grand rounds”)                                         | Initiate    | 20 | Implement   | 60 | Monitor | 20 |
| Harmonized Stroke System using stroke QBP for Planning and Implementation for Central East LHIN                                                                                                        | Ongoing     | 40 | Implement   | 40 | Monitor | 20 |
| Equitable access to acute rehabilitation and secondary prevention of cardiac services through analysis and improvements (e.g. Cardiac Rehabilitation, and Congestive Heart Failure clinic evaluations) | In Progress | 30 | In Progress | 40 | Ongoing | -  |

### How will we measure success?

The Vascular Health Strategic Aim Coalition has developed a draft scorecard for vascular health priority initiatives. This will continue to be developed and report back mechanisms identified during 2014/2015.

#### Overall Vascular Health Aim:

| Metric                                                                                                                  | Reporting Level |
|-------------------------------------------------------------------------------------------------------------------------|-----------------|
| Number of inpatient days saved                                                                                          | LHIN            |
| 28-Day Readmission After AMI (rate per 100)                                                                             | Hospital        |
| Percentage ALC days (AMI, stroke)                                                                                       | Hospital        |
| Hospital 30-Day Readmission for select CMG (CHF, diabetes)                                                              | Hospital        |
| 28-day Readmission of patients with stroke (rate per 100)                                                               | Hospital        |
| Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation | Hospital        |

For Diabetes Education Programs, we will be monitoring various statistics reported to us quarterly to help us analyze established improvement plans, such as:

| Metric                                       | Analysis                               |
|----------------------------------------------|----------------------------------------|
| Number of clients (carryover, re-admit, new) | Caseload totals for demand of services |
| Patient Profiles                             | Equitable access                       |
| Number of visits to each provider            | Variance in services                   |
| Wait times                                   | Access to services                     |
| Cancellations                                | Access to services                     |
| No Show rates                                | Access to services                     |
| Outreach activities                          | Promotion of services                  |

An interactive dashboard has been developed to increase the data analysis both at a cluster level and compare improvements across the region as we move into year 2 of the IHSP.

Through the Stroke QBP planning and roll-out, we have created a Central East LHIN specific scorecard that covers the 20 indicators as measured provincially by the Ontario Stroke Network, these include:

| Indicator                                                                                                                                                                               | Care Continuum Category                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| Proportion of patients who arrived at ED less than 3.5 hours from stroke symptom onset.                                                                                                 | Public awareness and patient education |
| Annual age- and sex-adjusted inpatient admission rate for stroke/TIA (per 1,000 population).                                                                                            | Prevention of stroke                   |
| Risk-adjusted stroke/TIA mortality rate at 30 days (per 100 patients).                                                                                                                  | Prevention of stroke                   |
| Proportion of ischemic stroke/TIA patients with atrial fibrillation prescribed or recommended anticoagulant therapy on discharge from acute care.                                       | Prevention of stroke                   |
| Proportion of ischemic stroke patients without atrial fibrillation who received carotid imaging prior to hospital discharge.                                                            | Prevention of stroke                   |
| Proportion of suspected stroke/TIA patients who received a brain CT/MRI within 24 hours of arrival at ED.                                                                               | Acute stroke management                |
| Proportion of ischemic stroke patients who arrived at ED less than 3.5 hours from symptom onset and received acute thrombolytic therapy (tPA) (excluding those with contraindications). | Acute stroke management                |
| Proportion of stroke/TIA patients treated on a stroke unit at any time during their inpatient stay.                                                                                     | Acute stroke management                |
| Proportion of stroke (excluding TIA) patients with a documented initial dysphagia screening performed during admission to acute care.                                                   | Acute stroke management                |
| Proportion of ALC days to total length of stay in acute care.                                                                                                                           | Acute stroke management                |
| Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation.                                                                | Acute stroke management                |
| Proportion of stroke (excluding TIA) patients discharged from acute care who received a referral for outpatient rehabilitation.                                                         | Stroke rehabilitation                  |
| Median number of days between stroke (excluding TIA) onset and admission to stroke inpatient rehabilitation (RCG-1 and RCG-2).                                                          | Stroke rehabilitation                  |
| Rehabilitation therapy staff/bed ratio for inpatient stroke rehabilitation.                                                                                                             | Stroke rehabilitation                  |
| Proportion of ALC days to total length of stay in inpatient rehabilitation (Active + ALC) (RCG-1).                                                                                      | Stroke rehabilitation                  |
| Median FIM efficiency for moderate stroke in inpatient rehabilitation (RCG-1).                                                                                                          | Stroke rehabilitation                  |
| Mean number of CCAC visits provided to stroke/TIA patients in 2008/09 and 2009/10.                                                                                                      | Stroke rehabilitation                  |
| Proportion of patients admitted to inpatient rehabilitation with severe strokes (RPG = 1100 or 1110) (RCG-1).                                                                           | Stroke rehabilitation                  |
| Proportion of stroke/TIA patients discharged from acute care to LTC/CCC (excluding patients originating from LTC/CCC).                                                                  | Re-integration                         |
| Age- and sex-adjusted readmission rate at 30 days for patients with stroke/TIA for all diagnoses (per 100 patients).                                                                    | Re-integration                         |

### **What are the risks/barriers to successful implementation?**

- Implementation of Emergency Management Services protocols to support CODE STEMI in North East cluster and stroke Acute care solutions across overlapping Central East Stroke Network boundaries
- Stakeholder resistance to change/confidence
- Variability in physician specialist (cardiology) models
- Resistance to clinical integrations across clusters by physicians, communities
- Leadership and change management support from senior hospital administration
- Provincially equitable access to on-call neurology/physician resources
- Timely implementation of Quality Based Funding procedures for vascular conditions (CKD, Stroke, CHF, Coronary Artery Disease)

### **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), the Ontario Renal Network and the Provincial Vascular Collaborative;
- 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; and
- 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.
- Leadership by the Ontario Stroke Network in partnership with Central East LHIN to redesign stroke system in the Central East LHIN.
- A Central East LHIN Vascular Health Coalition with adequate and appropriate membership of identified champions.
- An established governance structure of cluster-based Diabetes Networks across the Central East LHIN.

- An established alignment of the Vascular Lead and Primary Care Lead work plan with the Strategic Plan of the Central East LHIN.
- Ontario Telemedicine Network (OTN) use for vascular education and clinical opportunities.

### **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; and
- 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. Should persons require Emergency Department or hospital-based services, they will receive coordinated care from hospital and community teams so they can return home safely and security of supporting services

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.

## Current Status:

The Central East 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. It is also imperative that providers are linked to Primary Care resources through Health Links in order to provide services and supports to those with the highest and most complex needs. This population has been an identified cohort in the Peterborough Health Link. The project scorecard provides diagnostic information regarding the mental health or addiction visit, which has been instrumental to continuous quality improvement. Hospital to Home (H2H) has aimed to reduce unscheduled repeat visits by 10%. The complexity of those who require and receive these services has made achieving this aim highly complex. Although this aim has not been achieved, the Central East LHIN is committed to working closely with providers in order to improve this outcome.

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. The following are an example of projects targeted to the achievement of the MLPA targets and Strategic Aims.

- A Central East LHIN Mental Health and Addictions Implementation approach has been developed that will lead to the achievement of the Central East LHIN Strategic Aim and MLPA Targets. This strategy includes the creation of a Physician Lead for Mental Health and Addictions and the identification of high priority projects that will be led by health service providers in partnership with their peers. These projects will be targeted to the achievement of the MLPA Targets and the Strategic Aims.
- Continued development of 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 has undertaken a continuous Quality Improvement approach that will ensure the H2H Teams achieve their targets and reduce the rate of Unscheduled Returns for Mental Health and Addictions issues at the LHIN’s most active sites. An anti-stigma strategy is embedded in this team, as is a specific accessibility strategy directed to Aboriginal Peoples.
- The Durham Mobile Crisis Intervention Team (MCIT), a partnership between Durham Mental Health Services and Durham Regional Police, was reformatted during fiscal year 2013-2014. As a result the MCIT is closely linked with the Lakeridge Health H2H Team. Work is currently underway to develop performance metrics that will ensure that those who receive MCIT supports are linked to the larger system when this is indicated.
- The Central East LHIN and The Scarborough Hospital have been working with the Toronto Central LHIN regarding the development of recommendations for the expansion of MCIT Teams throughout the City of Toronto.
- The Central East LHIN has 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 have been used as strategic enablers to this aim. The installation of three new OTN machines in the North East cluster has made both direct treatment and consultation services more accessible. Canadian Mental Health Association, Haliburton, Kawartha, Pine Ridge (CMHA HKPR) has reported over 1500 OTN sessions during the

first three quarters of the Fiscal Year. This has established a wait list at that facility. In Fiscal Year 2013-2014, the Central East LHIN provided one-time funds to support the reduction of wait times for this important service. OTN has also fostered linkages to the Pinewood Centre at Lakeridge Health. This has provided improved access to specialized Addiction and Concurrent Disorder treatment and consultation services across the Central East LHIN. OTN has been 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 has supported 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) now uses OTN services to build relationships between Peer Support Providers across the LHIN as they develop joint training, consultation and networking initiatives. The Curve Lake, Mississaugas of Scugog and Alderville First Nations have received OTN resources this year. This will permit the provision of Mental Health and Addictions Services on site at these First Nations that were previously unavailable. The OTN Network has continued to expand its services under the leadership of Ontario Shores. In FY 2013-2014 a demonstration project was completed that provided Psychiatric Services to the Oshawa and TAIBU Community Health Centres.

- The Central East LHIN Opiate Strategy was implemented throughout the LHIN and has ensured that Methadone Clinics located in each of the three clusters are linked to both primary care and mental health and addiction service providers. The Central East LHIN Opiate Strategy has targeted the two key areas in the Central East LHIN where the population of Methadone registrants is highest. Methadone Case Management has been expanded in the Durham Cluster and established in the Northeast Cluster. Opiate related Pre and Perinatal services have been expanded throughout the Central East LHIN. The Opiate Strategy will continue to 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 Central East LHIN via a specific Aboriginal Concurrent Disorder Capacity Building Project. This project has further developed and solidified relationships between aboriginal service providers and local health service providers. This has resulted in a level of cultural competency that has not been present in the addictions system prior to the implementation of this project. The Opiate Strategy has provided specific training to the Health Units located in the Central East LHIN who are now able to provide opiate reversal kits. This training is provided by the Toronto Public Health Unit.
- Continued support of the Mental Health “Nurses in the Schools” program led by the CECCAC, has focused on children who require hospitalization for a Mental Health and/or Addiction issue to return to school.
- The Central East LHIN has continued 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 Francophone and Aboriginal Communities.
- The Central East LHIN has continued to find ways to work collaboratively across sectors to determine a system of support for people with complex dual diagnoses. The Central East LHIN will continue to support the inter-regional initiatives that promote optimal use of resources allocated to the Francophone school boards through the program of specialist nurses with mental health and addiction expertise. The Central East LHIN will continue to ensure that Mental Health and Addiction Services are available to Francophone residents residing in the LHIN within their preferred linguistic and cultural context.
- The Central East LHIN will continue to facilitate the 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. Access to Mental Health and Addictions resources has been identified as a priority by the Central East LHIN Aboriginal Health Advisory Circles. A meeting was held on December 6, 2013 with the members of the Central East LHIN Aboriginal Health Advisory Circles and all of the Mental Health and Addictions Health Service

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| <p>Providers throughout the LHIN at the Hiawatha First Nation. A follow up meeting is scheduled for April of 2014.</p> <ul style="list-style-type: none"> <li>• The Central East LHIN completed 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.</li> <li>• The Central East LHIN completed a Quality Improvement Process for Central East LHIN ACTT Teams. Among these recommendations was a “Step Down” process for those clients assessed as being able to move to a less intensive level of service. The Central East LHIN provided base funding to support this recommendation which will serve to increase the capacity of ACTT, while improving client satisfaction. All of the Quality Improvement recommendations are being implemented over the next two Fiscal Years using a Quality Improvement approach under the oversight of a Steering Committee.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <p><b>Goal(s):</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <ul style="list-style-type: none"> <li>• Reduce unscheduled return visits to Central East LHIN Emergency Departments by 10% by March 31, 2015</li> <li>• Reduce In-Patient Psychiatric Days by 10% by March 31, 2015</li> <li>• Increase the number of days spent at home by those with Mental Health and Addictions issues by 15,000 days by March 31, 2016</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <p><b>Consistency with Government Priorities:</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <p>These goals are in alignment with the Minister’s Ten Year Mental Health and Addictions Strategy, Ministry/LHIN MLPA Targets as well as with the Opiate Strategy Framework.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <p><b>Action Plans/Interventions:</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"> <li>• Implementation of the Central East LHIN Mental Health and Addictions Implementation Strategy</li> <li>• A comprehensive planning process with both service providers and users has resulted in a ranking of Mental Health and Addictions System Priorities in the Central East LHIN. A review of the Community Crisis System emerged from this process as the most pressing priority. Therefore the Central East LHIN will embark on a Quality Improvement based process to scope and assess the current Community Crisis System in the LHIN. This review will include the MCIT, (Mobile Community Intervention Teams) and will result in a series of recommendations for improvement</li> <li>• Hospital to Home Teams in the Durham and North East cluster</li> <li>• Continued support of the Community Crisis System and clear links to the Durham MCIT Team.</li> <li>• Investigation of housing options with cross-sectoral partners</li> <li>• Increase concurrent disorder capacity in the mental health and addictions system as well as in the primary care system through specific capacity building activities</li> <li>• Implementation and monitoring of the Assertive Community Treatment Team (ACTT) Value Stream Mapping and Performance Improvement recommendations</li> <li>• The development of an implementation plan for the Hospital based Child and Adolescent Psychiatric Services Recommendations Report</li> <li>• Central East LHIN Opiate Strategy will be assessed in order to determine its effectiveness in</li> </ul> |

| <p>meeting the treatment needs of people throughout the Central East LHIN and in supporting the LHIN in meeting its MLPA targets</p> <ul style="list-style-type: none"> <li>Client centred housing models will be developed and implemented in partnership with Mental Health and Addiction Service Providers to meet the articulated needs of people with complex needs who are either homeless or at risk of homelessness. This included a “Wrap Around” housing model intended to support those with very complex needs who have been hospitalized for extended periods of time at Ontario Shores</li> <li>Continued monitoring and potential expansion of Scarborough Integrated Addictions Treatment System</li> <li>Ongoing monitoring of Central East LHIN Common Assessment Tool and Schedule 1 Bed Registry</li> </ul> |             |     |                                                                                       |    |                                                                                       |   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----|---------------------------------------------------------------------------------------|----|---------------------------------------------------------------------------------------|---|
| Action Plans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |             |     |                                                                                       |    |                                                                                       |   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 2014/15     |     | 2015/16                                                                               |    | 2016/17                                                                               |   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Status      | %   | Status                                                                                | %  | Status                                                                                | % |
| Implement Central East LHIN Mental Health and Addictions Strategy throughout the LHIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | In Progress | 100 | Monitor                                                                               | -  | Monitor                                                                               | - |
| Continue Hospital to Home Teams in Durham and North East Cluster. Refine QI measures and continuous improvement mechanisms                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | In Progress | 100 | Monitor and continue to implement improvements based on Quality Improvement measures. | -  | Monitor and continue to implement improvements based on Quality Improvement measures. | - |
| Implement Opioid Strategy in Durham and North East cluster, targeting areas of highest Methadone use.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | In Progress | 70  | In progress                                                                           | 30 | Monitor and continue to implement improvements based on Quality Improvement measures. | - |
| Opioid Strategy includes a strategy for building CD capacity throughout the MH and A, and Primary Care System                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | In Progress | 90  | Completed. Integrate outcomes where appropriate across the LHIN.                      | 10 | Monitor and continue to implement improvements based on Quality Improvement Measures. | - |
| Implement Public Health Opioid Training Project                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Completed   | 100 | Monitor                                                                               | -  | Monitor                                                                               | - |
| Implement Aboriginal capacity building project and determine ongoing Aboriginal Strategy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Completed   | 100 | Monitor                                                                               | -  | Monitor                                                                               | - |

|                                                                                                                                                                                           |             |     |                                                                                       |   |                                                                                       |   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----|---------------------------------------------------------------------------------------|---|---------------------------------------------------------------------------------------|---|
| Establish Integrated Addiction Treatment system in the Scarborough Cluster. Includes CD capacity building strategy                                                                        | In Progress | 100 | Monitor and continue to implement improvements based on Quality Improvement measures. | - | Monitor and continue to implement improvements based on Quality Improvement measures. | - |
| 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 | In Progress | 100 | Monitor                                                                               | - | Monitor                                                                               | - |
| Continuous QI projects, such as the ACTT Value Stream Mapping work and the Schedule 1 Bed Registry                                                                                        | In Progress | 100 | Monitor and continue to implement improvements based on Quality Improvement measures  | - | Monitor and continue to implement improvements based on Quality Improvement measures. | - |

### 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
- Achievement of the MLPA Targets related to Mental Health and Addictions
- Achievement of the Mental Health and Addictions Strategic Aim of the Central East LHIN

### What are the risks/barriers to successful implementation?

- Complexity and interrelationship of the issues. Not all solutions are within the power of the Central East LHIN to enact, i.e.: housing stock, income level.
- Difficulties with the integrity of the Measurement Data related to Unscheduled Revisits. Problems with the subjectivity of the data and measures that artificially inflate the repeat visit rates. Effect of a small number of complex people who refuse connection to the larger system and exhibit a high revisit rate.
- 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?                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Close monitoring by the Central East LHIN and ongoing adjustment as necessary</li> <li>• Quality improvement strategies</li> <li>• Some mitigation strategies are beyond the purview of the Central East LHIN, i.e.: data collected, data issues, available solutions</li> <li>• Monitoring by Aboriginal Advisory Circles</li> </ul> |
| What are some of the key enablers that would allow us to achieve our goal?                                                                                                                                                                                                                                                                                                     |
| <ul style="list-style-type: none"> <li>• Ongoing use of quality improvement principles and development of achievable indicators</li> <li>• Strong relationships with providers</li> <li>• Systemic measures of concurrent disorders and secondary diagnoses</li> <li>• Continued work with the MOHLTC to resolve data issues</li> </ul>                                        |

## 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

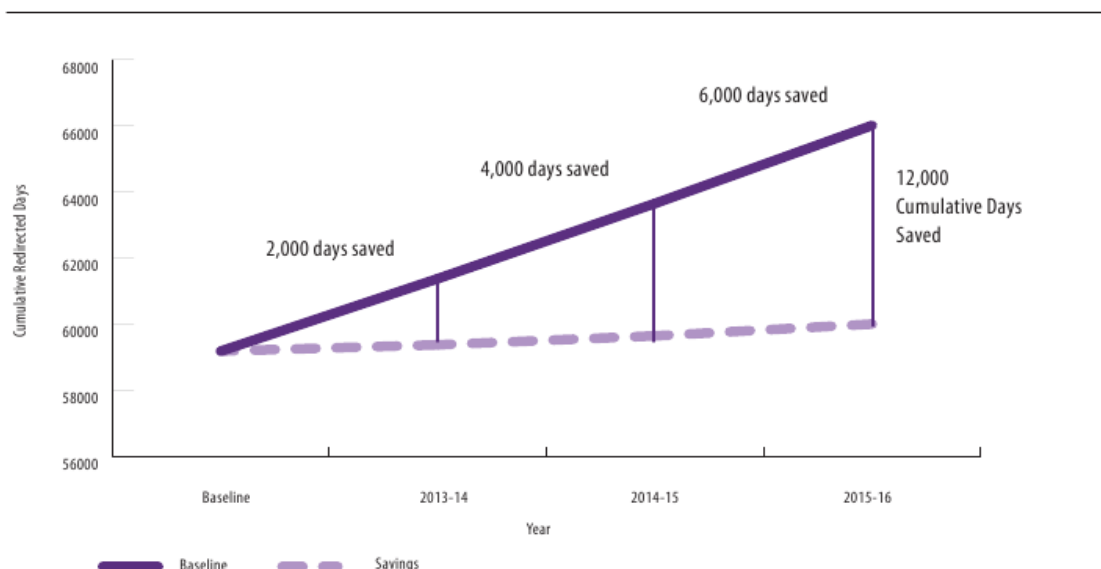
Palliative and end of life care is an approach to caring for people who are living with a life-threatening illness. It focuses on achieving comfort and ensuring respect for the person nearing death and maximizing quality of life for the patient, family and loved ones. Palliative and end of life care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

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 during this time. 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

In an effort to support achievement of the IHSP Palliative Strategic Aim, as well as action items and commitments identified in the Provincial Report, *Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action*, the Central East Hospice Palliative Care Network (CEHPCN) developed a Regional Palliative Care highlighting:

- Current gaps and barriers;
- Current services and capacity;
- Priority recommendations aligned with the provincial strategy; and
- Required resources and governance structures to address priorities recommendations.

