Central East **LHIN** | **RLISS** du Centre-Est

2015/2016 Annual Business Plan

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

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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JUL 2 4 2015

SENT ELECTRONICALLY

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

Dear Ms. Naylor:

Re: Central East LHIN 2015/16 Annual Business Plan

The Central East Local Health Integration Network (Central East LHIN) is pleased to share its 2015/2016 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 years' 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 Accountability Agreement (MLAA) 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.

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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 prevent avoidable hospitalization and long-term care utilization. Since our inception in 2006, and now in 2015/16, we will continue to work diligently in the achievement of better outcomes for patients, caregivers and our communities.

This document was approved by the Central East LHIN Board of Directors at its June 24, 2015 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
Brian Laundry, Senior Director - System Design & Integration, Central East LHIN
Stewart Sutley, 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, Local Health Integration Networks (LHINs) are striving to create 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 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 *Local Health System Integration Act, 2006* (LHSIA) outlines expectations for an end state, a mature system of planning and health care integration in Ontario. This end state requires careful planning for the creation of transitional programs and processes.

The Integrated Health Service Plan (IHSP) which is to be delivered by each LHIN in the fall of 2015 will be the fourth public presentation of each LHIN's' priorities and strategies for the three-year period starting in April 2016. This 2016/17 – 2019/20 IHSP will recognize earlier planning and implementation work and will continue to define health care system needs and strategies to integrate the local health system. With a strong focus on community engagement and patient experience, the development of the fourth IHSP will include describing the priorities, strategies and proposed outcomes for the local health system. It will reflect local priorities and align with provincial priorities of the Ministry of Health and Long-Term Care (MOHLTC) as described in latest Action Plan for Health Care.

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 innovative Strategic Aims and common enablers that will continue to serve as the aspiration of our health care community for the next year.

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, and also align with the ***Patient First: Action Plan for Health Care*** released February 2015. 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 that the sustainability of our health care system requires us to rethink how we keep people healthy and well in the community in order to prevent avoidable hospitalization and long-term care placement.

A "Community First" approach requires focused and disciplined action to create an integrated community-based health system that is able to proactively 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:

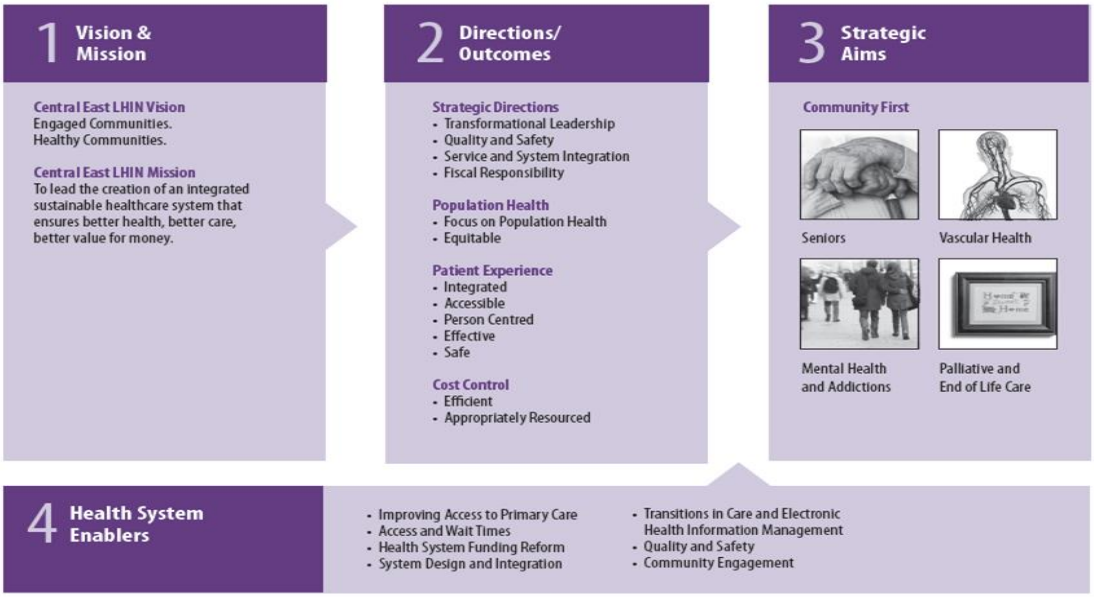
- *Reduce the demand for long-term care so that **seniors** spend 320,000 more days at home in their communities by 2016.*
- *Continue to improve the **vascular health** of residents so they spend 25,000 more days at home in their communities by 2016.*
- *Strengthen the system of supports for people 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 are consistently woven 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 2014/15 MOHLTC/LHIN Performance Agreement (MLPA) targets listed below. These measures will be updated with revised targets from the forthcoming 2015/16 MLPA.