The Regional Plan focuses on the following five priority areas:

- Dedicated Interdisciplinary Palliative Community Outreach;
- Enhanced Hospice Palliative Care Education and Training;
- Integrated Hospice Palliative Care Hospital Programs;
- Standardized Hospice Palliative and End of Life Care Programs in Long-Term Care Homes; and
- Development of Local Community Hospices as Central Hubs.

### Key Initiatives & Planning Partners

These initiatives will build upon current hospice, palliative and end of life care services across the region including:

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

The achievement of the Palliative Strategic aim along with implementation of priority areas as outlined in the Regional Palliative Plan require 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;
- Central East LHIN Hospitals;
- Central East LHIN Regional Cancer Program (Cancer Care Ontario);
- Interdisciplinary Care Teams;
- Primary Care;
- Community Palliative Nurse Practitioners; and

- Long-Term Care Homes.

The CEHPN specifically, plays an integral role in the accomplishment of the aim through active engagement with key Central East LHIN stakeholders. Additionally, the Network is helping to 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 (Declaration of Partnerships)*.

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; and
- 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; and
- 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 initiatives and programs that will enhance cultural awareness, expertise and service availability to support patients and families in need of palliative and end of life care including the following initiatives.

- Development of the Network's Central East Regional Palliative Plan and identification of priority recommendations to support achievement of IHSP Palliative Strategic Aim. This plan involves the collaborative efforts of key planning partners from across the Central East LHIN and fulfills Regional Network commitments as outlined in the Declaration of Partnerships and Commitment to Action.
- Enhanced Communication with Cancer Care Ontario's Central East Aboriginal Patient Navigator focusing on improved linkages and partnerships to support the development of improved cultural competencies and awareness regarding First Nations Inuit and Métis communities.
- The Provincial Hospice Palliative Care Data and Performance Subcommittee continues to work towards its deliverable of developing and implementing a data and performance measurement strategy for the delivery of palliative care in the province of Ontario. Through Central East LHIN leadership and continued Co-Chair support, the work of this Subcommittee will help to advance the commitments outlined in the *Declaration of Partnership* document.
- Continued Data Quality Research and Review through two Central East LHIN Applied Health Research Question Proposal submissions to the MOHLTC have helped to ensure complete and accurate information is reported and continues to support discussions and identified deliverables at

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>both the local and provincial levels.</p> <ul style="list-style-type: none"> <li>• Palliative Pain and Symptom Management Consultation Services expansion, equal distribution and access across Central East LHIN community organizations in the Durham, Scarborough and the Northeast clusters. These 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. Positions offer consultation, education, mentorship and linkages to palliative care resources across the continuum of care.</li> <li>• Community Palliative Nurse Practitioners Program continues to expand across Central East LHIN Clusters including the Scarborough, Durham and the Northeast. 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.</li> <li>• 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.</li> </ul> |
| <p><b>Goal(s)</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <p>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:</p> <ul style="list-style-type: none"> <li>• <b>Increased access and opportunity</b> for patients to receive palliative and end of life care within their homes and communities through enhanced interdisciplinary teams and outreach teams;</li> <li>• <b>Improved support in primary care settings</b> through advanced care planning;</li> <li>• <b>Enhanced system design and integration</b> through involvement with the Community Health Services Integration Strategy;</li> <li>• <b>Increased capacity and value for money</b> by redirecting services from acute care settings and into communities;</li> <li>• <b>Heightened quality and safety</b> through increased education and training opportunities; and</li> <li>• <b>Transitions in care and e-Health opportunities</b> by promoting alternative options and care settings within the community.</li> </ul>                                                                                                                                                                                                                                                                                                                                           |
| <p><b>Consistency with Government Priorities</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p>In addition to the IHSP enablers and activities above, 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 <i>Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action</i>. 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 settings in which the client receives care.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <p><b>Action Plans/Interventions</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p>Ensuring timely access to quality palliative and end of life care is not only an ethical imperative but a vital</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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.

| Action Plans                                                                                                                                                                                                                                       | 2014/15                                                                                                                                                                                 |    | 2015/16     |    | 2016/17     |    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-------------|----|-------------|----|
|                                                                                                                                                                                                                                                    | Status                                                                                                                                                                                  | %  | Status      | %  | Status      | %  |
| Education and leadership opportunities for primary care through enhanced collaboration and partnership with Primary Care (PC) Leads and PC Advisory Group consultation re: promotion/expansion of Advance Care Planning initiatives in PC settings | In Progress                                                                                                                                                                             | 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                                                                                 | Commence                                                                                                                                                                                | 25 | In Progress | 25 | In Progress | 50 |
| Integrate community and hospital services to support a LHIN-wide Palliative Care Program coordinated at the local level                                                                                                                            | In Progress<br><br>Progress has been made at Northeast CHS/Hospital Integration Planning Tables                                                                                         | 25 | In Progress | 50 | In Progress | 25 |
| Pursue opportunities for residential hospice                                                                                                                                                                                                       | In Progress<br><br>Discussions with MOHLTC identified organizations regarding 3 year planning; regular status updates provided. MOHLTC moving forward with RH Provincial Working Group. | 25 | In Progress | 25 | In Progress | 50 |
| Strengthen community hospice through the Community Health Services Integration Strategies                                                                                                                                                          | In Progress<br><br>Progress has been made at CHS/Hospital Integration Planning Tables in the Northeast                                                                                  | 25 | In Progress | 50 | In Progress | 25 |
| Increase the number of community palliative nurse practitioners to support individuals, families and professional caregivers                                                                                                                       | In Progress<br><br>Increased number of NPs supporting palliative care in the community                                                                                                  | 25 | In Progress | 50 | In Progress | 25 |

|                                                                                                                               |                                                                                                                                                 |    |             |    |             |    |
|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|----|-------------|----|-------------|----|
| Utilize eHealth solutions to improve patient discharge and help clients locate alternatives to care                           | Not Yet Started                                                                                                                                 | 0  | In Progress | 50 | In Progress | 50 |
| 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 | In Progress<br><br>Discussions/partnerships commenced with Champion LTCHs supporting effective and efficient palliative strategy and philosophy | 30 | In Progress | 30 | In Progress | 40 |

### 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.

Finalized palliative and end of life care Ministry LHIN Performance Accountability Agreement indicators include:

- Increase number of patients discharged “Home with Support”;
- Decrease number of patients discharged without “Home Support”;
- Reduced number of Alternate Level of Care days;
- Reduce the number of palliative patients who die in hospital; and
- Total patients died under Community Care Access Centre care.

Progress will also be measured according to a number of health service provider process and output indicators. These measures 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; and
- Number of patients supported by the Palliative Care Nurse Practitioner Program.

### 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 and or 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); and
- Poor working relationships and collaboration between Community Health Centre (CHC) sector and other Primary Health Care providers both on the ground and in communities.

### **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 submissions 1 and 2 to the MOHLTC); and
- Engagement of LHIN level primary health care leadership to champion system changes.

### **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; and
- 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Access:</b> Improving primary care so that it provides the right care, at the right time, by the right provider.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Integrated Health Service Plan Enabler Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"><li>• 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.</li><li>• 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 on building and strengthening our partnership with primary care, and their partnerships with other parts of the health care system.</li><li>• 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. The development of seven Health Links and the establishment of six GAIN community outreach teams are the most significant initiatives in which primary care will be engaged by LHIN.</li></ul> |
| Current Status                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <ul style="list-style-type: none"><li>• 93% of Central East residents report that they have a regular family doctor, while 70.3% of residents are satisfied with the availability of primary care in general. Data collected from public surveys suggests that access to family doctors may still be problematic for some Central East residents.</li><li>• Provincially, the lowest rate of enrollment (56%) in Patient Enrolled Models of primary care is the 90+ age cohort (Walker, 2011).</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

- Primary Care Providers in the Central East LHIN including:
  - 7 Community Health Centres
  - 11 Family Health Teams
  - 3 Nurse Practitioner Led Clinics
  - Approximately 1250 family/general practitioners
  - Durham = 466
  - Scarborough = 463
  - Northeast = 310
- Primary Care providers are a key member of the Health Link team for all patients. Primary care involvement in Health Links is required and each Health Link is to include the participation of no less than 65% of primary care providers in the designated community.
- In Central East LHIN our approach to establishment of Health Links initiates with engagement of primary care providers by the staff team and our Provincial Primary Care Lead.
- Seven Health Links will be developed in Central East – The Peterborough Health Link has been established and planning work is underway in Durham Northeast.

Recognizing the need to evolve the four existing hospital based Geriatric Assessment and Intervention Network assessment clinics in the LHIN, a significant community investment is being made to establish six GAIN community outreach teams. These interprofessional teams include a range of primary care providers GP/FP, NP, RNs, Social workers, Care Coordinators others. Their focus is to support the primary care (and other) needs of frail seniors to keep them living well and supported in their home communities.

## 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 involving primary care partners
- GAIN Community Outreach teams providing primary care (and other) supports to frail seniors
- 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

### Palliative Care Aim

- Education and leadership opportunities for primary care providers through enhanced collaboration and partnership with Primary Care Leads and Primary Care Advisory Group consultation regarding the promotion/expansion of Advance Care Planning initiatives in Primary Care settings

### Mental Health and Addiction Aim

- 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 and contribute to the eradication of the stigma of mental health
- OTN to enable access to Psychiatric Treatment and Consultation Services for Primary Care Providers thus allowing them to support people with more complex needs
- Increase concurrent disorder capacity in the mental health and addictions system and in the primary care system through specific capacity building activities

### Vascular Health Aim

- Ontario Integrated Vascular Health Strategy – Blueprint. (Early adopters for the Ontario Vascular Health Coalition )
- Harmonization of practices across primary and specialty care settings for screening and treatment of vascular disease
- Increasing access to diabetes care/education in community and primary care settings to reduce 30 day readmissions
- Improving access to comprehensive primary care by reducing the number of individuals who are 'unattached' to primary care providers.
- Early Chronic Kidney Disease (CKD) Management through Primary Care

### Seniors

- Involvement of primary care providers in the development of each of the seven Health Links
- 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
- Implement the GAIN Community teams which are a comprehensive primary health care model for at-risk seniors. This includes:
  - Identification of high-risk seniors who can enroll in the GAIN program with the collaboration of their primary care physician
  - Through the GAIN Community Case Managers, engage primary care physicians in collaborative care planning and follow-up for GAIN enrolled patients
  - Obtain feedback from involved primary care providers on the success and opportunities to improve the GAIN Community teams in the care of at-risk seniors

| Action Plans                                                                                                                                                                                                                                                                                                                 |             |    |             |    |             |    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|----|-------------|----|-------------|----|
|                                                                                                                                                                                                                                                                                                                              | 2014/15     |    | 2015/16     |    | 2016/17     |    |
|                                                                                                                                                                                                                                                                                                                              | Status      | %  | Status      | %  | Status      | %  |
| <b>Palliative Care</b>                                                                                                                                                                                                                                                                                                       |             |    |             |    |             |    |
| Education and leadership opportunities for primary care                                                                                                                                                                                                                                                                      | In Progress | 25 | In Progress | 25 | In Progress | 50 |
| <b>Mental Health and Addictions</b>                                                                                                                                                                                                                                                                                          |             |    |             |    |             |    |
| Support integration and capacity building between Primary Care and Mental Health and Addictions Service providers via Health Links and broader OTN use                                                                                                                                                                       | In Progress | 20 | In Progress | 20 | In Progress | 20 |
| Increase concurrent disorder capacity in the mental health and addictions system and in the primary care system through specific capacity building activities                                                                                                                                                                | In Progress | 20 | In Progress | 30 | In Progress | 10 |
| <b>Vascular Health</b>                                                                                                                                                                                                                                                                                                       |             |    |             |    |             |    |
| Early adopters for the Ontario Vascular Health Coalition                                                                                                                                                                                                                                                                     | In Progress | 25 | In Progress | 25 | In Progress | 25 |
| Increase access to patient education and self-management support or training for clinicians: <ul style="list-style-type: none"> <li>• Early Chronic Kidney Disease (CKD) Management through Primary Care</li> <li>• Coordinated Intake and Diabetes Education</li> <li>• Support for Diabetes Care and Management</li> </ul> | In Progress | 40 | In Progress | 20 | In Progress | 20 |
| Ontario Integrated Vascular Health Strategy – Blueprint: <ul style="list-style-type: none"> <li>• Harmonization of practices across</li> </ul>                                                                                                                                                                               | In Progress | 20 | In Progress | 40 | In Progress | 20 |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |             |    |             |    |             |    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|----|-------------|----|-------------|----|
| primary and specialty care settings for screening and treatment of vascular disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |             |    |             |    |             |    |
| Increasing access to diabetes care/education in community and primary care settings to reduce 30 day readmissions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | In Progress | 25 | In Progress | 25 | In Progress | 25 |
| <b>Seniors</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |             |    |             |    |             |    |
| Participate in establishment of in each of seven Health Links – Seniors or other High needs cohort                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | In Progress | 70 | In Progress | 20 | In Progress | 10 |
| Seniors/Geriatric Assessment and Intervention Network (GAIN) – Community Outreach Team establishment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | In Progress | 70 | In Progress | 20 | In Progress | 10 |
| Support Design Team or other implementation teams established to launch the Community GAIN program                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | In Progress | 25 | In Progress | 25 | In Progress | 25 |
| Support primary care awareness, buy-in, and early tests of change of the new GAIN Community teams                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | In Progress | 25 | In Progress | 25 | In Progress | 25 |
| <b>How will we measure success?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |             |    |             |    |             |    |
| <ul style="list-style-type: none"> <li>• Number of people with Individualized Integrated Coordinated Care Plans through Health Links</li> <li>• Number of unattached patients connected to primary care providers through Health Care Connects</li> <li>• Patients enrolled in the GAIN Community Teams <ul style="list-style-type: none"> <li>◦ Patient/Caregiver satisfaction with the GAIN Community Teams and collaboration with primary care</li> </ul> </li> <li>• Establishment of Health Links and accomplishments of identified metrics/outputs</li> <li>• Ambulatory care sensitive hospital admissions and re-admissions</li> <li>• Hospital Patient Discharge Information provided to primary care within 48 hours</li> </ul> |             |    |             |    |             |    |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What are the risks/barriers to successful implementation?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <ul style="list-style-type: none"> <li>• Poor working relationships and collaboration between CHC sector and other Primary Health Care providers both on the ground and in communities</li> <li>• Influence /hindrance created by physician compensation issues (and provincial negotiations) on local level collaborations and partnerships (with LHIN, cross PEM or cross CHC-PEM)</li> <li>• Poor physician buy-in and support of the emerging GAIN Community teams</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>For each risk/barrier, describe the plan to mitigate the risk?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <p>Risks identified will be mitigated through:</p> <ul style="list-style-type: none"> <li>• Engagement of Central East LHIN level primary health care leadership to champion system changes</li> <li>• Provincial collaboration with MOHLTC and other LHINs regarding Health Links implementation</li> <li>• Supporting strong project management and quality improvement focus within primary care programs/initiatives during implementation</li> <li>• Leverage leadership and peer to peer engagement of Primary Care Leads and community primary care providers</li> <li>• Provincial collaboration with MOHLTC on various PHC funding initiatives</li> <li>• Engage physicians in the design and evaluation of the emerging GAIN Community teams</li> <li>• Consultation and advice from the Central East LHIN's Primary Health Care Advisory Group (PHCAG)</li> </ul> |
| <b>What are some of the key enablers that would allow us to achieve our goal?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <ul style="list-style-type: none"> <li>• Central East LHIN Primary Care Leads in leading dialogue and change within the Central East LHIN primary health care sector</li> <li>• Central East LHIN Primary Health Care Advisory Group</li> <li>• Engagement of both LHIN funded Community Health Centres (CHC) and other non-LHIN funded primary health care entities or enrolment models through Health Links and 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</li> </ul>                                                                                                                                                                          |

## Access and Wait Times

| IHSP Enabler                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |                          |                           |                |    |     |                 |                    |          |                  |                          |                           |                |    |     |                 |                    |                                |  |  |  |  |   |  |   |  |                  |   |   |   |   |   |   |   |  |                               |   |  |  |   |   |   |   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------|---------------------------|----------------|----|-----|-----------------|--------------------|----------|------------------|--------------------------|---------------------------|----------------|----|-----|-----------------|--------------------|--------------------------------|--|--|--|--|---|--|---|--|------------------|---|---|---|---|---|---|---|--|-------------------------------|---|--|--|---|---|---|---|--|
| <b>Access:</b> Monitoring and improving MLPA wait time targets.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                          |                           |                |    |     |                 |                    |          |                  |                          |                           |                |    |     |                 |                    |                                |  |  |  |  |   |  |   |  |                  |   |   |   |   |   |   |   |  |                               |   |  |  |   |   |   |   |  |
| IHSP Enabler Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                          |                           |                |    |     |                 |                    |          |                  |                          |                           |                |    |     |                 |                    |                                |  |  |  |  |   |  |   |  |                  |   |   |   |   |   |   |   |  |                               |   |  |  |   |   |   |   |  |
| <p><b>MLPA Wait time Targets</b></p> <p>Maintaining and improving wait times for key services aligns with MOHLTC's 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 replacement, knee replacement, 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.</p> <p><b>How is success being measured?</b></p> <p>Success is being measured according to the following 2013/14 Ministry-LHIN Performance Agreement (MLPA) performance targets:</p> <ul style="list-style-type: none"> <li>• Percent of Priority IV Cases Completed within Access Target for Cancer Surgery</li> <li>• Percent of Priority IV Cases Completed within Access Target for Cataract Surgery</li> <li>• Percent of Priority IV Cases Completed within Access Target for Hip Replacement Surgery</li> <li>• Percent of Priority IV Cases Completed within Access Target for Knee Replacement Surgery</li> <li>• Percent of Priority IV Cases Completed within Access Target for Diagnostic MRI Scan</li> <li>• Percent of Priority IV Cases Completed within Access Target Diagnostic CT Scan</li> </ul> |                  |                          |                           |                |    |     |                 |                    |          |                  |                          |                           |                |    |     |                 |                    |                                |  |  |  |  |   |  |   |  |                  |   |   |   |   |   |   |   |  |                               |   |  |  |   |   |   |   |  |
| Current Status                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |                          |                           |                |    |     |                 |                    |          |                  |                          |                           |                |    |     |                 |                    |                                |  |  |  |  |   |  |   |  |                  |   |   |   |   |   |   |   |  |                               |   |  |  |   |   |   |   |  |
| <p><b>Target Populations</b></p> <p>Seven hospitals in the Central East LHIN provide wait time-related or Wait Time Strategy-funded services:</p> <table border="1"> <thead> <tr> <th>Hospital</th><th>Cataract Surgery</th><th>Hip Replace-ment Surgery</th><th>Knee Replace-ment Surgery</th><th>Cancer Surgery</th><th>CT</th><th>MRI</th><th>General Surgery</th><th>Paediatric Surgery</th></tr> </thead> <tbody> <tr> <td>Campbellford Memorial Hospital</td><td></td><td></td><td></td><td></td><td>✓</td><td></td><td>✓</td><td></td></tr> <tr> <td>Lakeridge Health</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td></td></tr> <tr> <td>Northumberland Hills Hospital</td><td>✓</td><td></td><td></td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td></td></tr> </tbody> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                          |                           |                |    |     |                 |                    | Hospital | Cataract Surgery | Hip Replace-ment Surgery | Knee Replace-ment Surgery | Cancer Surgery | CT | MRI | General Surgery | Paediatric Surgery | Campbellford Memorial Hospital |  |  |  |  | ✓ |  | ✓ |  | Lakeridge Health | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  | Northumberland Hills Hospital | ✓ |  |  | ✓ | ✓ | ✓ | ✓ |  |
| Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Cataract Surgery | Hip Replace-ment Surgery | Knee Replace-ment Surgery | Cancer Surgery | CT | MRI | General Surgery | Paediatric Surgery |          |                  |                          |                           |                |    |     |                 |                    |                                |  |  |  |  |   |  |   |  |                  |   |   |   |   |   |   |   |  |                               |   |  |  |   |   |   |   |  |
| Campbellford Memorial Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |                          |                           |                | ✓  |     | ✓               |                    |          |                  |                          |                           |                |    |     |                 |                    |                                |  |  |  |  |   |  |   |  |                  |   |   |   |   |   |   |   |  |                               |   |  |  |   |   |   |   |  |
| Lakeridge Health                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ✓                | ✓                        | ✓                         | ✓              | ✓  | ✓   | ✓               |                    |          |                  |                          |                           |                |    |     |                 |                    |                                |  |  |  |  |   |  |   |  |                  |   |   |   |   |   |   |   |  |                               |   |  |  |   |   |   |   |  |
| Northumberland Hills Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ✓                |                          |                           | ✓              | ✓  | ✓   | ✓               |                    |          |                  |                          |                           |                |    |     |                 |                    |                                |  |  |  |  |   |  |   |  |                  |   |   |   |   |   |   |   |  |                               |   |  |  |   |   |   |   |  |

|                                     |   |   |   |   |   |   |   |   |
|-------------------------------------|---|---|---|---|---|---|---|---|
| Peterborough Regional Health Centre | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |   |
| Ross Memorial Hospital              | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |   |
| Rouge Valley Health System          |   | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| The Scarborough Hospital            | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

### **Community Engagement and Leadership**

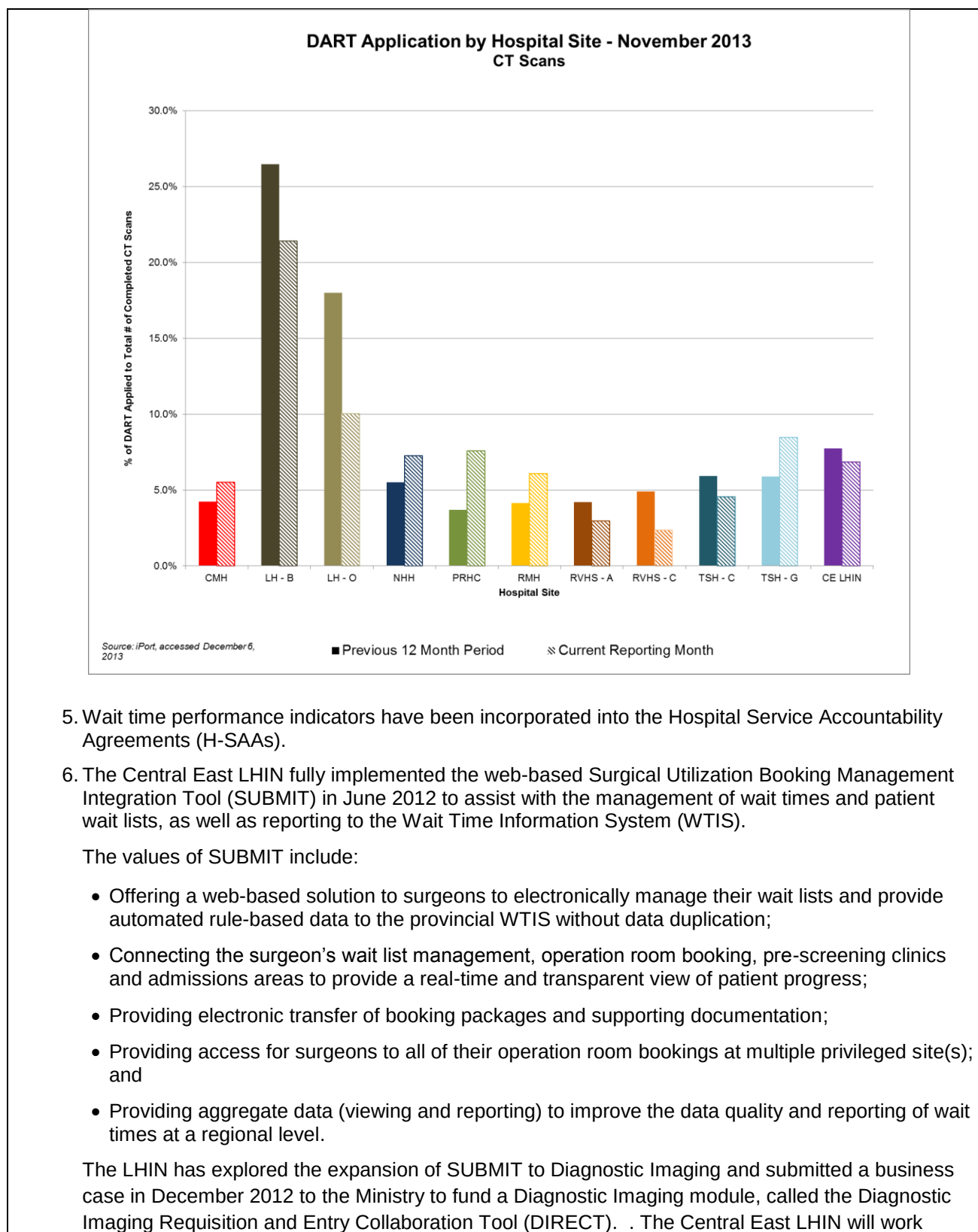
#### *Wait Times Strategy Working Group*

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, 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 below target for each hospital and volume management, including the identification of additional capacity and volumes for reallocation. 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. Use of standardized best practices in hospitals, including participation in Phase 3 of the Ministry's MRI Performance Improvement Plan (PIP3) initiative.
3. Hospital wait time performance by key services is posted on the Central East LHIN public website on a monthly basis, and issues and actions/strategies are highlighted for each key service.
4. Continued application of Dates Affecting Readiness to Treat (DART) by the Central East LHIN's hospitals. DARTs exclude the period of time a patient is unavailable for a procedure due to patient-related reasons. The application of DARTs gives a more accurate reflection of the amount of time a patient waits for surgery or a diagnostic scan.



with health service providers in 2014/2015 to review the potential for this project to be a pilot for the first modality (MRI) with the capability to spread to all hospitals and all other modalities. This will include an e-request component that addresses the intake and Wait Times 1 tracking, as well as the capability for appropriateness of the request, validation and acceptance, notification back to the requestor and scheduling of the request. While integration directly into scheduling and RIS systems has been identified, they are not in current scope. Also, the system of e-request and intake will be developed so as to be applied to other care services including Surgical, Palliative, and Cardio-Vascular etc.

7. 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).

More specifically, The Integrated Orthopaedic Capacity Plan (IOCP) in 2014/2015 will transition from the planning to the implementation phase through the establishment of the Orthopaedic Planning and Implementation Committees (OPICs). Each of the three clusters within the Central East LHIN will have an OPIC responsible for the submission of a Directional Plan outlining the future state of orthopaedics in the Central East LHIN. Directions Plans will be received by the LHIN on March 31<sup>st</sup> 2014, and reflect the following information:

- Articulate a vision statement for orthopaedics and confirm goals;
- Identify 'in-scope' and 'out of scope' objectives;
- Prioritize Key System Changes and Action Steps;
- Describe strategies to achieve the desired outcomes (using the Central East LHIN decision-making framework); and
- Establish future planning and implementation processes and timelines, including required Working Groups.

Following the submission of the Directional Plans, the full implementation of the IOCP will take place under the direction of an Advisory Committee which will be populated with membership post March 31<sup>st</sup>, 2014. This expert wide Advisory Committee will be responsible for the following next steps:

- Oversee planning and implementation of the IOCP, including spread of promising practices;
- Ensure alignment and consistency of approach across clusters;
- Ensure standardization of process and care provision, where appropriate;
- Coordinate LHIN-wide service provision;
- Provide expert guidance ;
- Ensure best practice design; and
- Provide advice and counsel to Central East LHIN.

## **Current Environment**

### *Key Issues and Successes*

There are systemic issues impacting wait time performance across almost all services. The key issues include referral patterns, demand exceeding funded volumes, and patient choice/preferences. Historically, hospitals have also provided services over and above the funded volumes from their global budgets. 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. The LHIN will continue to work with health service providers (HSPs) and other key stakeholders to identify opportunities to improve wait times in 2014/15. As of year-to-date (YTD) September 2013, the Central East LHIN met all wait time targets.

## Goal(s)

### Central East LHIN IHSP AIM

#### *MLPA Targets for Surgical and Diagnostic Imaging*

| Indicator                                                                           | 2013/2014 Baseline | 2013/2014 Final Central East LHIN MLPA Target |
|-------------------------------------------------------------------------------------|--------------------|-----------------------------------------------|
| Percent of Priority IV Cases Completed within Access Target for Cancer Surgery      | 96%                | 90%                                           |
| Percent of Priority IV Cases Completed within Access Target for Cataract Surgery    | 99%                | 90%                                           |
| Percent of Priority IV Cases Completed within Access Target Hip Replacement         | 96%                | 90%                                           |
| Percent of Priority IV Cases Completed within Access Target for Knee Replacement    | 96%                | 90%                                           |
| Percent of Priority IV Cases Completed within Access Target for Diagnostic MRI Scan | 47%                | 50%                                           |
| Percent of Priority IV Cases Completed within Access Target for Diagnostic CT Scan  | 91%                | 90%                                           |

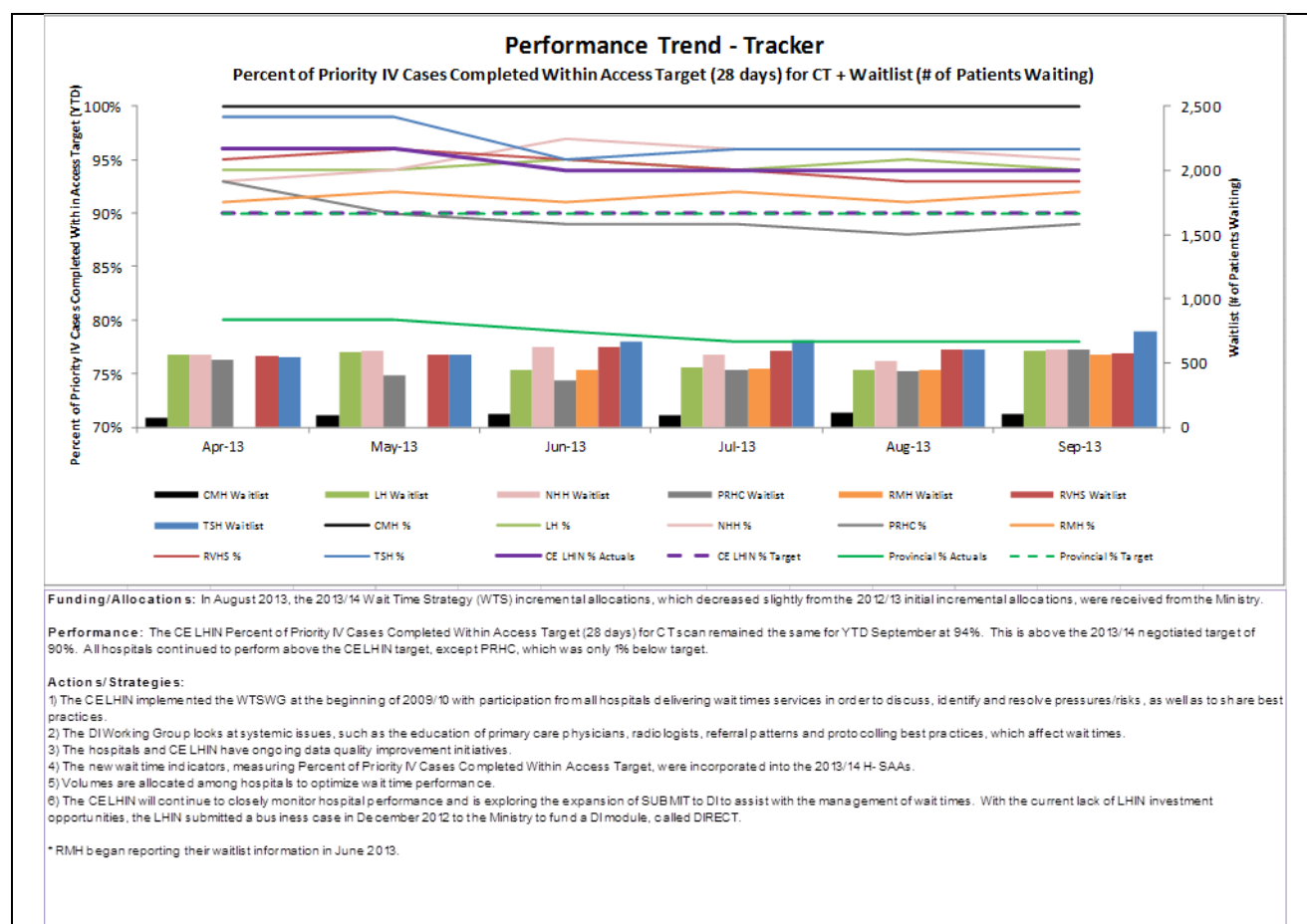
## Action Plans/Interventions

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 2013/14 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 the resulting impact on health conditions; and
- A sustainable health system framework.

| Action Plans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 2014/15         |   | 2015/16         |   | 2016/17         |   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|---|-----------------|---|-----------------|---|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Status          | % | Status          | % | Status          | % |
| Hospitals and the Central East LHIN implemented a <b>Data Quality Improvement Working Group</b> . 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 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 <b>WTSWG</b> . 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         | - |
| <b>One-on-one meetings</b> with each hospital as needed to discuss hospital-specific performance issues, such as additional capacity and integration. <b>Wait Time performance</b> is also an integral part of the <b>H-SAA negotiation process which is well underway for 2014/15</b> .                                                                                                                                                                                                                                  | Ongoing         | - | Ongoing         | - | Ongoing         | - |
| <b>Reallocation of a portion of the Central East LHIN's surplus dollars</b> 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 | - |
| <b>Maintain the Surgical Utilization Booking Management Integration Tool (SUBMIT)</b> , which is a web-based project to improve patient wait list management and wait times reporting for surgeons and hospitals in the Central East LHIN.                                                                                                                                                                                                                                                                                | Ongoing         | - | Ongoing         | - | Ongoing         | - |

|                                                                                                                                                                                                                                                                                                                                                                                                |         |    |             |    |             |    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----|-------------|----|-------------|----|
| <b>Engagement sessions at the hospital level</b> with administrators and physicians, through the HSFR Local Partnership (previously the QBP Working Group).                                                                                                                                                                                                                                    | Ongoing | -  | Ongoing     | -  | Ongoing     | -  |
| <b>Orthopaedic Planning and Implementation Committee (OPIC):</b> Upon the completion of the Integrated Orthopaedic Capacity Plan (IOCP), the OPICs are now working towards the development of cluster specific Directional Plans which will provide recommendations on the implementation phase of the IOCP. Implementation of the Directional Plans will take place from May 2014-March 2016. | Started | 20 | In progress | 40 | In progress | 40 |
| <b>How will we measure success?</b>                                                                                                                                                                                                                                                                                                                                                            |         |    |             |    |             |    |
| The Central East LHIN utilizes a monthly dashboard system to monitor and manage MLPA Indicators. The dashboard is discussed at a variety of leadership groups, including the Central East LHIN Senior Team and Central East Executive Council. This information is published on the Central East LHIN public website on a monthly basis. See an example below.                                 |         |    |             |    |             |    |



## What are the risks/barriers to successful implementation?

- Various challenges have resulted in increasing wait times. The Central East LHN is working with stakeholders to more fully utilize all the MRI 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, hip replacements and knee replacements, has drastically impacted the planning of volume delivery in the LHN. Hospitals and stakeholders are reviewing potential solutions to the volume and funding levels in order to assist the hospitals' ability to plan accordingly.

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

- In 2013/2014, the Central East LHN received additional Wait Time Strategy incremental volumes (compared to 2012/13). The LHN successfully sought approval from the Ministry to use 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 late in the year (late Q3). Hence, hospitals are

unable to plan in advance. The LHIN will work with stakeholders to find a sustainable source of funding for the DIRECT project. The benefits associated with this initiative will ensure an efficient use of existing resources, including appropriateness. The Central East LHIN underwent a regional planning process to determine the optimal service delivery model for vision care services. As part of the MOHLTC strategy to shift low-risk procedures from hospitals to community-based specialty clinics, LHINs have been asked to develop a vision care plan. Any proposals to shift volumes to these community-based specialty clinics must be evaluated against this vision care plan. The anticipated completion date for the plan is Summer 2014. 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 also underway to determine the optimal model of service delivery for all orthopaedic QBPs. Furthermore, Directional Plans from the Orthopaedic Planning and Implementation Committee (OPIC) will provide recommendations on how best to deliver orthopaedic services based on the action items and key system changes emerging from the IOCP.