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	12.8%
90th Percentile Emergency Room Length of Stay for Admitted Patients	30
90th Percentile ER Length of Stay for Non-Admitted Complex Patients	6.45
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated Patients	4
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions	17%
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions	22.5%
90th 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	14.8%

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 (eHealth) 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 2015/16 Annual Business Plan are outlined within the *Integrated Communications Strategy (see page 115)* and *Community Engagement (see page 120).*

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 the MOHLTC.

The quarterly Declaration of Compliance involves a very stringent review of the Central East LHIN's compliance with its obligations under the MOHLTC/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 all classified agencies receiving more than $5 million in MOHLTC funding are under a 5% 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 in the *Operations Spending Plan (see page 113)* starting fiscal year (FY) 2014/15 and continues to be included in the planned expenses through FY 2017/18. 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, 2015/16 will be a year in which the Central East LHIN will continue to 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 require participation from patients, providers and organizations across multiple sectors. The Central East LHIN Board has approved the creation of seven Health Links covering the entire

Central East region. Two Health Links have received approval from the Ministry of Health and Long-Term Care – Peterborough and Durham North East – and by the end of Q1 (2015/16), it is expected that the business plans of the five remaining Health Links will have been submitted and possibly approved by the Ministry of Health and Long–Term Care – Northumberland County, Haliburton County - City of Kawartha Lakes, Scarborough North, Scarborough South and Durham West.

- *Home and Community Health Sector, Community Health Services (CHS) Integration, and Small Rural Northern Hospital Transformation Fund (SRNHTF)* – 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. The first phase of the CHS Integration planning and implementation initiatives were completed in the Durham Cluster, Haliburton County/Kawartha Lakes, Northumberland, Scarborough, and Peterborough. The second phase of the CHS Integration focusing on identifying common integration opportunities across various communities and/or sectors will commence in 2015/16. The SRNHTF fund has enabled small and medium size hospital and community integration in the Northeast Cluster of the Central East LHIN.

- *Geriatric Assessment and Intervention Network (GAIN) Regional Programs* – There are four hospital based GAIN clinics located in the four largest hospitals in the Central East LHIN and six community based GAIN teams, which offer comprehensive geriatric assessment and treatment. In FY 2015/16 GAIN will support the evolution of the GAIN community stream into rural communities. GAIN Rural Community teams will be expanding to Haliburton (Haliburton Highlands Health Services) and Trent Hills (Campbellford Memorial Hospital) Communities. The community, and rural community teams 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 linking with primary care and Health Links.

- *Health System Funding Reform (HSFR)* – The Central East LHIN Local Partnership was developed in 2013 to manage change in the HSFR environment and to inform planning as funding models continue to evolve. Some areas of focus for FY 2015/16 include orthopaedics, stroke, congestive heart failure, chronic obstructive pulmonary disease, and vision strategy. The Central East LHIN Local Partnership is aware of new and proposed Quality Based Procedures (QBPs), and will continually assess their relevance as local priorities.

- *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. With the appointment of Dr. Ian Dawe as the Physician Lead for the Central East LHIN Mental Health and Addictions Aim, and the implementation of the Central East LHIN Mental Health and Addictions Coordinating Council in FY 2014/15, these identified priority projects are receiving ongoing oversight. The Hospital to Home Strategy has been expanded to include other key hospitals throughout the LHIN, with full implementation expected in FY 2015/16.