### **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.

## Health System Funding Reform

| IHSP Enabler                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Capacity and Funding:</b> Health System Funding Reform                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| IHSP Enabler Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <p>The ongoing activities of Health System Funding Reform (HSFR) continue to alter the way health care is funded in Ontario. This shift represents a transition 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. HSFR began and continues to evolve with Hospitals and Community Care Access Centres (CCAC). Patient Based Funding will be expanding in scope and is expected to be introduced in the community sector by 2015/16. There are two key components of Health System Funding Reform – Health Based Allocation Model (HBAM) and Quality-Based Procedures (QBP).</p> <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Current Status                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <p>Going forward, hospitals' funding will be comprised of three different streams. Hospitals will still receive some Global Funding. 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.</p> <p>Health Based Allocation Model (HBAM) 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.</p> <p>Quality Based Procedures (QBP) provides reimbursement to health care providers based on the types and quantity of services they deliver.</p> <p>As part of Health System Funding Reform, the LHIN has established the Central East LHIN Local Partnership (LP) in 2013. As the Local Partnership matures, it 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.</p> <p>The LP will:</p> <ul style="list-style-type: none"> <li>• Proactively discuss local implementation planning and change management imperatives related to all aspects of HSFR;</li> <li>• Identify and discuss critical implementation issues and the associated strategies to ensure coordination across providers;</li> <li>• Provide advice and strategies on volume management and alignment to service accountability agreements; and</li> <li>• Proactively engage and communicate with local providers across sectors, with emphasis on</li> </ul> |

|                                                                                                                                                                                                                                                                   |             |     |             |    |             |    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----|-------------|----|-------------|----|
| implementation planning and the impact on the health care system as well as health service providers.                                                                                                                                                             |             |     |             |    |             |    |
| <b>Goal(s)</b>                                                                                                                                                                                                                                                    |             |     |             |    |             |    |
| Develop recommendations for an effective volume management strategy for all Quality-Based Procedures as they are introduced.                                                                                                                                      |             |     |             |    |             |    |
| <b>Consistency with Government Priorities</b>                                                                                                                                                                                                                     |             |     |             |    |             |    |
| The Ministry of Health and Long-Term Care has asked the LHIN to develop and implement volume management strategies.                                                                                                                                               |             |     |             |    |             |    |
| <b>Action Plans/Interventions:</b>                                                                                                                                                                                                                                |             |     |             |    |             |    |
| Action Plans                                                                                                                                                                                                                                                      |             |     |             |    |             |    |
|                                                                                                                                                                                                                                                                   | 2014/15     |     | 2015/16     |    | 2016/17     |    |
|                                                                                                                                                                                                                                                                   | Status      | %   | Status      | %  | Status      | %  |
| Develop an accepted process for establishing volume management strategies for Quality-Based Procedures                                                                                                                                                            | Ongoing     | -   | Ongoing     | -  | Ongoing     | -  |
| Develop standards and processes for tracking and forecasting medical QBP volumes                                                                                                                                                                                  | Complete    | 100 | Monitor     | -  | Monitor     | -  |
| Effectively manage the new policy direction of shifting low-risk procedures (cataracts) from hospitals to community-based specialty clinics if appropriate                                                                                                        | In Progress | 50  | In progress | 40 | In progress | 10 |
| <b>How will we measure success?</b>                                                                                                                                                                                                                               |             |     |             |    |             |    |
| Success will be measured by the development of volume management strategies through consensus building.                                                                                                                                                           |             |     |             |    |             |    |
| <b>What are the risks/barriers to successful implementation?</b>                                                                                                                                                                                                  |             |     |             |    |             |    |
| There are number of risks and barriers to the successful implementation of this aim. These include issues surrounding change management, resources and work.                                                                                                      |             |     |             |    |             |    |
| <b>For each risk/barrier, describe the plan to mitigate the risk?</b>                                                                                                                                                                                             |             |     |             |    |             |    |
| <ul style="list-style-type: none"> <li>To develop a strong communication strategy with members of the Local Partnership and Health Service Providers</li> <li>To continue data quality reviews to ensure complete and accurate information is reported</li> </ul> |             |     |             |    |             |    |

## Health System Design and Integration

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| <b>IHSP Enabler:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Health System Design and Integration                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>IHSP Enabler Description:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Health system design and integration activities will improve the quality of client care, performance of the local health system and system sustainability                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Current Status:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <p><b>Health System Design and Integration: Integration Strategies</b></p> <p><b>Health Links</b></p> <p>The Central East LHIN is fully engaged in supporting our health care provider partners in the development of several Health links across the region which focus on high-users or high-risk populations in an attempt to:</p> <ul style="list-style-type: none"> <li>• Understand the health care and non-health care needs of that population to better tailor services to improve patient outcomes; and</li> <li>• 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.</li> </ul> <p>The Central East LHIN Board has approved the creation of seven Health Links covering the entire Central East with geographic areas informed by several factors including but not limited to catchment areas of hospitals, physician and patient loyalty to hospital services, and referral patterns between primary health care to specialist care. Health Links in the Central East LHIN will include Peterborough, Durham North East, Durham West, Northumberland, Haliburton-Kawartha Lakes, Scarborough North, and Scarborough South.</p> <p>By April 2014, it is expected that two Health Links will be approved – Peterborough and Durham North East. The LHIN will be initiating the balance of the planned Health Links in 2014/15 so that by the end of the March 2015, all 7 Health Links will be active at various stages</p> <p>Initial focus for the Peterborough Health Link has been on three patient cohorts:</p> <ol style="list-style-type: none"> <li>1. 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, financial issues).</li> <li>2. 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, financial issues).</li> <li>3. Seniors with exacerbated chronic obstructive pulmonary disease (COPD) and at least one other co morbidity with the possibility of other complicating factors (such as inadequate housing or transportation, isolation, palliation, responsive behaviours, financial issues).</li> </ol> <p>Durham North East Health Link is adopting these three cohorts and also adding a fourth cohort for early focus:</p> <ol style="list-style-type: none"> <li>4. Patients with complex chronic conditions identified through the GAIN Community teams</li> </ol> |

It is expected that subsequently developing Health Links will also focus on these cohorts, or a sub-set, with possible customization at a local level.

### **Community Health Services Integration Strategy 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.

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; and
- Make the best use of the public's investment.

This strategy resulted in the commencement of integration planning processes in Northumberland County, City of Kawartha Lakes 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 have been instituted to the CHS Integration Strategy:

- The North East cluster process was initiated January 2013;
- The North East cluster process proceeded 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 have now been included in the North East phase of the strategy;
- There were no change to the current CHS process in the Durham cluster; and
- The Scarborough process, which had been scheduled to start in November 2012, was delayed until June 2013.

#### *Haliburton County/Kawartha Lakes Integration Process*

Building on the work that transpired in Haliburton County between April and October 2012, the integration process re-initiated January 2013 with the addition of providers from the City of Kawartha Lakes. The process culminated with an Integration Plan that was developed and approved by the six participating Health Service Providers (HSP) Boards in December 2013. The Central East LHIN Board approved the plan December 2013 and the Implementation Phase is to begin January 2014.

### *Northumberland County Integration Process*

This process was initiated January 2013 with seven health services providers in Northumberland. This included two hospital corporations – Campbellford Memorial Hospital and Northumberland Hills Hospital. In February 2014 the Integration Planning Team will deliver its Final Integration Plan to the Central East LHIN Board. This will be followed by more detailed implementation planning into Q4 2013/2014. The Small, Rural, Northern Hospital Transformation Fund is being applied to various integration enablers/projects identified by the Team.

### *Scarborough and Peterborough CHS Integration Processes*

Scarborough and Peterborough CHS Integration Processes will continue in the early part of 2014/15. Planning timelines are such that Central East LHIN review of health service provider Integration Plans are scheduled for June 2014. Implementation of approved plans will begin immediately following approval and complete by March 2015

## **Health System Design and Integration: Hospital Services**

### **Hospital Clinical Services Planning and Delivery**

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; and
- 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, Vision Care and Critical Care (“Life or Limb” Policy). That vision is *“Improved and equitable patient access to an integrated hospital system that provides the highest quality of care across the Central East LHIN”*

2014/15 implementation activities related to the original 2009 Clinical Services Plan include:

- Finalized Hospital Regional Service Agreements for Vascular Surgery;
- Monitor existing Hospital Regional Service Agreements (e.g., Thoracic Surgery);
- Work towards the achievement of the 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. The Central East LHIN has initiated a project that has developed system improvement recommendations. The project is now transitioning to the second phase that will develop implementation recommendations;
- Develop a regional hospital repatriation agreement in alignment with the provincial “Life and Limb Policy”;
- Explore a common integrated back office solution to support hospital physician credentialing and privileging services; and
- Continue to plan for, maintain and manage local surge capacity management plans with a focus on system level moderate to major surge events.

## **Critical Care Capacity and Improvement**

In 2014/2015 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 Central East LHIN and Critical Care Lead will support:

- The implementation of the Life or Limb Policy. The Life or Limb policy embraces a philosophy of care for the sickest, most vulnerable and critically ill patients, and promotes the patients' clinical condition as priority. The Central East LHIN staff, along with the Central East LHIN's Critical Care Physician Lead, Dr. Randy Wax, are developing a roll out plan. Preparatory work is underway to set the foundation for a timely implementation of this provincial implementation. Key responsibilities essential to the success of the policy include but are not limited to:
  - Participation in Ontario's Surge Capacity Management Plan;
  - Utilization of CritiCall Ontario for patient referral process;
  - Ensuring reporting in the Critical Care Information System is kept current to enable performance measurement and system improvements and; and
  - Utilizing CritiCall Ontario's repatriation tool to track and monitor repatriation requests and processes.
- 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; and
  - Better leverage technology, specifically Telehealth, to support rapid resuscitation of critically ill patients, and reduction in unnecessary transfers.
- Critical care service delivery, timely repatriation of any transferred patient, surge planning and event management. The Central East LHIN Lead will:
  - Oversee the implementation, maintenance and management of local surge capacity management plans with a focus on moderate and major surge. This will be in conjunction with the Central East LHIN ED Lead;
  - Identify opportunities to improve system efficiency and optimization of resources;
  - Create or maintain a Critical on-call roster for the LHIN to support surge capacity response; and
  - Work with local and provincial stakeholders to enhance a patient referral framework that will improve patient transfers in the LHIN.
- 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.

## **Maternal Neonatal and Child**

In 2013 The Central East LHIN established the Central East LHIN Maternal, Newborn and Paediatric Advisory Committee (MNPAC). The Committee functions 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.

The following achievements were completed during the inaugural year of the Central East LHIN MNPAC:

1. Central East LHIN Support for the Establishment of the MNPAC
2. Inaugural meeting of the LHIN Wide Advisory Committee
3. Provincial and Regional Model Information and Education
4. Strategic Visioning – draft Mission, Vision and Values
5. Strategic Planning and Engagement Session
6. Central East LHIN – Stakeholder Engagement Sessions

To further drive the work, the MNPAC created a list of planning filters that will guide planning with respect to advancing integrated and sustainable excellent services across the Central East LHIN:

- The healthcare needs of mothers, newborns, children, youth, and their families (circle of care) should be the key focus of the design and delivery of the services across the Central East LHIN.
- Evidence-based practice and innovation must guide the design, planning, delivery, and ongoing measurement of all elements of the system.
- Delivery of services at the local, sub-LHIN and LHIN level, must consider the implications of patient volumes, patient acuity, case complexity, and sustainability (i.e. high complexity/low volume services should be planned and delivered to provide optimal health outcomes, maximize efficiencies and offer sustainable solutions).
- Critical mass requirements (for human resources, capital equipment, and facilities) will be incorporated in the delivery of high quality patient care.
- Systems of coordinated and/or centralized intake will be considered in order to ensure access to services is timely and seamless.
- Sharing of evidence-based care pathways, processes and training will occur across organizations as appropriate in order to optimize standardization of care and reduce variability.
- Patients, families, and providers will be engaged in the coordination of care.
- Where the patient benefits, information will be shared across organizations.
- The program must be designed as an integrated system and patient need/acuity stratified across that system. This stratification relates back to the need for attention to critical mass of patients (i.e. in the event of a “critical patient issue” the necessary technical and health human resources must be available to support the care of the patient).
- An evaluation framework will enable change, monitor clinical and system outcomes and improve services.

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

Emergency department overcrowding is a problem that requires system-wide solutions. 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. Given our shared commitment to improve ALC in the Central East LHIN, regular meetings are initiated with our hospital and community partners. The Central East LHIN in partnership with these Health Service Providers (HSPs) is constantly developing strategies that take a close look at the current gaps or less-than-optimal links and processes being used by providers involved in the patient's transition of care. Many of these strategies are customizable to meet the unique needs of patients. 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 MLPA indicators.

#### *Target Populations*

The Central East LHIN is addressing rising patient demands, higher acuity that comes with a rapidly aging population, lack of primary care and lack of inpatient bed availability. Focus is being placed on the targeted populations with complex and long-term medical, physical, social and/or cognitive conditions that place the client at risk of avoidable hospital admission or readmission, premature institutionalization in Long-Term Care, or other health decline. 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 improving the vascular health of residents in the Central East LHIN.

#### *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
- Approach #3: Improving Hospital Bed Utilization, including Reducing Alternate Level of Care (ALC) Days

Initiatives like Home First, Resource Matching and Referral (RM&R), are contributing towards reducing ED wait times and improving patient flow. The implementation of the Acute to Complex Continuing Care (CCC) Pathway in relation to the RM&R initiative at the Ross Memorial Hospital (RMH) and Peterborough Regional Health Centre (PRHC) in conjunction with implementation partners Central East LHIN and Central East CCAC are identifying efficient ways to enable matching of patients to appropriate clinical programs/services and the transmission of electronic referrals. Data consistently demonstrates that prolonged ED wait times is not only an ED problem but requires hospital wide solutions and interventions. These initiatives will improve client transition through the continuum of care by focusing on a client-centred approach to managing referrals across sectors.

The purpose of Home First is to facilitate the provision of appropriate care to all patients, by matching resources with their needs. The expectation is that every admitted patient will be discharged to wherever he or she came from at the end of the acute length of stay, even if that will not be the patient's final destination. The sentinel measure of Home First is the rate of ALC designation in hospital, and particularly of ALC-LTC designation. The desired outcome is that all new LTC applications will be completed in the community, not in the hospital. A large number of processes and programs are in place throughout the

LHIN to support the culture of Home First. In general, these fall into three points of intervention in the patient journey—before admission to the hospital, during the acute length of stay in the hospital, and after ALC designation. Implementation of Home First was project-led by the Central East CCAC and ongoing management and sustainability remains within the purview of the Central East CCAC. A LHIN-wide Home First steering committee is chaired by the CCAC, with representation from the LHIN, each hospital, each CSS agency, and the CCAC itself.

The Central East CCAC processes both internal data from its own operations and data provided by each hospital. A number of outcome, process, and balancing indicators are gathered for each hospital site, and reports of these are submitted to the Central East LHIN, sustainability committee for each site, and to the steering committee for all sites. The LHIN regularly analyzes the data to aid in efficient and effective patient care.

#### *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 8,063 visits or a 2% increase over the 2010/2011 visits. If compared to visits in 2009/2010 the number of visits represents an increase by 33,645 or a 7% increase.

|                      | Fiscal Year 2010 |         |         |         | Fiscal Year 2011 |         |         |         | Fiscal Year 2012 |         |         |         |
|----------------------|------------------|---------|---------|---------|------------------|---------|---------|---------|------------------|---------|---------|---------|
| Unscheduled Visits   | Q1               | Q2      | Q3      | Q4      | Q1               | Q2      | Q3      | Q4      | Q1               | Q2      | Q3      | Q4      |
| High Acuity          | 73,423           | 75,954  | 78,126  | 77,698  | 78,760           | 80,821  | 81,199  | 83,665  | 83,867           | 84,123  | 77,485  | 78,993  |
| Low Acuity           | 48,533           | 49,797  | 46,035  | 44,023  | 47,785           | 51,070  | 49,309  | 46,562  | 48,234           | 51,109  | 50,014  | 53,409  |
| Quarterly Totals     | 121,956          | 125,751 | 124,161 | 121,721 | 126,545          | 131,891 | 130,508 | 130,227 | 132,101          | 135,232 | 127,499 | 132,402 |
| <b>Annual Totals</b> | <b>493,589</b>   |         |         |         | <b>519,171</b>   |         |         |         | <b>527,234</b>   |         |         |         |

Source: ER\_Pay For Results Operational Report\_201309

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. The Central East LHIN is making an investment of \$27,827,000 stemming from the 2013-2014 community investment. The investments will be in the following high impact areas:

- Mental Health and Addictions Strategy Implementation and Physician Leadership
  - Child and Adolescent Hospital Based Services Project
- Assertive Community Treatment Teams (ACTT) Quality Improvement and Expansion
- Mental Health Supportive Housing Services
- CCAC Home Care Services
- Assisted Living Services for High Risk Seniors (ALS-HRS)
- Adult Day Programming (ADP)
- GAIN Community Teams to Support Seniors and Others with Complex Health Needs

Funding is being directed to these projects/interventions that will have a positive impact on Emergency Department (ED) visits and Alternate Level of Care (ALC) Days. 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 | 2013-14 YTD |      |      |      |      |      |
|------------------|---------|-------------|------|------|------|------|------|
|                  |         | Apr         | May  | Jun  | Jul  | Aug  | Sep  |
| ED Admitted      | 33.7    | 29.2        | 27.1 | 27.6 | 28.7 | 28.2 | 29.2 |
| ED Low Acuity    | 4.1     | 3.9         | 3.9  | 3.7  | 3.8  | 3.9  | 3.7  |
| ED High Acuity   | 6.5     | 6.0         | 5.9  | 6.0  | 5.9  | 6.1  | 5.8  |
| PIA              | 3.0     | 2.7         | 2.8  | 2.5  | 2.7  | 2.7  | 2.6  |
| ALC Throughput * | 0.99    | 0.99        | 1.05 | 1.05 | 0.90 | 0.96 | 0.91 |

Source: ER\_Pay For Results Operational Report\_201309, \* iPort ATC

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. Encourage consistency in designating patients ALC in all care settings;
- 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;
- Shorten wait times for patient assessment;
- Reduce duplication in roles and improve timeliness of information flow;
- Improve tracking and strategically target critical issues; and
- 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. 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, and reducing demand for future hospital-based care.

*Goals:*

| <b>Indicator</b>                                                                                                                                                      | <b>2012/13<br/>Baseline</b> | <b>2013/14<br/>Final<br/>Central<br/>East LHIN<br/>Target</b> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------------------------|
| 90 <sup>th</sup> Percentile ER length of stay for admitted patients                                                                                                   | 33.72                       | 30.00                                                         |
| 90 <sup>th</sup> Percentile ER length of stay for non-admitted complex patients                                                                                       | 6.45                        | 6.45                                                          |
| 90 <sup>th</sup> Percentile ER length of stay for non-admitted minor/ uncomplicated patients                                                                          | 4.13                        | 4.00                                                          |
| Percentage of ALC days                                                                                                                                                | 13.48%                      | 12.80%                                                        |
| Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions                                                                                       | 18.60%                      | 17.00%                                                        |
| Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions                                                                                     | 24.30%                      | 22.50%                                                        |
| 90 <sup>th</sup> Percentile Wait Time from Community for CCAC In-Home Services – Application from Community Setting to first CCAC Service (excluding case management) | 29                          | 29                                                            |

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-centred 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, funding provided to the Central East LHIN for FY 2013-14 was \$10,827,979. The Central East LHIN allocation has increased by 5% from the Year 5 total of \$10,294,329. 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.

As mentioned above, 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.

### **Capital Planning Process and Review**

A joint Ministry and LHIN capital planning process for hospital capital 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 was to improve alignment of expectations for capital builds between Ministry facilities and LHIN programs/services, and integration and operations funding. Subsequently community capital (e.g. CHC) was included in the new framework.

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 priorities and developments within the LHIN.

### **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 initiated a comprehensive orthopaedic and musculoskeletal planning process for a regional system of orthopaedic care from pre-operative education and intake to community-based rehabilitation for all orthopaedic procedures.

The development of the Central East LHIN-endorsed Integrated Orthopaedic Capacity Plan (IOCP) and the Musculoskeletal Rehab Plan were supported by two working groups made up of representatives from a variety of Central East LHIN Health Service Providers (HSPs). The IOCP Key System Changes (see below) are being reviewed and prioritized by cluster-based Orthopaedic Planning and Implementation Committees (OPICs). The OPICs for each of the three LHIN clusters (North East, Durham, and Scarborough) are developing Directional Plans for implementing the key action steps of the IOCP for Central East LHIN Board endorsement in April 2014 and are expected to focus on Key System Changes #1 and #2 at a minimum. Implementation will follow throughout the remainder of the year.

#### *IOCP Key System Changes*

- 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

Implementation of the Musculoskeletal Rehab Plan will include the establishment working groups early in 2014/15 to (a) plan and implement LHIN-wide standards of rehab care related to hip and knee replacements, hand surgery and other procedures (including fracture care); and (b) to review information requirements and develop standardized data collection and metrics leveraging provincial conversations.

The IOCP and Musculoskeletal Rehab Plan 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. 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.

### **Implementation of Stroke Quality Based Procedures**

The objective for stroke care within the Central East LHIN is to align our planning and strategy with the Quality Based Procedures Handbook. The unification of our facilities to coordinate increased access to the best quality care while maintaining our balanced measures is our goal. The alignment with community re-integration and secondary prevention will follow a cluster-based approach when finalizing options. The Stroke QBP Working Group will utilize the LHIN Decision Making Framework to ensure due diligence occurs with our stakeholders in reaching consensus on recommendations regarding the most appropriate planning option. See the Vascular Health Aim on page 24 for additional information.

### **Development of a Vision Care Strategy**

As part of the MOHLTC strategy to shift low-risk procedures from hospitals to community-based specialty clinics, LHINS have been asked to develop a Vision Care Plan. Any proposals to shift volumes to community-based specialty clinics must be evaluated against this Vision Care Plan. The anticipated completion date for the plan is Summer 2014.

## **Health System Design and Integration: Priority Populations**

### **French Language Services**

Key activities for implementing French Language Services (FLS) in 2014/2015 include:

- Supporting Health Services Provider's (HSPs) capacity to develop services in French as per the 2013/2015 FLS survey after assessing their French-speaking/bilingual health professionals service capacities (e.g. Creation of a Francophone Coalition table for Healthy Community in Scarborough).
- Working collaboratively with the French Language Health Planning Entity (FLHPE) to continue to provide HSPs with opportunities to learn more about principles of Active Offer in the Health Care System by providing them with tools that will help apply Active Offer in the development of health services in French.
- Ongoing planning of health services which takes the needs of the francophone population into consideration during implementation of the 2013-2016 IHSP aims.
- Ongoing communication by health care providers in both English and French through patient transitions between care providers (i.e. Hospital to Community Support Services).
- Ensuring sustainability of French-Language Services by supporting certain HSPs who are willing to offer some services in French. This would be possible based on the 2013/2014 Central East FLS survey results and other relevant data from the Entity.

The Central East LHIN and the FLHPE will continue to obtain key results on French Language Services as required by the Ministry, such as:

- Educate Central East LHIN staff, 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 2014/2015 in collaboration with the French Language Health Planning Entity #4, as partner in change.

Partnering with the French Language Health Planning Entity (the Entity) is a key enabler that will continue to strengthen the engagement of, and health outcomes for the Francophone community within the Central East LHIN region by focusing on following key priority sectors:

- Care for Seniors;
- Mental Health & Addictions;
- Primary Care; and
- Care for patients with a chronic condition.

Focussing on these priorities will help improve quality and safety of care, improve patient experience and reduce detrimental impact of linguistic and cultural barriers on health care. Based on this partnership, the Central East LHIN will be able to support provincial or local initiatives that provide the opportunity to improve the utilization of health care services by Francophone by ensuring appropriate health care system planning. The Central East LHIN will continue maintaining mechanisms that foster ongoing dialogue with the Entity, and ensuring that the Entity recommendations which are aligned with the 2013-2016 IHSP are taken into consideration, rationally analyzed and provided with timely responses. The implementation of the 2014/2015 Annual Business Plan will also have a focus on increasing the participation of the francophone community in health services planning via community engagement activities, Francophone discussion round tables organized jointly by the LHIN and the FLHPE (i.e. Francophone Coalition for Healthy Community in Scarborough). In FY 14/15 the above key priorities sectors will be implemented to:

- Improve the quality of care and safety offered to Francophone 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.
- Improve access for seniors to health services in French, by identifying and implementing services adapted to their linguistic and cultural needs (e.g. Francophone Adults Day Program services in Durham region, Cognitive Health Program, etc).
- Encourage the use by seniors of available services offered Health Services Providers capable of offering services in French in the Central East LHIN area.
- Improve access to services in French for Francophones with mental health conditions (e.g. Support the Entity in implementing a Care Continuum of Mental Health for Francophone, and educating the Ethnocultural Francophone Community on Mental Health issues and Awareness

on Stigmas and Taboos regarding Mental Health).

- Encourage the use of resources available to Francophones experiencing mental health issues offered by Health Services Providers offering services in French in the Central East LHIN area.
- Improve access to primary care in French for the Francophone community, by Identifying jointly with the entity, at least one project that contributes to the improvement of access to French primary care services. This includes analysis of existing environment for development of primary care services tailored for the Francophone population of the Central East LHIN.
- Improve the quality of life of people living with chronic illness including diabetes and reduce complications associated with these diseases, by supporting providers with the organization of the second part of the Chronic Disease Self-Management workshops in French where there is a large Francophone Population.
- Develop jointly with the Entity a network of French-speaking peer leaders trained in chronic disease Self-Management.

### **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 personal support worker 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; and
- 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 are 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 continue to be implemented during Fiscal Year 14/15.

Year 1 of the Central East LHIN Integrated Health Services Plan, 2013-16 marked a number of key developments in moving forward with improvements to Health Care for Aboriginal Peoples residing in the Central East LHIN area. These were:

- In March of 2013, the Central East LHIN Board approved the implementation of a Concurrent Disorders Capacity Building Project to be led by a partnership of Four Counties Addictions Services, Nijikiwendidaa Anishnaabekwewag Services Circle, and the Nogojiwanong Friendship Centre to build the capacity of both on and off reserve Aboriginal Health Service Providers.
- In May of 2013, the Central East LHIN Board approved a Motion requiring all Health Service Providers receiving funding from the Central East LHIN to demonstrate Cultural Competency in providing health care to Aboriginal Communities.
- Meetings were held throughout May, June and July at the Curve Lake First Nation with Mental Health and Addictions Service Providers to discuss ways of dealing with growing suicide attempts in the community.
- In June of 2013, all Central East LHIN Board and Staff Members attended a full day Cultural Competency Training with Kelly Brownbill at the Alderville First Nation.
- In August of 2013, Cancer Care Ontario hired their first Aboriginal Navigator with the support of The Central East LHIN First Nations Health Advisory Network.
- In October of 2013, the Central East LHIN Board approved a partnership proposal between the Victorian Order of Nurses and the Curve Lake First Nation to provide an Adult Day Program on site.
- In December of 2013, the Alderville First Nation signed a Memorandum of Understanding with the Central East CCAC following a facilitated process supported by Central East LHIN staff.
- In December of 2013, a full day meeting was held between members of both Central East LHIN Aboriginal Health Advisory Circle and Mental Health and Addictions Health Service Providers to build competency and further joint planning initiatives.
- OTN machines were installed at the Alderville First Nation and the Curve Lake First Nation in Fiscal Year 13/14
- Many local hospitals have initiated the process of reaching out to their Aboriginal Communities in order to develop internal Cultural Competency. The Peterborough Regional Health Centre Senior Management held meetings with both the Alderville and Curve Lake First Nations to discuss service improvements.
- A link was established between the Central East LHIN Aboriginal Health Advisory Circles and the Central East Palliative Care Network.

The Central East LHIN plans to build on these successes during Fiscal Year 14/15 in the following areas:

- The development of criteria to monitor Health Service Provider compliance with the Cultural Competency Motion;
- The inclusion of the Motion in the SAA process;

- Additional Memoranda of Understanding are planned for each of the remaining First Nations;
- Follow up meetings with Mental Health and Addictions Providers are planned; and
- The Palliative Care Network will continue to include Aboriginal Stakeholder feedback in its planning and program development.

## **Health System Design and Integration: Other Programs**

### **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); and
- 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

Central East LHIN OTN Activity:

As of January 2014, 17.5 FTE of the 20 FTE (9.75 FTE RN and 10.25 FTE RPN) telemedicine nurses were in place across the Central East LHIN. As of Q3 2013-14 the Central East LHIN sites have conducted over 13,000 clinical events – surpassing the MOHLTC target of 10,050.

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.

The Central East LHIN has engaged the Community of Practice (Telemedicine Nurses and sites) in Central East LHIN to initiate a review of the opportunities and challenges with respect to telemedicine within the LHIN. Objectives of this review include – full deployment of nurses; equitable distribution of event/access across the LHIN, best practice uptake within various clinical practice areas and aligned to Strategic IHSP Aims and extension of support to non-nurse sites. An interim report will be provided to the

LHIN Board in March with a Strategic Planning session planned for May with the Community of Practice.

OTN Equipment Investments:

- In 2013-14 the Central East LHIN did not invest in additional OTN equipment

### Emergency Preparedness

As part of recovery phase for the 2009 H1N1 pandemic, the Ministry of Health and Long-Term Care (MOHLTC) led a review process to identify opportunities to strengthen emergency response processes and plans. Three provincial reports were issued to document lessons learned from the 2009 H1N1 pandemic in Ontario and all three reports identified the need to formalize the roles and responsibilities of Local Health Integration Networks (LHINs) during an emergency. Also the 2010-2012 LHIN Performance Agreement includes a new provision directing that "both parties (MOHLTC & LHINs) jointly develop guidelines and/or protocols clarifying roles and responsibilities related to emergency management".

Endorsed by the LHIN CEOs in September 2013, the LHINs are now working with the Ministry to operationalize the LHIN emergency management role which is intended to support the local health care system to prepare for, respond to and recover from emergency events. The focus of LHIN emergency response activities is capacity management and to ensure facilities funded under the LHIN structure can continue to deliver health care services.

With no new resources identified to support this responsibility, the Central East LHIN is creating an internal team supported by Communications and Planning, to develop and implement this role.

### Goal(s):

To improve the quality of client care, performance of the local health system and system sustainability

### Consistency with Government Priorities:

- Action Plan for Health
- Health System Funding Reform (HSFR): The Ministry of Health and Long-Term Care has asked the LHIN to develop and implement volume management strategies, and regional service plan strategies (e.g., Stroke, Vision, Orthopedics) to support HSFR Implementation
- ED Pay for Results Program
- Health Links
- Integration as defined by the *Local Health System Integration Act*
- Small Rural and Northern Hospitals Transformation Initiative
- Critical Care Life and Limb Policy
- Ontario's Emergency Preparedness planning and policy

### Action Plans/Interventions:

| Action Plans                                                                              |             |    |          |    |               |   |
|-------------------------------------------------------------------------------------------|-------------|----|----------|----|---------------|---|
|                                                                                           | 2014/15     |    | 2015/16  |    | 2016/17       |   |
|                                                                                           | Status      | %  | Status   | %  | Status        | % |
| <b>Health Links</b><br>Plan and implement seven Health Links across the Central East LHIN | In progress | 50 | Continue | 50 | Sustain gains | - |

|                                                                                                                                                                                                                                                          |                                         |     |                                  |    |             |    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----|----------------------------------|----|-------------|----|
| <b>CHS Integration Strategy</b>                                                                                                                                                                                                                          | In progress, and complete by March 2015 | 40  | Implementation Steps as required | -  |             | -  |
| <b>Hospital Regional Program Service Agreements</b><br>Finalize Service Agreements with respective hospitals (Vascular Surgery) implement and monitor                                                                                                    | Complete                                | 100 | Monitor                          | -  | Monitor     | -  |
| <b>Implement Provincial Life and Limb Policy</b><br>Policy implementation including (a.) ensuring compliance with hospital use of the Critical care service; (b.) updating hospital mild and LHIN moderate surge plans.                                  | Complete                                | 100 | Monitor                          | -  | Monitor     | -  |
| <b>Central East LHIN Advanced Centre for Maternal and Newborn Paediatric Services</b><br>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         | 40  | In Progress                      | 20 | In Progress | 40 |
| <b>Regional Delivery Model for In-Patient Adolescent Mental Health and Addiction Services</b><br>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         | 40  | Implementation planning          | 60 |             | -  |
| <b>Explore Technology Solutions to Enable Better Patient Care</b><br>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 | -  |
| <b>How will we measure success?</b>                                                                                                                                                                                                                      |                                         |     |                                  |    |             |    |
| <ul style="list-style-type: none"> <li>• Wait times for Cardiac and Vascular Services</li> <li>• Program Specific Service and Quality Volumes (Cardiac, Vascular, Thoracic)</li> </ul>                                                                   |                                         |     |                                  |    |             |    |

- % 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 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
- Critical
- 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |             |     |             |    |         |   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----|-------------|----|---------|---|
| <b>Electronic Health:</b> Integrated Electronic Health Record Strategy and Roadmap for Implementation                                                                                                                                                                                                                                                                                                                                                                                                          |             |     |             |    |         |   |
| IHSP Enabler Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |             |     |             |    |         |   |
| <p>The Electronic Health Record Strategy establishes the priority areas of Information Management for the 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. Once completed, the strategy needs to be translated into a roadmap that guides the implementation and success of the strategy in the region to 2017.</p>                 |             |     |             |    |         |   |
| Current Status:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |             |     |             |    |         |   |
| <p>The strategy was developed and completed as part of the Central Ontario Cluster (6 LHIN partnership) in 2012. It was presented to the Central East LHIN CEO and 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. The next stage is underway to develop the roadmap including projects in progress from 2013 – 2017.</p>                                                  |             |     |             |    |         |   |
| Goal(s):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |             |     |             |    |         |   |
| <p>Utilize the <i>Electronic Health System Strategy</i> to completion of a subsequent <i>Roadmap to Implementation</i> to inform at the LHIN level, the multitude of existing local, cluster based and provincial initiatives and collaborations. The strategy will ensure effective integration and collaboration, minimize duplication, leverage existing assets; processes and best practices to provide best value for the patient / clients and best value for dollar spent in the Central East LHIN.</p> |             |     |             |    |         |   |
| Action Plans/Interventions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             |     |             |    |         |   |
| Action Plans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2014/15     |     | 2015/16     |    | 2016/17 |   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Status      | %   | Status      | %  | Status  | % |
| Update Communication Plan derived from the eHealth system strategy to increase awareness and understanding of the LHIN strategy and its alignment to the IHSP 2013-2017 and cluster strategy                                                                                                                                                                                                                                                                                                                   | Not started | 100 | Monitor     | -  | Monitor | - |
| Develop Implementation Roadmap for eHealth Strategy to provide guidance and alignment to the IHSP and cluster strategy                                                                                                                                                                                                                                                                                                                                                                                         | Not started | 100 | Monitor     | -  | Monitor | - |
| Planning:<br>1. Work with the cluster and the                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | In progress | 80  | In progress | 20 | Monitor | - |

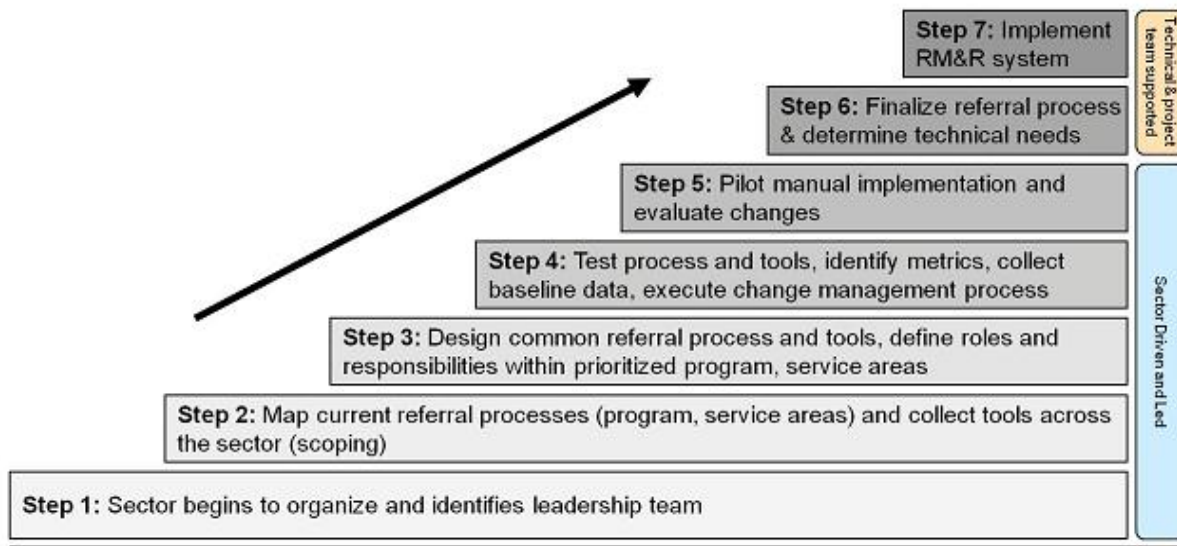
|                                                                                                                                                                                                                                                                    |             |     |             |    |             |   |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----|-------------|----|-------------|---|--|
| Provincial agencies to complete development of detailed plans for implementation within the LHINs                                                                                                                                                                  |             |     |             |    |             |   |  |
| Planning:<br>2. Work with the cluster to complete and implement the approach for shared cluster priorities (e.g. IM Strategy)                                                                                                                                      | In progress | 100 | Monitor     | -  | Monitor     | - |  |
| Planning:<br>3. Develop current state of infrastructure and assets with the LHIN and cluster to determine future planning and collaboration (i.e. utilizing or sharing of assets, consolidation of applications etc.) and the related gap analysis                 | Not started | 75  | In progress | 20 | Not started | 5 |  |
| Planning:<br>4. Develop vision and principles for eHealth and hospitals for the Central East LHIN towards achieving high HIMMS scores and high availability in privacy, security and interconnectivity to participate and implement provincial roadmap initiatives | Not started | 80  | In progress | 20 | Monitor     | - |  |
| Planning:<br>5. Identify any major initiatives that require new funding and develop business cases                                                                                                                                                                 | In progress | 100 | Monitor     | -  | Monitor     | - |  |
| Planning:<br>6. Development of process and framework to address issues arising as privacy and security issues to share information between organizations and to develop this as a regional or cluster approach                                                     | In progress | 75  | In progress | 25 | Monitor     | - |  |
| Governance:<br>1. Develop LHIN framework based on review of Terms of reference to better utilize the strategic leadership for Hospitals, Community and clinicians and restructure committees to develop regular planning cycles of eHealth for the region.         | In Progress | 100 | Monitor     | -  | Monitor     | - |  |