- *Diabetes and Vascular Health Improvement Strategies* – A Vascular Health Strategy has been developed with four overarching areas; enhancing patient/family supports and 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 a Vascular Collaborative – a collaborative strategy led by the Ontario Stroke Network, Cardiac Care Network, and the Ontario Renal Network.

- *Palliative Care* – In 2011, the Central East LHIN committed to work to advance the delivery of palliative care in the province, as documented in *Advancing High Quality, High Value Palliative Care in Ontario: Declaration of Partnership and Commitment to Action*. The Central East LHIN Regional Palliative Care Plan and the IHSP Strategic Aim to "increase the number of palliative

care patients who die at home by choice and spend 12,000 more days in their communities by 2016", both align with this provincial document. One priority that is changing the way palliative care is delivered in Central East LHIN is the implementation of Palliative Care Community Teams. Teams will be implemented over a 3-year phased approach, creating interdisciplinary team-based models providing clinical and non-clinical community-based care to palliative and end of life patients.

- *Housing and Homeless Strategy* – In September 2014 the Central East LHIN Board approved the initiation of a significant strategic partnership with the Central East LHIN and Municipal Service Managers to improve housing and support services for homeless and precariously housed residents across the Central East LHIN. A Housing and Homelessness Framework was developed and approved in February 2015 which identifies guiding principles and a Terms of Reference. These foundational documents will provide the basis for initiation of a joint Steering Committee supporting the Municipal Service Managers in Durham, City of Kawartha Lakes-Haliburton, Northumberland County and the City of Peterborough. Similarly, the Central East LHIN has initiated a partnership with the City of Toronto housing and homelessness teams to focus on Scarborough.
- *Special Needs Strategy* – The Special Needs Strategy announced in February 2014 aims to connect children and youth with special needs to the services they require as early as possible and to improve the service experience of families and children. In November 2014, the Central East LHIN committed to supporting the planning tables in our geographic catchment area to work towards the development of the two Special Needs Strategy proposals: Coordinated Service Planning and Delivery of Rehabilitation Services. Over the course of the next 6 months the Central East LHIN will contribute to the design, planning and proposal development for the Special Needs Strategy to ensure a more coordinated and streamlined delivery of services to families accessing care in the Central East LHIN.

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 is projected to increase by 17%. Ontario's population is expected to increase by 13% 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: 2014-2015	
	Per Central East LHIN ($)
Operation of Hospitals	1,231,015,066
Grants – Municipal Taxation – Public Hospitals	280,275
Grants – Municipal Taxation – Specialty Psychiatric Hospitals	25,425
Long-Term Care Homes	437,367,196
Community Care Access Centre	274,137,192
Community Support Services	47,571,175
Acquired Brain Injury	1,632,344
Assisted Living Services in Supportive Housing	15,224,305
Community Health Centres	28,772,419
Community Mental Health	50,306,781
Addictions Programs	9,449,315
Specialty Psychiatric Hospital	116,062,017
TOTAL HSPs	**2,211,843,510**
LHIN Operations	4,534,130
eHealth	0
LHIN Initiatives	1,936,301
TOTAL Central East LHIN Allocations	**2,218,313,941**

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 the Central East region will greatly assist with local physician supply.
- The MOHLTC has implemented a number of interventions to assist with nurse, physician, and physician assistant supply (recruitment). Examples include introduction of new health care roles

(i.e. Physician Assistants), full implementation of HFO MRA, Health Care Connect, Family Health Teams (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

The CHCs within the LHIN have been successful in recruiting for vacancies. Brock CHC, TAIBU, and the City of Kawartha Lakes have successfully recruited. The developing Pickering Youth Centre – Satellite site (2.2) still maintains a vacancy; however, through integration discussions with the Oshawa CHC 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.