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| Governance:<br>2. Work with the Cluster to finalize Decision Making Frameworks and Operating Principles                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | In progress | 100 | Monitor | - | Monitor | - |
| Governance:<br>3. Establish and report on key performance indicators using a balanced scorecard                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | In progress | 100 | Monitor | - | Monitor | - |
| <b>How will we measure success?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |             |     |         |   |         |   |
| <ul style="list-style-type: none"> <li>Completed update of communication plan and improved awareness of eHealth strategy and initiatives within the region according to survey – end of 2014</li> <li>Completed roadmap and approved by CEEC and Board of Directors to implement strategy</li> <li>Formal documentation (business plans and decision making documents) presented as appropriate for new initiatives</li> <li>Completed and approved detailed plans that support and align to the strategy within the clusters</li> <li>Completed vision for eHealth and hospitals based on stakeholder input and approval</li> <li>Completed decision making frameworks and Operating Principles</li> <li>Development of an approach or framework to the sharing of information between multi-sector / multi-organizations with respect to privacy, security</li> <li>Completed Dashboard to provide regular performance indicator using a balanced scorecard</li> </ul> |             |     |         |   |         |   |
| <b>What are the risks/barriers to successful implementation?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |             |     |         |   |         |   |
| <ul style="list-style-type: none"> <li>Lack of consensus for approval on roadmap, initiatives, or detailed plans put forward</li> <li>Initiatives identified under the strategy fails</li> <li>Limited resources</li> <li>Lack of awareness or understanding of the privacy / security issues and constraints; education and approval</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |             |     |         |   |         |   |
| <b>For each risk/barrier, describe the plan to mitigate the risk?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |             |     |         |   |         |   |
| <ul style="list-style-type: none"> <li>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.</li> <li>Ensure dedicated and capable leadership is in place to drive each initiative.</li> <li>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.</li> <li>Use of resources throughout the cluster and province to provide information that will support the framework development for security and privacy related to sharing; work to receive authority and recommendations from provincial authority or larger bodies (i.e. eHealth, MOHLTC, Privacy</li> </ul>           |             |     |         |   |         |   |

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| <p>Commission).</p> <ul style="list-style-type: none"> <li>• Utilize formal project management processes and tools to minimize and mitigate risks (i.e. initial risk planning, monitoring and change control).</li> <li>• 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.</li> </ul>                                                                                                                                                                                                                                                                                               |
| <p><b>What are some of the key enablers that would allow us to achieve our goal?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <ul style="list-style-type: none"> <li>• Key supporting processes that must be in place to ensure success in both implementation and adoption</li> <li>• Use of formal and standard toolsets such as project management or Change Management to guide these supporting practices: Governance, Change, and Sustainability Models are closely related and have key points of overlap</li> <li>• Use of Communication tools on a regular basis for both inputs and output to ensure the initiatives and adoption are well and correctly monitored and managed</li> <li>• Principles of collaboration for technology that will guide collaboration and integration; developed out of the restructuring and framework for committees</li> </ul> |

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| <b>IHSP Enabler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Transitions:</b> Resource Matching and Referral (RM&R)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>IHSP Enabler Description</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <p>Technology enablers are critical to support patient transitions between organizations and the required information flow; including data capture and connectivity for transitions and between providers. For example <a href="#">Resource Matching and Referral (RM&amp;R) and related Assessment and Business tools</a> are considered a critical technology enabler to manage patient flow between sectors and organizations.</p> <p>The ALC RM&amp;R program 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 by providing access to information such as which providers provide what support, wait times, increased collaboration, standardized referrals and a shared commitment to project success, ALC RM&amp;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.</p> <p>The initial implementation of the Provincial RM&amp;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:</p> <ul style="list-style-type: none"> <li>• Acute (Medical and Surgical Inpatient) sending referrals to Rehabilitation</li> <li>• Acute (Medical and Surgical Inpatient) sending referrals to Complex Continuing Care (CCC)</li> <li>• Acute (Medical and Surgical Inpatient) sending referrals to Long-Term Care through CCAC</li> <li>• Acute (Medical and Surgical Inpatient) sending referrals to CCAC In-Home Services</li> </ul> <p>ALC RM&amp;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.</p> |
| <b>Current Status</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <p>The RM&amp;R solution is being implemented provincially and all the LHINs. LHINs now divided into three clusters (Central East LHIN is in the Central Ontario Cluster with 5 other LHINs) are working through a seven-step model developed by the Toronto Central LHIN. Beginning in 2011, this process began with development of the model, and each LHIN has been working to complete to stage 7 (see diagram below).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

## Resource Matching & Referral 7-Step Model



RM&R is, once complete, 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 phase for 2012-2013 (Phase 5) of the project is to standardize and streamline referrals in preparation for the implementation of electronic RM&R solutions. 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.

Each of the three clusters is leading the work on a care pathway. The Central Ontario cluster which includes the Central East LHIN is working to develop the standards and implementation of Acute to CCAC to Long Term Care as this cluster has already had significant development in the LTC pathway in existing RM&R solutions). 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.

In 2013 work was undertaken to implement this pathway in the Central East LHIN and also to test the standards developed for the Acute to Complex Continuing Care pathway. This pathway is primarily internal to hospitals (i.e. the patient is generally transferred from inpatient to Complex Continuing Care within the same hospital). The pilots undertaken in Central East LHIN were at Ross Memorial Hospital and Peterborough Regional Health and completed with a combination of paper and electronic documentation through Meditech. It was identified that this paper process would not be the final solution and will use lessons learned as a basis to determine the electronic solution.

The Central East LHIN has strongly supported Community Care Information Management (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. It has been identified that there will be no funding provided in 2014-2015 for

electronic implementation of the RM&R solution to the LHINs, and with the requirement to implement these four pathways, the solution is in the planning phase. Next steps will be to identify the appropriate electronic solution that is either already in place and can be utilized with modifications to meet the minimum data set and standards or method to reach stage 7 with other tools.

## Goal(s)

- Improved access and transparency
- Mandatory and standardized referral information for the four pathways identified
- Referral monitoring and tracking
- Reportable data
- Referral pathway specific needs

## Action Plans/Interventions

| Action Plans                                                                                                        | 2014/15          |     | 2015/16     |    | 2016/17     |    |
|---------------------------------------------------------------------------------------------------------------------|------------------|-----|-------------|----|-------------|----|
|                                                                                                                     | Status           | %   | Status      | %  | Status      | %  |
| Communication and education around lessons learned from 2012-13 early implementation pilots                         | Not Started      | 100 | Monitor     | -  | Monitor     | -  |
| Validation of two pathways already implemented electronically to confirm they meet provincial standards and dataset | Not Started      | 100 | Monitor     | -  | Monitor     | -  |
| Detailed planning to implement the remaining pathways according to the provincial requirement                       | Not Started      | 75  | In progress | 25 | Monitor     | -  |
| Implement the future state process for Rehab/CCC in all Central East LHIN hospitals                                 | Note yet started | 100 | Monitor     | -  | Monitor     | -  |
| Implement an automated system for resource matching and referral at Central East LHIN                               | Not yet started  | 20  | In progress | 55 | In progress | 25 |

## How will we measure success?

Successful adoption of the standard referral future core data set across the hospitals will be measured by:

- A reduction in total ALC days. This occurrence drives all other system measures that claim benefit from RM&R including the 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?**

- Ability to find required resources in 2014 to implement the electronic solution for RM&R
- Sustainability
- Competing resources in both Central East LHIN eHealth and hospitals to complete the project

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

- Central East LHIN to reinforce in stakeholder communications, the system stakeholders and health care dollars
- Central East LHIN explicitly link RM&R with Excellent Care for All strategy. This project will ultimately identify gaps in the system and access barriers, thereby improving quality and equity
- Central East 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
- Central East 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
- Central East 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
- Central East 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 Central East LHIN, cluster and Provincial levels
- Address privacy issues early in the planning to ensure PHIPA is followed

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| <b>IHSP Enabler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <p><b>Transitions and Electronic Health:</b> Continue to drive delivery of <a href="#">Timely Discharge Information System (TDIS)</a>, a tool that is used to exchange information within the Primary Care system, and implement the Provincial tool <a href="#">Hospital Report Manager (HRM)</a> within the region.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>IHSP Enabler Description</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <p>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.</p> <p>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.</p> <p>Hospital Report Manager (HRM) is the equivalent application to TDIS and was initiated by Ontario MD (OMD). This has become the provincial standard and all transfer from acute to primary care systems will be migrated over time to this system. HRM is based upon the Rhapsody interface engine (the standard currently used for provincial health initiatives) and is integrated with the Cluster 2 Health Information Access Layer (HIAL) and repository; connecting GTA (CGTA). It will route all transcribed and generated reports from the CGTA project, which includes hospitals, Community Care Access Centre, EMRs, Long Term Care and attached repositories including Ontario Laboratory Information Systems (OLIS) to the primary care electronic medical system.</p>                                                                                                                                                                 |
| <b>Current Status</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p>TDIS has been implemented for several years with all hospitals capable of connectivity to TDIS to provide hospitals reports. Currently the specifications for the Ross Memorial Hospital connection have been upgraded to provide a correction to the format of reports in 2013. Also, Ontario Shores is now working to implement fully both the fax and routing method to complete all 9 hospitals utilizing the TDIS system.</p> <p>Currently there are 550+ physicians using and integrated with TDIS to automatically transfer hospital reports to registered physicians within the Central East LHIN. With a renewed call to connectivity in 2013, there are two additional vendors who have come on board and several new physicians.</p> <p>HRM has successfully implemented their system into the CGTA system and in 2013 had begun planning for full implementation across the province. As Central East LHIN already has an information transfer system, Ontario MD reviewed and identified approximately 300 physicians not on TDIS that have EMRs that are capable to connect to HRM. Initial implementation of 4 hospitals and 300 physicians has begun and expected to be completed by April 2014.</p> <p>As part of this implementation, a plan to align both systems and an eventual migration for all physicians will be developed to completion over a 2-3 year plan. In addition, to continue to leverage the assets of TDIS already in place, an improvement plan to improve the system and "keep the lights on" updates as required. The intention is to utilize this asset as physicians are transitioned to HRM for other transfer needs.</p> |
| <b>Goal(s)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <ol style="list-style-type: none"> <li>1. Enable patient care throughout the care provider continuum through 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-</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

making and better care planning.

2. Support and engagement of physicians including primary and specialists in use of eHealth and provincial, cluster and LHIN assets including CGTA, OLIS etc.
3. Improve the TDIS system in registration, delivery and monitoring of the system and determine further uses for the system (i.e. transfer of information between new pathways to support initiatives such as Health Links).
4. Implement the HRM system in the Central East LHIN to a maximum of 4 hospitals and 300 physicians.
5. Complete an alignment plan for transition of TDIS using physicians to HRM.
6. Provide reporting on usage, types of reports and issues or challenges to the system and users on a regular basis to stakeholders based on their requirements

**Action Plans/Interventions:**

| Action Plans                                                                                                                                                                                   | 2014/15     |     | 2015/16     |    | 2016/17     |    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----|-------------|----|-------------|----|
|                                                                                                                                                                                                | Status      | %   | Status      | %  | Status      | %  |
| Work with Ontario MD (OMD) and E-Health Ontario (eHO) to increase EMR adoption within the Central East LHIN for those not currently on approved EMR and at the required level for HRM adoption | In progress | 60  | In progress | 20 | In progress | 20 |
| Review and develop processes to improve registration process (i.e. automation) for the TDIS system                                                                                             | Not started | 100 | Monitor     | -  | Monitor     | -  |
| Implement improvements to TDIS to “keep the lights on” including upgrades, monitoring and fully implementation and fixes to RMH and Ontario Shores systems                                     | Not started | 100 | Monitor     | -  | Monitor     | -  |
| Develop utilization plan and implement for use of TDIS between new pathways to support current initiatives including Health Links                                                              | In progress | 100 | Monitor     | -  | Monitor     | -  |
| Implementation of HRM in the Central East LHIN                                                                                                                                                 | In progress | 50  | In progress | 30 | Monitor     | 20 |
| Implementation of Alignment plan for transition of physicians from TDIS to HRM to utilize provincial assets                                                                                    | Not Started | 50  | In progress | 30 | In progress | 20 |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |             |     |         |   |         |   |
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| Develop and implement regular reporting for HRM and TDIS to stakeholders according to their requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Not Started | 100 | Monitor | - | Monitor | - |
| <b>How will we measure success?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |             |     |         |   |         |   |
| <ul style="list-style-type: none"> <li>Improvement of electronic patient information sharing confirmed through physician approval and satisfaction (reduction of 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).</li> <li>Identification and engagement of all physicians in the Central East LHIN (identification includes those with EMRs and those not using electronic documentation).</li> <li>HRM implementation in the Central East LHIN for all physicians with appropriate EMRs which will provide connection to the cluster and provincial assets such as CGTA, OLIS, CHRIS Etc. to meet the Statement of Work (SOW) requirements from eHealth Ontario.</li> <li>Improvement in registration, connection and monitoring of TDIS system through upgrades, automation and process streamlining through physician and hospital satisfaction and approval of the system.</li> <li>Transition of all physicians to HRM system (they may have concurrent connections of TDIS and HRM if appropriate).</li> </ul> |             |     |         |   |         |   |
| <b>What are the risks/barriers to successful implementation?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |             |     |         |   |         |   |
| <ul style="list-style-type: none"> <li>Obtaining a comprehensive list of all physicians within the Central East LHIN that are eligible to participate in TDIS and HRM and identification of those physicians without EMRs</li> <li>Resources available from physician offices, vendors and hospitals due to competing priorities</li> <li>Resources to properly support the physician community including Ontario MD</li> <li>Identification and use of successful communication channels to the physician community</li> <li>Continued funding for the implementation and continued use of HRM and TDIS</li> <li>Unknown issues and challenges associated with utilizing the TDIS system for other initiatives and pathways both in financial, technical and resources</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                     |             |     |         |   |         |   |
| <b>For each risk/barrier, describe the plan to mitigate the risk?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |             |     |         |   |         |   |
| <ul style="list-style-type: none"> <li>Work closely with other groups such as the OMD, OLIS and CGTA to cross reference physician lists.</li> <li>Develop a method of communication with physicians in the region and utilize the physician advisory group to increase awareness of the eHealth initiatives.</li> <li>Request the LHIN's Physician leads to assist in communication to physicians.</li> <li>Work closely with eHealth Ontario and OMD to ensure continued funding of the initiative through its completion over the three years. This will include regular reporting and updates between LHIN and the agencies and required identification of issues and successes.</li> <li>Early and consistent communication to the physician community and hospital stakeholders to</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                     |             |     |         |   |         |   |

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| <p>address and schedule resources for TDIS updates / HRM implementation to minimize resource competition between initiatives.</p> <ul style="list-style-type: none"> <li>• Formalized planning and documentation (Project management) of the initiatives to ensure process is successful and risks / barriers are minimized (including a risk management and change control plan).</li> <li>• Stakeholder input of the TDIS system use to ensure maximum options available for utilization early and a detailed Cost Benefit Analysis to determine additional pathways.</li> </ul>                                                                         |
| <p><b>What are some of the key enablers that would allow us to achieve our goal?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <ul style="list-style-type: none"> <li>• Physician acceptance and buy in for project goals</li> <li>• An engaged and enthusiastic Physician Champion(s)</li> <li>• Health Records /Information Technology from Hospitals acceptance and buy in of project goals</li> <li>• Appropriate funding for all project components including project management component</li> <li>• Implementation of a shared services agreement for technology components</li> <li>• Reputable experts for governance structures, Privacy Impact Assessments and Threat Risk Assessments</li> <li>• Availability of communications expertise to engage clinical users</li> </ul> |

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| <b>IHSP Enabler</b>                                                                                                                                                                                                                                                                                                                                             |             |     |             |    |             |    |  |
| <b>Electronic Health:</b> Ontario Laboratory Information Systems (OLIS)                                                                                                                                                                                                                                                                                         |             |     |             |    |             |    |  |
| <b>IHSP Enabler Description</b>                                                                                                                                                                                                                                                                                                                                 |             |     |             |    |             |    |  |
| 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. |             |     |             |    |             |    |  |
| <b>Current Status</b>                                                                                                                                                                                                                                                                                                                                           |             |     |             |    |             |    |  |
| 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 an early adopter.                                                                                                                                                                                                                                     |             |     |             |    |             |    |  |
| One hospital is slated for completion by 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.                                                                                                                                                                                                                                                         |             |     |             |    |             |    |  |
| <b>Goal(s)</b>                                                                                                                                                                                                                                                                                                                                                  |             |     |             |    |             |    |  |
| Enable physicians to receive Lab results directly into their EMRs.                                                                                                                                                                                                                                                                                              |             |     |             |    |             |    |  |
| <b>Update</b>                                                                                                                                                                                                                                                                                                                                                   |             |     |             |    |             |    |  |
|                                                                                                                                                                                                                                                                                                                                                                 |             |     |             |    |             |    |  |
| Action Plans                                                                                                                                                                                                                                                                                                                                                    | 2014/15     |     | 2015/16     |    | 2016/17     |    |  |
|                                                                                                                                                                                                                                                                                                                                                                 | Status      | %   | Status      | %  | Status      | %  |  |
| Encourage physicians currently using a certified EMR to upgrade in order to receive Lab results from OLIS promoting funding options and benefits such as access to provincial systems.                                                                                                                                                                          | In progress | 75  | In Progress | 15 | In Progress | 10 |  |
| Work with Ontario MD (OMD) and E-Health Ontario (eHO) to increase EMR adoption within the Central East LHIN                                                                                                                                                                                                                                                     | In progress | 40  | In Progress | 20 | In Progress | 20 |  |
| Work to increase access of OLIS data physicians through the CGTA initiative where EMR is not present (i.e. Web based access)                                                                                                                                                                                                                                    | Not Started | 75  | In Progress | 25 | Monitor     | -  |  |
| Through cGTA Project, hospitals as early adopters are participating                                                                                                                                                                                                                                                                                             | In          | 100 | Monitor     | -  | Monitor     | -  |  |

|                                                                                                                                                                                                                                                                                              |             |     |             |    |         |   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----|-------------|----|---------|---|--|
| in providing data into the OLIS system (The Scarborough Hospital, Rouge Valley Health System) where feeding data will be completed by April 2014 and access to the data with cGTA completion at fall 2014.                                                                                   | progress    |     |             |    |         |   |  |
| Through cGTA Project, hospitals actively participating in providing data into the OLIS system (Ross Memorial, Peterborough Regional, Northumberland, Campbellford, Halliburton) where feeding data will be completed by April 2014 and access to the data with cGTA completion at fall 2014. | In progress | 100 | Monitor     | -  | Monitor | - |  |
| Through View only access with the next wave of the CGTA project, access to larger health organizations not yet connected to OLIS; note that approval from eHO has not been completed thus the organizations approved are not identified at this time (CE LHIN has approx. 5)                 | Not started | 75  | In progress | 25 | Monitor | - |  |

### How will we measure success?

Success will be measured based on the number of physicians having access to lab results.

### What are the risks/barriers to successful implementation?

- Hospital having competing priorities
- eHealth Ontario Funding approval
- Ontario MD funding initiatives renewed
- Physicians not ready to adopt EMR
- Support for physicians to understand and utilize the tools, funds and supports available

### 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
- Work closely with OMD and Physician Peers for support and to encourage adoption; and work closely with LHIN Physician Leads to promote adoption
- Develop a communication strategy to inform physicians of options to access OLIS information

- Utilize cluster to inform and support physician community towards 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
- Communication, engagement and better information available to physicians to improve awareness

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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| <b>IHSP Enabler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Transitions and Electronic Health:</b> Support the development of data definition standards and mapping tools such as the Standardized Discharge Summary Template project.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>IHSP Enabler Description</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p>Participate and contribute at various levels of creating standardization to provide consistency in information sharing and discharge planning process.</p> <p>The Standardized Discharge Summary Template Project involves the Central Ontario Cluster (6 GTA LHINS) in order to provide consistency of information sharing and discharge planning processes within the cluster. This will improve the ability to align with other E-Health and LHIN initiatives within the cluster including:</p> <ul style="list-style-type: none"> <li>• Hospital Report Manager (Ontario MD);</li> <li>• Discharge Summary exchange projects in other LHINS;</li> <li>• Referral and Resource Matching;</li> <li>• E-Health Standards Discharge Summary Specification (2009); and</li> <li>• Connecting GTA.</li> </ul> <p>The eventual solution will be the electronic transition of discharge summary information in a standard data set that can cross multiple sectors and provider groups in electronic processes.</p> |
| <b>Current Status</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p>The Standardized Discharge Summary Template was approved by the GTA Health Information Custodian (HIC) CEOs in 2013. The project goal was to develop a minimal data set to improve communication between healthcare providers to support care transition. The template was utilized in a pilot to validate the data set and with lessons learned possibly undergo minor revisions before broad implementation. St. Michael's Hospital was the lead for the pilot through the end of 2013.</p> <p>A final template and data set has been provided to the Cluster along with lessons learned for planning and implementation within each of the LHINS. Initial discussion and concept planning was begun at the end of the fiscal year 2013 in order to begin the project in 2014/15.</p>                                                                                                                                                                                                                         |
| <b>Goal(s)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <ul style="list-style-type: none"> <li>• Consistency of clinical definition of discharge data elements across the Central East LHIN hospitals</li> <li>• Implementation of the standardized dataset across the Central East LHIN hospitals</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

| Action Plans/Interventions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                 |     |             |    |             |    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----|-------------|----|-------------|----|
| Action Plans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2014/15         |     | 2015/16     |    | 2016/17     |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Status          | %   | Status      | %  | Status      | %  |
| Engage and communicate the findings of the St. Michael's pilot and resulting completion of the standard discharge summary template and data set                                                                                                                                                                                                                                                                                                                                                                                                                     | In progress     | 100 | Monitor     | -- | Monitor     | -- |
| Conduct hospital readiness for implementation either electronically or paper-based discharge summaries                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Not yet started | 100 | Monitor     | -- | Monitor     | -- |
| Plan sequential implementation for the remaining hospitals at the Central East LHIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Not yet started | 50  | In progress | 30 | In progress | 20 |
| Plan and implement electronic implementation of the Standardized Discharge Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Not yet started | 50  | In progress | 30 | In progress | 20 |
| How will we measure success?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                 |     |             |    |             |    |
| <ul style="list-style-type: none"> <li>Hospital adoption of the final discharge summary standard template either manually or electronically</li> <li>Eventual electronic implementation of the template</li> </ul>                                                                                                                                                                                                                                                                                                                                                  |                 |     |             |    |             |    |
| What are the risks/barriers to successful implementation?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                 |     |             |    |             |    |
| <ul style="list-style-type: none"> <li>Agreement of the standards</li> <li>Hospitals having other competing priorities</li> <li>Funding available for changes to automation of discharge summary</li> </ul>                                                                                                                                                                                                                                                                                                                                                         |                 |     |             |    |             |    |
| For each risk/barrier, describe the plan to mitigate the risk?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                 |     |             |    |             |    |
| <ul style="list-style-type: none"> <li>Central East LHIN CEO to endorse the standards within the Central East LHIN based on having gained approvals from the GTA Health Information Collaborative CEOs</li> <li>Communication and awareness provided to CEOs and other stakeholders of the Central East LHIN hospitals to ensure endorsement</li> <li>Approval and endorsement of the standards by hospital CEOs</li> <li>Central East LHIN to provide funding, if appropriate, to offset the potential burden it has on their current limited resources</li> </ul> |                 |     |             |    |             |    |

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| <ul style="list-style-type: none"><li>• Support through Central East LHIN project management for hospitals to ensure successful implementation with minimal change and risk</li><li>• Project management support to ensure implementation success for all hospitals</li></ul>                                                                                                                          |
| <b>What are some of the key enablers that would allow us to achieve our goal?</b>                                                                                                                                                                                                                                                                                                                      |
| <ul style="list-style-type: none"><li>• Hospital CEOs understand the value of consistency in information sharing</li><li>• Central East LHIN CEO advocating to hospital CEOs to adopt</li><li>• Clinical staff to promote the value of standard data set to improve communications between providers</li><li>• Technology infrastructure capable to implement the standard discharge summary</li></ul> |

## **IHSP Enabler: CCT – Coordinated Care Plan Tool**

**Transitions and Electronic Health:** The Coordinated Care Plan Tool (CCT) project is the development and implementation of the tool that is being developed provincially as an integrated care plan to support Health Links in the Central East LHIN.

### **IHSP Enabler Description**

Health Links was initiated in the province in 2012/13 and part of the process was to develop and utilize an integrated care plan. With so many Health Links in place, a request for some direction and standardization was made. The eHealth Transformation office has been afforded this task and looked to using the tool procured as part of the Orion Suite of applications currently used for the provincial Integrated Assessment Repository (IAR) for mental health assessments (Orion's Case Management Tool).

Begun in the summer of 2013, the Transformation Team led by Greg Hein conducted a series of workshops held across the province to gather input from stakeholders on the initial requirements for such a tool. Included in the process were the Ministry of Health, eHealth Ontario, Ontario MD, LHINs, physicians, hospitals, community care and mental health and addictions providers and support.

At the end of the process in December 2013, a set of requirements and initial data set has been identified. Through the end of the fiscal year to April 2014, a series of forums are being held to spread the stakeholder awareness and input to provide a comprehensive dataset. Each LHIN has put forth a request and subsequent list of participants to meet monthly between January and April and review the requirements and dataset:

1. Coordinated Care Plan (CCP) Template
2. Patient Engagement
3. Secure Messaging and Notification
4. Data Migration and Integration

Based on the data gathered, the project team determined that to best provision the tool, the integration of existing system is required (i.e. Demographics must be fed from current system so providers are not re-keying information and validation of data is available). To complete this, the system will not be available to pilot until the fall 2014. In addition, with many Health Links ready and wanting to pilot the template, the opportunity has been provided to implement as a paper based copy and provide feedback and lessons learned to the provincial team. This information will be used along with the forums above to develop the electronic tool for the province.

### **Current Status**

The tool in paper format is available to pilot as of January 2014 and the Peterborough Health Link has agreed to work with this tool. Updated with drop down menus, this tool will be tested and feedback provided to the project team both to ensure the readiness of Health Links in the Central East LHIN to accept the electronic tool, and to provide input to the final CCT.

In addition, to minimize the effort and capture the data electronically, the Central East LHIN along with the CCAC are reviewing the use of the regional SharePoint system to see if the template can be used in electronic (partial) format through a fillable PDF file. This will:

- a) Capture the data electronically for future use and reporting
- b) Provide a centralized environment to access the tool (including versioning and access to all providers)

- c) Through an electronic form, minimize the duplication of data entry and error rates on categories needed for reporting

### Conditions

A number of conditions must be fulfilled for Health Links to pursue one of the above two approaches. Health Links who do so:

- May not use the portion of their funding which is to be dedicated to CCT implementation for the interim electronic system
- Must have their interim electronic system in place and being used before June 2014
- Must not impact their CCT readiness (as defined in the CCT readiness criteria) by undertaking the interim electronic system
- Must abide by a number of privacy best practices, including:
  - Full compliance with the *Personal Health Information Protect Act*
  - Following Canada Health Infoway's security requirements for hosting environments (will likely restrict hosting to a health service provider with an existing environment)
  - Ensuring that role-based access is configured to respect the privacy model that the Health Link agrees to
  - Ensuring that adequate mechanisms and processes are in place to audit user access to coordinated care plans
  - Ensuring a Privacy Impact Assessment (PIA) and Threat Risk Assessment (TRA) exist on the interim electronic system to be used for sharing coordinated care plans
- Must agree to participate fully in the focus groups, fulfilling all of the "roles and responsibilities" noted above
- Must abide by *Broader Public Sector Accountability Act* for procurement where applicable
- Agree that the use of the interim electronic system for coordinated care planning will be stopped once the CCT is implemented in their Health Link, and that:
  - A plan is developed to migrate data from the interim solution to the CCT
  - The personal health information maintained in the interim electronic system will be disposed of in compliance with the health information custodian's Personal Health Information Protection Act (PHIPA) requirements

The Regional SharePoint site housed at the Peterborough CCAC is reviewing the conditions to determine additional requirements. The PIA will be required as this is a new application and if viable will be developed to utilize this electronic option.

### Goal(s)

- Develop and use of current template for CCT in pilot form (either paper or partial electronic) as participation in the CCT by the Health Links in the Central East LHIN. This includes regular updates to the project team on use, issues and recommendations
- Evaluate the use of the SharePoint electronic tool as an interim step to the CCT tool
- If viable, develop and use of the SharePoint electronic interim solution

| Action Plans/Interventions                                                                                                                                                                                                                                                                                                                    |             |     |             |    |             |    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----|-------------|----|-------------|----|
| Action Plans                                                                                                                                                                                                                                                                                                                                  | 2014/15     |     | 2015/16     |    | 2016/17     |    |
|                                                                                                                                                                                                                                                                                                                                               | Status      | %   | Status      | %  | Status      | %  |
| Determine the use of SharePoint and electronic version of the tool as interim system                                                                                                                                                                                                                                                          | In progress | 100 | Monitor     | -  | Monitor     | -  |
| Complete electronic form and SP list work and workflow including access                                                                                                                                                                                                                                                                       | Not started | 100 | Monitor     | -  | Monitor     | -  |
| Participate in the CCT interim use including Feedback and input to the Project Team                                                                                                                                                                                                                                                           | Not started | 100 | Monitor     | -  | Monitor     | -  |
| Organization readiness to use the CCT tool (i.e. data integration and infrastructure identification and preparation                                                                                                                                                                                                                           | Not Started | 50  | In Progress | 50 | Monitor     | -  |
| Implementation of CCT Tool                                                                                                                                                                                                                                                                                                                    | Not Started | 25  | In Progress | 60 | In Progress | 15 |
| How will we measure success?                                                                                                                                                                                                                                                                                                                  |             |     |             |    |             |    |
| <ul style="list-style-type: none"> <li>Utilization of tool in pilot as readiness for Electronic CCT</li> <li>Implementation of electronic tool as early adopter (2014) for Health Links</li> <li>Number of providers accessing the CCT</li> <li>Satisfaction of providers using the tool (both for interim solution and final CCT)</li> </ul> |             |     |             |    |             |    |
| What are the risks/barriers to successful implementation?                                                                                                                                                                                                                                                                                     |             |     |             |    |             |    |
| <ul style="list-style-type: none"> <li>Resistance to use of a comprehensive tool (more info than previous captured)</li> <li>Agreement to trial the tools</li> <li>Meeting of the conditions to use the SharePoint system and electronic tool (interim)</li> <li>Integration challenges to supply the final CCT with source data</li> </ul>   |             |     |             |    |             |    |
| For each risk/barrier, describe the plan to mitigate the risk?                                                                                                                                                                                                                                                                                |             |     |             |    |             |    |
| <ul style="list-style-type: none"> <li>Develop awareness and communication to stakeholders</li> <li>Provide education on use of the tool and clear expectations on feedback and input</li> <li>Funding to complete the conditions to use the SharePoint site and interim electronic tool</li> </ul>                                           |             |     |             |    |             |    |

- Engage and develop planning early on the integration requirements with stakeholders (hospitals, FHTs, organizations etc.) Using project management processes to identify and mitigate the requirements for integration (i.e. Risk plan, alignment with current initiatives and project support)

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

- Health Links stakeholders acceptance and buy in for project goals
- Appropriate funding for all project components including project management component
- Implementation of a Data Sharing agreement for technology components
- Identified champions in each provider sector
- Successful Privacy Impact Assessments and Threat Risk Assessments
- Regular and strong communications tools build awareness and inform / engage users

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
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| <b>IHSP Enabler: Transitions in Care and Electronic Health Information Management</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Transitions and Electronic Health:</b> Support the adoption of EMRs with Central East physicians and connectivity to the provincial initiatives that support the spread of the patient health electronic records.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>IHSP Enabler Description</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| To support the physician community in the Central East LHIN, the eHealth program will provide awareness, communication and support to improve and spread electronic EMR adoption and related electronic tools to physicians within the region.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Current Status</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| There are approximately 2000 physicians in the region with the split of approx. 55% as primary care and the rest as specialists. Of this family practice, there are 248 that have received funding for the electronic EMR program (PCIT); thus there is an opportunity in the Central East LHIN to work with approximately 750 primary care and 525 specialists to support their implementation of an electronic documentation solution within their practice. There is also a percentage of the 248 of physicians that have implemented the connection to the Ontario Laboratory Information Systems (OLIS) system and receive the lab results into their EMR electronically.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Goal(s)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <ol style="list-style-type: none"> <li>1. Develop a method to define the physician community (i.e. names, contact and geographic information), specifically those that are not captured through EMR funding.</li> <li>2. Engage those physicians not participating and using electronic systems (i.e EMR) and support in last round of participation in EMR funding through Ontario MD.</li> <li>3. Improve the adoption of provincial electronic tools for physicians through engagement, support in coordination etc. including: <ul style="list-style-type: none"> <li>o Making use of the EMR funding window by Ontario MD</li> <li>o OLIS access to the EMR</li> <li>o CGTA Connectivity</li> <li>o Intake and referrals</li> <li>o HRM and TDIS</li> <li>o Connectivity to the provincial CCT (coordinated care tool)</li> <li>o Proposed project for Physician Credentialing</li> </ul> </li> <li>4. To participate with OMD and eHealth Ontario in a pilot testing of physicians with EMRs to utilize an automated practice query from OLIS that will update the OLIS information automatically (in the background) into their EMR. The goal is to locate 2-4 physicians or practices that already use the on demand OLIS query and 2-4 physicians / groups that are new EMR implementations.</li> </ol> |

| Action Plans/Interventions                                                                                                                                                                                                                                                                                                                                 |                 |     |             |    |             |    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----|-------------|----|-------------|----|
| Action Plans                                                                                                                                                                                                                                                                                                                                               | 2014/15         |     | 2015/16     |    | 2016/17     |    |
|                                                                                                                                                                                                                                                                                                                                                            | Status          | %   | Status      | %  | Status      | %  |
| Develop a method to identify and communicate with the physician community in the Central East LHIN                                                                                                                                                                                                                                                         | Not Started     | 100 | Monitor     | -  | Monitor     | -  |
| Planning and formal project to engage non-EMR physicians including non-privileged physicians to build awareness and support their adoption of physicians electronic tools                                                                                                                                                                                  | Not yet started | 50  | In progress | 25 | In progress | 25 |
| Through additional projects, engage and communicate to physicians the opportunity for adoption of provincial electronic solutions                                                                                                                                                                                                                          | Not yet started | 100 | Monitor     | -  | Monitor     | -  |
| Project planning and documentation for each of the adoption tools and measurement/ tracking of adoption for specifically HRM, OLIS, TDIS and cGTA                                                                                                                                                                                                          | Not yet started | 100 | Monitor     | -  | Monitor     | -  |
| Engagement and communication to identify the potential EMR / Physicians that would participate in the automated practice query pilot with OMD and eHealth Ontario                                                                                                                                                                                          | Not yet started | 100 |             | -  |             | -  |
| Along with the planning and engagement of non-EMR physicians, to include in project planning the connectivity to the OLIS system providing on demand OLIS data into the EMR                                                                                                                                                                                | Not Yet Started | 100 |             | -  |             | -  |
| How will we measure success?                                                                                                                                                                                                                                                                                                                               |                 |     |             |    |             |    |
| <ul style="list-style-type: none"> <li>• Identification of physicians in the region and method of tracking updates</li> <li>• Feedback by physician community on engagement and communication methods – building of awareness</li> <li>• Participation % met of adoption of provincial initiatives including EMR, OLIS and automated OLIS query</li> </ul> |                 |     |             |    |             |    |

| <b>What are the risks/barriers to successful implementation?</b>                                                                                                                                                                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Difficulty identifying appropriate physicians</li> <li>• Engagement and participation on programs with physicians</li> <li>• Support and follow-up along with Ontario MD and ehealth to support implementation to completion</li> <li>• Potential funding and resource constraints for participation</li> </ul> |
| <b>For each risk/barrier, describe the plan to mitigate the risk?</b>                                                                                                                                                                                                                                                                                    |
| <ul style="list-style-type: none"> <li>• Survey and data gathering from Ontario College and Health Force to identify physicians and determine the tracking method</li> <li>• Look to support from Health Force, physician champions and regional advisory council to support and engage physicians</li> </ul>                                            |
| <b>What are some of the key enablers that would allow us to achieve our goal?</b>                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"> <li>• Physician Advisory Council</li> <li>• Communication tools available through Ontario MD, College of Physicians, and Health Force</li> </ul>                                                                                                                                                                      |

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| <b>IHSP Enabler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Electronic Health:</b> Surgical Utilization Booking Management Information Tool (SUBMIT) Continuous Improvements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>IHSP Enabler Description</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <p>SUBMIT is a Central East LHIN funded project that was implemented to provide a regional web-based solution to improve patient Wait List management and Wait Time reporting for surgeons and hospitals in the Central East LHIN. The centralized system, hosted by Lakeridge Health Hospital, provides: a standardized method for wait list management at the surgeon's office; surgical offices with e-booking to the OR systems at any of the hospitals in which they are privileged; patient pre-registration and automated (complex) submission of Wait Times data (open, change and close) without additional data entry. Implemented for 7 surgical hospitals and 350 Surgeons, all booking to the OR is through the system whether wait times are measured or not, providing a standardized method for physicians to report on regional surgical data.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Current Status</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p>The SUBMIT System has been fully implemented for 2 years and is used by all surgeons booking elective surgery through their offices. Hospitals manage and maintain their access list and tables for pre-operative tests and document uploads.</p> <p>There are many portions of the application that are not fully utilized by the stakeholders that would improve the usage and benefits of the system. In addition, there are regular updates to the system by the vendor – Novari Health, which provide bug fixes and enhancements to the system and need to be implemented. There are also other users of the system on a single hospital basis in the cluster who continue to manage and improve their utilization (specifically Southlake, Mackenzie Health, and Stevenson Hospital).</p> <p>In the last year, separation of the reporting capability was implemented with a separate reporting server to minimize the load on procedure transaction processing and prepare for (once the Data Sharing Agreements are in place) to utilize all the data with a crystal reporting or other system.</p> <p>There is a desire to implement several of the enhancements in the system including:</p> <ol style="list-style-type: none"> <li>1) Pre-Op test scheduling from the physician's office</li> <li>2) Full use of hospital protocols to provide recommended tests to the surgeon at time of procedure booking</li> <li>3) Full use of scanning and uploading for support documents to eliminate all paper / fax material</li> <li>4) Improved use of the documentation pre-population system to provide letters of consent, instructions etc. in the offices</li> </ol> <p>In addition, there is an opportunity to partner with eHealth Ontario in a pilot to use the provincial EMPI (provincial patient index) as validation and identification of multiple organizations identifiers with the Novari SUBMIT system.</p> |
| <b>Goal(s)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <p>To improve the utilization of the SUBMIT System in the Central East LHIN includes:</p> <ol style="list-style-type: none"> <li>1) Spread of pre-op appointment scheduling at the surgeon's offices</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