Actions in 2015/16 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.
- CHCs will continue to monitor and take action on the Access to Primary Care indicator within their MSAAs with a goal to reach 85% of their Standardized Adjusted Clinical Groupings (SAMI) score by end of 2016/17.

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 2015/16 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 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

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. As mentioned previously, over 14% of Central East LHIN's population consists of 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.

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

Source: *Intellihealth, 2011 Census*

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

- 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. A total of 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.

The total number of Alternate Level of Care (ALC) days in the Central East LHIN increased from 14,096 days in October 2013 to 14,660 days in October 2014. 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.

As of November 2014, there were 517 patients designated ALC on the waitlist in acute and post-acute care settings. This translates to 93 (22%) more patients on the waitlist compared to November 2013. Specifically, in November 2014 there were 37% more patients waiting in acute care beds, 4% more patients waiting in Complex Continuing Care (CCC) beds, 16% fewer patients waiting in Mental Health (MH) beds, and 120% more patients waiting in Rehab Beds (RB).The highest number of patients designated ALC on the waitlist since July 2011 was on November 30, 2014 (517). Currently, 61% of patients designated ALC are waiting in acute care and 39% are in post-acute care (CCC: 26%, MH: 9%, RB: 4%).

Since the adoption of Home First, 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. On October 27, 2014 Fairview Lodge, a 198-bed Long Term Care (LTC) facility located in Whitby, Durham Region suffered a catastrophic fire. The loss of this 198-bed facility and the net loss of over 80 LTC beds came at a challenging time, especially in the LHIN's Durham cluster, which already has the lowest number of long term care beds per population. Currently, the longest wait time at the median and 90th percentile wait time is for long term care (median wait time of 55 days; 90th percentile wait time of 297 days).

In October 2014, Central East LHIN had the 4th highest (19.5%) ALC rate in the province and had contributed 1.7% to the provincial ALC rate. The highest ALC rate since July 2011 was 19.5% in October 2014. In October 2014, Central East LHIN also had the 4th highest percentage of patient's designated ALC occupying acute care beds (19.1%). For post-acute care, Central East LHIN had the 3rd highest percentage of beds being occupied by patients designated ALC (20.2%).

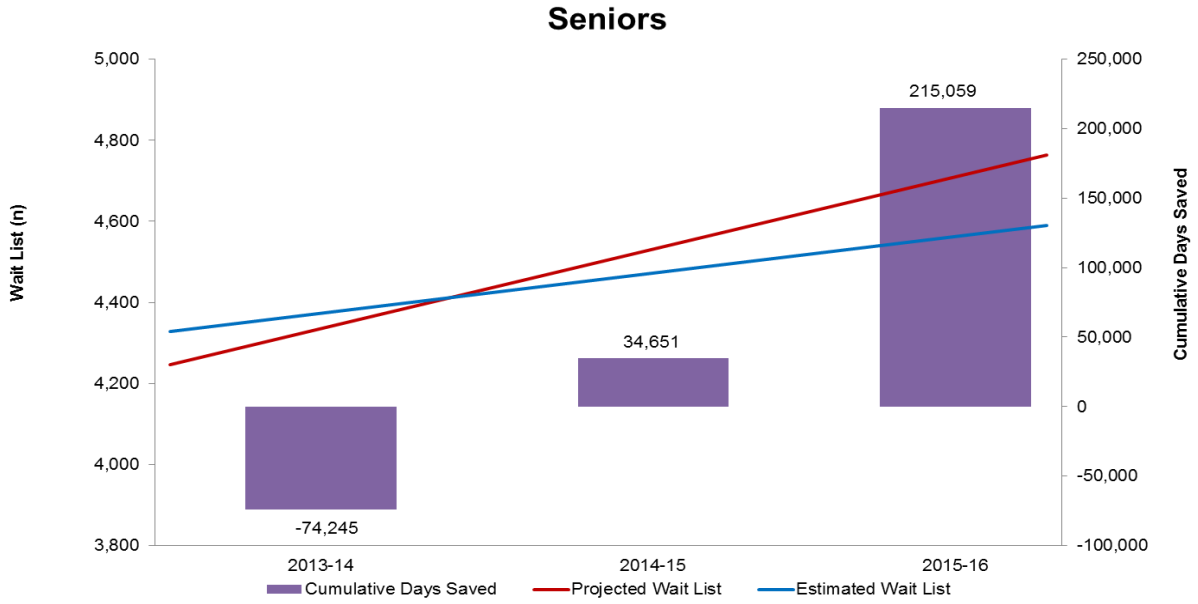
Of the 314 patient's designated ALC waiting in acute care beds as of November 2014, 95% were waiting for their most appropriate discharge destination (MADD). For the four most frequent discharge destinations that patients designated ALC were waiting for in acute care, 97% of patients waiting for long term care, 94% of patients waiting for rehab, 96% of patients waiting for complex continuing care and 100% of patients waiting for convalescent care were appropriately placed.