- 2) Full use of hospital protocols to provide recommendations to the surgeon on tests according to the patient profile
- 3) Documentation templates developed to pre-populate with system data for forms provided to the patient such as procedure instructions or dates, or appointment times
- 4) Improved and new reporting capability both in canned reports and adhoc reporting
- 5) Improved interface management through transition over to the Rhapsody interface engine by Novari / organizations
- 6) Explore potential use of the EMPI with Novari (through a project with eHealth Ontario) to validate and provide improved access to patient identifiers in the system

### Action Plans/Interventions

| Action Plans                                                                                                                                                            | 2014/15     |     | 2015/16        |    | 2016/17 |   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----|----------------|----|---------|---|
|                                                                                                                                                                         | Status      | %   | Status         | %  | Status  | % |
| Formal Project planning and coordination and use of the Novari support by eHealth program to formally drive the implementation of the PSS work in each of the hospitals | In Progress | 75  | Implementation | 20 | Monitor | - |
| Administrators inventory of protocols, and updating; and then implementation for use in pre-op testing                                                                  | In progress | 75  | Implementation | 25 | Monitor | - |
| Development of template documentation to utilize at the hospitals (for customization)                                                                                   | Not Started | 100 | Monitor        | -  | Monitor | - |
| Training and Education by Novari and administrators on reporting capabilities                                                                                           | In progress | 90  | Monitor        | 10 | Monitor | - |
| Data Sharing Agreement completed with the organizations to allow for back end reporting tools                                                                           | In progress | 100 | Monitor        | -  | Monitor | - |
| Transition to Rhapsody engine by all organizations including testing and go live                                                                                        | Not Started | 100 | Monitor        | -  | Monitor | - |
| Ehealth / Novari project using EMPI; project planning through approvals and implementation                                                                              | In progress | 100 | Monitor        | -  | Monitor | - |

### How will we measure success?

- 1) Pre-op and surgical booking all at the surgeons offices by 2015
- 2) Reduction in interface blockages by 80% through interface upgrade
- 3) Elimination of paper copy for surgical procedures in both surgeons office and hospitals by 50%

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 4) Reduction in registration effort to check and provide registration to patients with MRNs already through the EMPI project by 50%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>What are the risks/barriers to successful implementation?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <ul style="list-style-type: none"> <li>• Hospital having competing priorities</li> <li>• Resources and consensus to update protocols in the organizations to utilize in test recommendations</li> <li>• Competing resources in both CE LHIN eHealth and hospitals to complete the change management work</li> <li>• EHealth Ontario and organizations approval not completed to proceed with the EMPI project</li> </ul>                                                                                                                                                                                                             |
| <b>For each risk/barrier, describe the plan to mitigate the risk?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <ul style="list-style-type: none"> <li>• Work with the user group to plan in advance and schedule upgrades, projects in sufficient time to avoid resource crunch.</li> <li>• Support by champions and available committees to have protocols updated and approved for use in test recommendations at both the hospital and regional levels.</li> <li>• Support through an overall program of change management in the region to develop tools and expertise for change management.</li> <li>• Detailed discussion and support by Regional CIO to have project approved and funded for implementation of the EMPI project.</li> </ul> |
| <b>What are some of the key enablers that would allow us to achieve our goal?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <ul style="list-style-type: none"> <li>• Physician acceptance and buy in for project goals</li> <li>• Appropriate funding and resources for all project components of planning and implementation</li> <li>• Engaged and enthusiastic Physician Champions</li> <li>• Support and engagement of Hospital leadership</li> </ul>                                                                                                                                                                                                                                                                                                        |

## Quality and Performance Improvement

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>IHSP Enabler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Quality and Safety</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>IHSP Enabler Description</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p>Since 2007, the Central East LHIN Board and staff have been guided by four strategic directions:</p> <ul style="list-style-type: none"> <li>• <i>Fiscal responsibility and organizational health</i>: Resource investments in the Central East LHIN will be fiscally responsible and prudent</li> <li>• <i>Transformational leadership</i>: The LHIN Board will lead the transformation of the health care system into a culture of interdependence</li> <li>• <i>Health service and system integration</i>: Create an integrated system of care that is easily accessed, sustainable and achieves good outcomes</li> <li>• <i>Quality and safety</i>: Health care will be person-centred in safe environments of quality care</li> </ul> <p>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.</p> <p>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.</p>                                                                                                                                                                                      |
| <b>Current Status</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <p>Notable performance on key safety and quality indicators in the Central East LHIN are noted below:</p> <ul style="list-style-type: none"> <li>• Hospitalizations for falls among Long-Term Care Home (LTCH) residents (rate of hospitalizations for falls per 1,000 LTCH residents): Central East LHIN has been below the provincial rate for six of the last eight Quarters up to and including the last reported Quarter - Q3 2012/2013 (6.3 versus 8.3, respectively)</li> <li>• 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 2013/2014 (0.34 versus 0.29, respectively)</li> <li>• Emergency visits for total adverse reaction to drugs (rate per 100,000 population): Central East LHIN rate was lower than the province in Q3 2012/2013 (77.4 versus 81.8, respectively)</li> </ul> <p>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.</p> <p>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.</p> |

### **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 full year (2014/2015) and spreads throughout all long-term care homes. The BSO Design Team will be reconstituted to support spread and sustainability of the gains made in long-term care homes who involved themselves in the first phase of the project. Process and outcome measures have been designed to show impact of behavioural supports in all long-term care homes, including measures for spread and sustainability and as of April 2014, monthly run charts will be complete for participating homes for a time period of over 12 months (12+ measures per home).

### **Senior Friendly Hospital Initiative**

The Senior Friendly Hospital (SFH) Strategy was launched across the LHINs in 2010/2011 as a LHIN high priority project and is focused on enhancing the care and reducing the risk of functional decline of seniors when 'in hospital'. The 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 and sustainability of Behavioural Supports Ontario to all long-term care homes
- Continue to provide introductory quality improvement training to LHIN staff and provider staff working on system planning
- Develop and implement a shared falls prevention strategy
- Enhancement of Senior friendly hospitals initiative and measurement of functional decline and delirium
- 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                                                                                                                                                                                                                                                                                                                                                                                                   |             |    |             |    |           |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                | 2014/15     |    | 2015/16     |    | 2016/17   |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                | Status      | %  | Status      | %  | Status    | %  |
| Introductory and intermediate level training for the Central East LHIN staff in QI and patient engagement methods.                                                                                                                                                                                                                                                                                             | In progress | 40 | In progress | 40 | Completed | 20 |
| Integration of QI tools and methods in HSP initiatives for all sectors.                                                                                                                                                                                                                                                                                                                                        | In progress | 40 | In progress | 30 | Completed | 30 |
| Standardize and develop a repository of CE LHIN quality Improvement toolkits and protocols                                                                                                                                                                                                                                                                                                                     | In progress | 90 | In progress | 5  | Completed | 5  |
| How will we measure success?                                                                                                                                                                                                                                                                                                                                                                                   |             |    |             |    |           |    |
| <ul style="list-style-type: none"> <li>Number of staff training sessions and staff trained</li> <li>Degree to which quality improvement methodology is used in system redesign initiatives</li> <li>Degree to which patient experience is embedded within Health Links planning and implementation</li> <li>Availability of standard QI tools and protocols centrally through the Central East LHIN</li> </ul> |             |    |             |    |           |    |
| What are the risks/barriers to successful implementation?                                                                                                                                                                                                                                                                                                                                                      |             |    |             |    |           |    |
| <ul style="list-style-type: none"> <li>Staff availability for training</li> <li>Ability to fund training costs as needed</li> <li>Participation in surveys/ data collection methods to identify QI and patient engagement uptake</li> <li>Agreement on standard tools and protocols</li> </ul>                                                                                                                 |             |    |             |    |           |    |
| For each risk/barrier, describe the plan to mitigate the risk?                                                                                                                                                                                                                                                                                                                                                 |             |    |             |    |           |    |
| <ul style="list-style-type: none"> <li>Collaborate with Health Quality Ontario in providing training for system planning teams such as Health Links and Behavioural Supports Ontario</li> <li>Provide training in smaller parcels (theory bursts) and online and at convenient times</li> <li>Provide in-house training whenever possible</li> </ul>                                                           |             |    |             |    |           |    |
| What are some of the key enablers that would allow us to achieve our goal?                                                                                                                                                                                                                                                                                                                                     |             |    |             |    |           |    |
| <ul style="list-style-type: none"> <li>Leadership support</li> <li>Staff expertise</li> <li>Facility with Prezi and other presentation software</li> </ul>                                                                                                                                                                                                                                                     |             |    |             |    |           |    |

## Central East LHIN Staffing Plan

| Central East LHIN Staffing Plan (Full-Time Equivalents) |                                                     |                               |                               |                               |
|---------------------------------------------------------|-----------------------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Position Title                                          | 2013/2014<br>Actuals as of<br>March<br>31/2013 FTEs | 2014/2015<br>Forecast<br>FTEs | 2015/2016<br>Forecast<br>FTEs | 2016/2017<br>Forecast<br>FTEs |
| CEO                                                     | 1                                                   | 1                             | 1                             | 1                             |
| Senior Director                                         | 2                                                   | 2                             | 2                             | 2                             |
| Manager/Controller                                      | 1                                                   | 1                             | 1                             | 1                             |
| Team Lead/Lead                                          | 7                                                   | 7                             | 7                             | 7                             |
| Program Manager -eHealth                                | 1                                                   | 1                             | 1                             | 1                             |
| Consultant                                              | 7                                                   | 7                             | 7                             | 7                             |
| Planner                                                 | 4                                                   | 4                             | 4                             | 4                             |
| Improvement Facilitator                                 | 1                                                   | 1                             | 1                             | 1                             |
| Public Affairs                                          | 1                                                   | 1                             | 1                             | 1                             |
| Coordinator                                             | 6                                                   | 6                             | 6                             | 6                             |
| Analyst                                                 | 6                                                   | 6                             | 6                             | 6                             |
| Assistants                                              | 4                                                   | 4                             | 4                             | 4                             |
| Receptionist/Records administrator                      | 1                                                   | 1                             | 1                             | 1                             |
| <b>Total FTEs</b>                                       | <b>42</b>                                           | <b>42</b>                     | <b>42</b>                     | <b>42</b>                     |

## Central East LHIN Operations

| <b>LHIN Operations (\$)</b>                                                    | <b>2013/14 Actuals</b> | <b>2014/15 Allocations</b> | <b>2015/16 Planned Expenses</b> | <b>2016/17 Planned Expenses</b> |
|--------------------------------------------------------------------------------|------------------------|----------------------------|---------------------------------|---------------------------------|
| <b>Operating Funding (excluding initiatives)</b>                               | <b>4,534,130</b>       | <b>4,534,130</b>           | <b>4,534,130</b>                | <b>4,534,130</b>                |
| <b>Initiatives Funding (including E-Health, A&amp;MH, ED, Wait Time, etc.)</b> | <b>1,902,301</b>       | <b>1,872,301</b>           | <b>1,872,301</b>                | <b>1,872,301</b>                |
| <b>Salaries and Wages</b>                                                      | 2,785,836              | 2,785,836                  | 2,785,836                       | 2,785,836                       |
| <b>Employee Benefits</b>                                                       |                        |                            |                                 |                                 |
| HOOPP                                                                          | 278,584                | 278,584                    | 278,584                         | 278,584                         |
| Other Benefits                                                                 | 334,300                | 334,300                    | 334,300                         | 334,300                         |
| <b>Total Employee Benefits</b>                                                 | <b>612,884</b>         | <b>612,884</b>             | <b>612,884</b>                  | <b>612,884</b>                  |
| <b>Transportation and Communication</b>                                        |                        |                            |                                 |                                 |
| Staff Travel                                                                   | 48,400                 | 48,400                     | 48,400                          | 48,400                          |
| Governance Travel                                                              | 30,000                 | 30,000                     | 30,000                          | 30,000                          |
| Communications                                                                 | 40,000                 | 40,000                     | 40,000                          | 40,000                          |
| Others                                                                         | -                      | -                          | -                               | -                               |
| <b>Total Transportation and Communication</b>                                  | <b>118,400</b>         | <b>118,400</b>             | <b>118,400</b>                  | <b>118,400</b>                  |
| <b>Services</b>                                                                |                        |                            |                                 |                                 |
| Accommodation                                                                  | 260,584                | 260,584                    | 260,584                         | 260,584                         |
| Community Engagement                                                           | 24,000                 | 24,000                     | 24,000                          | 24,000                          |
| Advertising                                                                    | 5,000                  | 5,000                      | 5,000                           | 5,000                           |
| Banking                                                                        | 12,000                 | 12,000                     | 12,000                          | 12,000                          |
| Consulting Fees                                                                | 20,075                 | 20,075                     | 20,075                          | 20,075                          |
| Equipment Fees                                                                 | -                      | -                          | -                               | -                               |
| Insurance                                                                      | 12,000                 | 12,000                     | 12,000                          | 12,000                          |
| LSSO Shared Costs                                                              | 340,000                | 340,000                    | 340,000                         | 340,000                         |
| LHIN Collaborative                                                             | 50,000                 | 50,000                     | 50,000                          | 50,000                          |
| Other Meeting Expenses                                                         | 35,000                 | 35,000                     | 35,000                          | 35,000                          |
| Board Chair's Per Diem Expenses                                                | 50,000                 | 50,000                     | 50,000                          | 50,000                          |
| Other Board Members' Per Diem Expenses                                         | 74,000                 | 74,000                     | 74,000                          | 74,000                          |
| Other Governance Costs                                                         | 20,000                 | 20,000                     | 20,000                          | 20,000                          |
| Printing and Translation                                                       | 15,471                 | 15,471                     | 15,471                          | 15,471                          |
| Staff Development                                                              | 43,000                 | 43,000                     | 43,000                          | 43,000                          |
| Other Services                                                                 |                        |                            |                                 |                                 |
| <b>Total Services</b>                                                          | <b>961,130</b>         | <b>961,130</b>             | <b>961,130</b>                  | <b>961,130</b>                  |
| <b>Supplies and Equipment</b>                                                  |                        |                            |                                 |                                 |
| IT Equipment                                                                   | 8,880                  | 8,880                      | 8,880                           | 8,880                           |
| Office Supplies & Purchased Equipment                                          | 37,000                 | 37,000                     | 37,000                          | 37,000                          |
| Other S & E                                                                    |                        |                            | -                               | -                               |
| <b>Total Supplies and Equipment</b>                                            | <b>45,880</b>          | <b>45,880</b>              | <b>45,880</b>                   | <b>45,880</b>                   |
| Capital Expenditures                                                           | 10,000                 | 10,000                     | 10,000                          | 10,000                          |
| <b>LHIN Operations: Total Planned Expense</b>                                  | <b>4,534,130</b>       | <b>4,534,130</b>           | <b>4,534,130</b>                | <b>4,534,130</b>                |
| <b>Annual Funding Target</b>                                                   | <b>6,436,431</b>       | <b>6,406,431</b>           | <b>6,406,431</b>                | <b>6,406,431</b>                |
| <b>Operating Surplus (Shortfall)</b>                                           | <b>-</b>               | <b>-</b>                   | <b>-</b>                        | <b>-</b>                        |

## Integrated Communications Strategy

### Objectives

#### **Business Objective**

The Central East LHIN's 2014-15 Annual Business Plan once again operationalizes the goals contained in the LHIN's 2013-16 "Community First" 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 currently being implemented as part of 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, specifically 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 2014-15 Annual Business Plan. Additionally, this will include:

- Continuing to increase understanding among Central East residents and health care providers of the need for health system transformation;
- Ensuring 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, co-ordinated, effective and efficient services based on funding available and tracking performance against signed accountability agreements;
- Providing accurate and timely information to all audiences.

## 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 continue to 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.
- In the Central East LHIN, our "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.
- This includes achieving aims that will have a positive impact on Seniors, people with Mental Health and Addiction issues, people trying to improve their Vascular Health and individuals and their caregivers requiring Palliative and End-of-Life Care.
- Each LHIN is governed by a nine-member Board of Directors made up of members from the local community. The board makes decisions about health services based on what is important to the community.
- Through an agreement with the Ministry of Health and Long-Term Care, each LHIN must measure how it is performing against a detailed list of requirements that includes looking at access to care and quality of care improvements.
- LHINs work to ensure that every individual, regardless of gender, race, income or social status, has the same access to health care.
- The benefits of LHINs are numerous and proven – they are able to build solutions around people and populations, to be flexible to allow for locally-driven solutions and to engage communities and individuals in health care design and delivery.
- 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

- Central East LHIN Planning Partners (see 7.5)
- 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.
- Continue to 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.

## **Key Messages - Provincial**

Ontario is shifting the focus of its health care system to revolve around the person. We have a plan to ensure Ontarians have access to high quality care and a sustainable health system for years to come. By organizing our system differently and focusing on the medical evidence, we will provide Ontarians with better care and better value for tax dollars.

**Through these changes, we expect to see:**

- Reduced wait times and faster access to family doctors
- Fewer unnecessary visits to the emergency room and re-admissions to hospital
- Patients receiving care at home or in the community instead of in a hospital

**How are we transforming the health care system?**

- Partnering with the sector and enabling them to play an active role in how the system will change.
- Strengthening community agencies to support providers and encourage integration around the patient's needs.
- Health care funding will be determined based on the best evidence and will follow the patient.

**What can we expect from these changes to the healthcare system?**

- A system built for patients by the health care providers and leaders closest to them.
- A health care system that integrates providers around patients to deliver better outcomes.

**Key Messages - Local**

- The Central East 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.
- Current fiscal realities and demographic trends have created a need for transformation.
- 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. To respond, the LHIN is working with our health care partners to address these realities and develop innovative solutions to keep Central East LHIN residents healthy.
- 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; and
- 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 through inclusion of stakeholders involved in the development/implementation or receipt of positive initiatives and outcomes in public communication materials and engagement events.
- 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 2014-15, 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 (see 7.4), 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 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
- Northeast 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
- GAIN Community Team – Advisory and Design Teams
- HPAC – Health Professionals Advisory Committee
- LEAN Community of Practice
- NPSTAT
- Pay for Results Working Group
- RM&R – Resource Matching and Referral
- System Surge Management
- 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
- Health Links Durham North East

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 Northeast (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.

The Central East LHIN's commitment to equity and respect for diversity recognizes the requirements of the French Language Services Act (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). FLS 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.