Of the 203 patient's designated ALC waiting in post-acute care beds as of November 2014, 99% were waiting for their MADD. For the four most frequent discharge destinations that patients designated ALC were waiting for in post-acute care, 98% of patients waiting for long term care, 100% of patients waiting for supervised or assisted living, 100% of patients waiting for complex continuing care and 100% of patients waiting for home with community services were appropriately placed.

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 in over the past years directed towards improving the system and continuum of care for seniors and their caregivers.

These interventions are continuously evaluated for their impact on access to appropriate care. The Central East LHIN recognizes the importance of process improvements and considers the same in designing and developing projects/programs that enhance system effectiveness and efficiencies and “increases overall reliability in care delivery and patient outcomes.”

By 2016, the Central East LHIN aims to reduce the demand for long-term care so that seniors spend 320,000 more days at home in their communities. The graph below highlights our success to-date; as of 2014/15 the Central East LHIN has reduced 34,651 days, with a projection of 215,059 days reduced by 2015/16.



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
- Home and Community Health Sector Review
- CCAC-CSS Regulatory Amendments & Policy
- 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 Guidelines
- 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 Central East LHIN, including Health Links and the Community Health Services Integrations. The focus of activities specific to the Seniors Strategic Aim, are centered on addressing – and where possible – reversing frailty. The key activities are:

- Seniors Care Network (previously named the Central East Regional Specialized Geriatric Services)
- Home First approaches and transitions in care;
- Increasing capacity to support seniors in the community ;
- Senior Friendly Hospitals;
- Assess and Restore;
- Behavioural Supports Ontario;
- Health Links;
- 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) – hospital and community teams.

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 long-term care homes).

The Seniors Care Network (previously Regional Specialized Geriatric Services)

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. In 2014, RSGS went through a re-branding exercise to more effectively communicate the core promise of "value delivered for those who work with the older adults and caregivers we support". Through the re-branding, RSGS became the Seniors Care Network. With its new strategic priorities, directions, and goals, the Seniors Care Network 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.

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 need to be increased proportionally to match 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 of 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.

There are four formal Specialized Geriatric Services (SGS) in the Central East LHIN, including the Geriatric Assessment and Intervention Network (GAIN), Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT), Behavioral Supports Ontario (BSO), and Geriatric Emergency Management (GEM). These specialized services, in addition to the Central East Senior Friendly Hospital Strategy, form the core of SGS activity. The Seniors Care Network is positioned to improve the planning and coordination of all these programs and initiatives.

The Strategic Priorities of the Seniors Care Network are:

- Improve Care
- Foster Excellence
- Increase Awareness

In 2015/16 The Seniors Care Network, along with its core programs and initiatives, will be pursuing the following primary drivers of theses strategic priorities:

Improve Care	Improve Access to Care
	Integrate SGS Service Delivery
	Develop an SGS Human Resource Strategy
Foster Excellence	Develop SGS Clinical Excellence
	Implement a Quality Framework
	SGS Clinical Integration
	Patient Engagement
Improve Awareness	Advocate for the Health of Frail Seniors

Physiotherapy Reform

A major change 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:

Exercise and Falls Prevention Classes

The Central East LHIN has worked 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 was undertaken to identify locations for new and/or expansion sites for classes. An additional round of new and/or expansion classes are expected to be operationalized over FY 2015/16.

Physiotherapy and Exercise in Long-Term Care Homes (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 (LTCH) to help them restore their mobility and function. All LTC homes in the Central East LHIN have either hired physiotherapy staff directly or subcontracted for the service.

In-Home Physiotherapy (CCAC)

In addition to in home services provided by the Community Care Access Centres (CCAC) 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.

Physiotherapy Clinics in the Community

The MOHLTC released a Call for Applications for additional volumes of service in a clinic setting. An episode of care relates to the assessment, diagnosis, treatment, and then discharge/transition for a specific issue. The MOHLTC 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 by the Central East LHIN, were considered in the decision making process in which the LHINs were invited to participate in November 2013. Upon completion of a process of due diligence, the MOHLTC has now identified 24 locations in the Central East LHIN to support the provision of clinic-based physiotherapy services.

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 of 2013 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 MOHLTC. Upon completion of a process of due diligence, the MOHLTC identified Northumberland Family Health Team (NFHT) as an appropriate location. NHFT has begun the implementation of physiotherapy services at their location.

Community Health Services Integration

Please see page 74 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 (see page 19 of this document for the CCAC-CSS Regulatory Amendments & Policy**)**. 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 Emergency Department or upon discharge, 2015/16 will further progress into other patient pathways through the Resource Matching and Referral project, the expansion of Assisted Living Services for High Risk Seniors and the Adult Day program. 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 Central East 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. A LHIN-wide Home First steering committee chaired by the Central East CCAC (CECCAC), with representation from the Central East LHIN, each hospital, each CSS agency, and the CCAC itself continues to monitor Home First. All Alternate Level of Care (ALC) designations are reviewed regularly for appropriateness by the CECCAC in partnership with the Health Service Providers at the Home First meetings. The meetings include CSS, CECCAC and hospitals. 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 MOHLTC 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.

The Resource Matching and Referral (RM&R) initiative is also a significant contributor toward improving patient flow and ensuring the timely and safe return home of every patient (read more about RM&R on page 101 of this document).

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 2015/16.

Assess and Restore

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.
Funding is being provided each year between 2014-2017 on a one time basis to enhance:

- Timely and appropriate access to facility-based Assess and Restore (A&R) interventions
- Appropriate capacity across all the elements of an A&R approach to care and
- Quality of care through the development and dissemination of standards and best practices

The MOHLTC released the provincial Assess and Restore (A&R) Guideline, 2014, which provides guidance and direction to LHINs and health service providers (HSPs) delivering A&R care. In December 2014, the MOHLTC allocated $10.7 M one-time three year targeted funding to Ontario's LHINs to expand A&R capacity and access. The Central East LHIN allocation, each year for three years is $ 1,334,400. Funding is being utilized to fulfill the service delivery roles and responsibilities described under each of the five elements of the Assess and Restore Guideline. The Central East LHIN considered opportunities to build on 2013/14 projects that were particularly meaningful in advancing A&R goals.
The Central East LHIN is focusing on projects that demonstrate accessibility, quality of care, and sustainability. The project will benefit high-risk seniors across the Central East LHIN region.
A system-centered approach for restorative care will:

- Complement 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;
- Assess patients directly in the Emergency Department (ED);
- Prevent acute care admission through clinical support and access to A&R;
- Increase process efficiency for referrals to A&R through improved communications and clinicians' education;
- Rely on comprehensive gerontology assessments, base A&R care on geriatric syndromes;
- Enhance the coordination of care at the point of discharge and build capacity in collaboration with primary care to support continuity of care;
- Use geriatric syndromes in the context of measuring and managing lengths of stay, re-admission rates, patient flow and alternate levels of care rates.

The Central East LHIN has made investments in five hospitals and one community based Assess and Restore project for FY 2014/15. Projects representing an expenditure of $487,225 are focused on expanding capacity in the Central East LHIN. Projects amounting to $1,334,400 are focused on increasing access in four hospitals and one community support service agency for FY 2015/16. A written report on results will be submitted to the MOHLTC in June 2015.

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 ten full-time and two 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 emergency department 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, 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. In 2014, the RRN program focused on increasing the number of referrals to the program and implementing a program component for complex pediatric patients.

Given the significant similarities between the RRN target population and the Health Links population, the RRN program housed at Peterborough Regional Health Centre is piloting a project to develop and implement Coordinated Care Plans for appropriate hospital discharged patients in collaboration with the Peterborough Health Link (PHL). Using a quality improvement methodology, the Health Link will test, change and spread identified improvements with PHL and across Health Links within the Central East LHIN.

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 69 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 2015/16, NPSTAT will continue to advance their participation and leadership in LHIN–funded initiatives including Geriatric Assessment and Intervention Network (GAIN) (see below) and 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. NPSTAT often plays a role in supporting other system level initiatives including GAIN Community Teams and repatriation of residents to Long-Term Care Homes during times of hospital and emergency department surge. In 2015/16, NPSTAT will continue to support residents in Long-Term Care homes from having to make unnecessary visits to emergency departments and to expedite hospital admissions when possible.

CCAC-CSS Regulatory Amendments & Policy Guidelines

The LHINs are leading the provincial implementation of the new policy guidelines and regulatory amendments for Community Care Access Centres (CCAC) and Community Support Service (CSS) agencies in the delivery of personal support services and collaborative care coordination. The project has been identified by LHINs as a key deliverable in alignment with the Home and Community Sector review. This expanded mandate will enhance CSS capacity to provide Personal Support Services (PSS) to

clients who are relatively independent and improve the ability of CCACs to focus on providing PSS to clients with moderate, complex or post-acute needs. The Central East LHIN has reviewed drafts of this guideline with the Central East CCAC (CECCAC) and the Seniors Care Network.

The anticipated overall timeframe for provincial implementation is 2 years, but a phased implementation approach will be used beginning with 3-4 early adopter LHINs to test new processes, standards, and tools, and to generate lessons learned to inform the broader roll out. The Central East LHIN has been identified as an Early Adopter.

Managing this change will require action from the CECCAC at several levels, including sustained commitment as well as cross-sectorial collaboration. We realize that there will be significant work involved, yet are confident that we can collectively take advantage of the work already accomplished in the Central East that has strengthened the coordination of the CCAC and CSS agencies – including Home First, supportive referral coordinators, and the standardization and capacity building of common assessments. We hope that this model will improve access, standardize service delivery, while maintaining the required flexibility to meet client, community, and system needs. The Central East LHIN is participating in provincial early adopter discussions in relation to this implementation and is also conducting discussions and initial planning at the regional level.

Primary Care

Geriatric Assessment and Intervention Network (GAIN)

In 2011, the Central East LHIN established four Geriatric Assessment and Intervention Network Teams 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). In 2014, six new community GAIN teams were established (Peterborough Regional Health Centre, Carefirst, St. Paul's L'Amoreaux Centre, Community Care City of Kawartha Lakes, Port Hope Community Health Centre, Oshawa Community Health Centre). Another two teams were approved late in 2014 in the rural communities of Haliburton and Campbellford.

These specialized geriatric services 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 GAIN program 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. These teams include BSO clinicians and CCAC Care Coordinators to provide intensive case management to eligible clients. GAIN patients may be referred by their primary care provider, other community health professionals, emergency departments (ED) or inpatient units prior to discharge, or self/family referral.

In 2013/14 GAIN (hospital-based teams) received 5352 referrals. As well the GAIN hospital-based teams completed 3456 comprehensive geriatric assessments (CGAs), bringing the total number of CGAs to 9849 since the program began. This is an increase of 4% from 2012/13.

Aligned with Dr. Sinha's recommendations, an important component of the GAIN model 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.

Going forward in FY 2015/16 the program will continue to focus on the development of the GAIN community and rural streams into a comprehensive managed care model or philosophy for the most complex patients that works closely with Primary Care within a Health Link. GAIN Hospital based teams are expanding their roles to support the transition of seniors between acute and community care.

The following principles were identified by the Central East LHIN and adopted by the Seniors Care Network 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 connected 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.

GAIN's priorities for 2015/16 include:

- Standardization of processes
- Development of data & metrics to measure progress
- Development of Service User Groups
- Enhanced communication
- Human resources planning
- Increased relationships with physicians including Primary Care, Geriatricians
- Optimizing the use of E-technology
- Integration with Health Links

In addition, the GAIN program is an important element of Health Links in the Central East LHIN and is represented at the Health Links planning tables.

Geriatric Emergency Management

Geriatric Emergency Management (GEM) nurses provide specialized geriatric emergency management services to frail older adults in the emergency department (ED). The goal of the GEM program is to deliver targeted geriatric assessment to high-risk seniors in the ED and to help senior's access appropriate services and/or resources that will enhance functional status, independence and quality of life. Further, GEM nurses strive to build geriatric and senior-friendly capacity within the hospital through knowledge transfer and education opportunities with staff. GEM nurses are uniquely positioned within an ED to identify and assess at-risk seniors and connect them with services to better meet their health needs. There are a total of nine GEM nurses working at nine hospitals within the Central East LHIN.

Priorities for 2015/16 include:

- Standardizing roles, competencies and assessment approaches
- Strengthening linkages between GEM and other SGS services
- Optimizing the GEM role and exploring spread opportunities

Health Links

Please see page 72 of this document.

Capacity and Funding

Investing in the Community Sector

The primary objective of the 2014/15 community investment is to continue to support accessibility to community based health services for individuals with complex and long-term medical, physical, social and/or cognitive conditions and **allowing them to stay in their home and communities.** The Central East LHIN continues to focus on:

- Better patient outcomes
- Coordination of care
- Enhanced patient flow across the system
- Lower Alternate Level of Care (ALC) readmission rates
- Lower Emergency Department (ED) Length Of Stay (LOS) for admitted patients
- Patient and provider satisfaction

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 investments in the following:

Seniors: Strengthening comprehensive Primary Health Care models for at-risk seniors through new GAIN Community Teams, expansion of Adult Day Programs and Assisted Living Services to helping individuals and their caregivers lead active lives and spend more time in their homes and communities

Mental Health and Addictions: Advance a comprehensive mental health strategy, building on success and including innovations to increase supports within housing

Palliative: Develop Palliative Care Community Teams to support palliative patients to spend more days in their home and community

Vascular: Expand access to Cardiac Rehabilitation and Secondary Prevention to continue to improve the vascular health of residents so they spend fewer days in the hospital

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 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 the Central East LHIN residents living with responsive 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 Central East 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 Central East 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
1. LTCH: Part 1 Action: Continue spread and sustainability throughout all 69 LTCHs	• Improved quality of life and safety in LTCHs • Reductions in senior hospitalizations and ALC days • Sustainability Plan – in place to continue spread and hold senior care gains
2. LTCH: Part 2 Action: Continue spread and sustainability throughout all 69 LTCHs	• Pursue standardization of Geriatric Mental Health Outreach Teams/hospital transfer tools and processes across the LHIN in collaboration with the Seniors Care Network • Engagement of Integrated Care Team to reduce ED transfers and increase the number of days clients spend at home
3. Community Action: Complete BSO staffing in GAIN Community Teams	• Reduce the demand for LTC by having seniors spend more days at home in their communities • Standardized tools, processes, and response times to help keep seniors in home (in development) • Achieve full standardization of transfer tools and processes across the LHIN • Achieve service integration along a seamless continuum of care for frail seniors
4. Hospital and Tertiary Care Action: Complete value stream map and initiate implementation throughout community	• Enhance quality of care for seniors by standardizing care plans and pathways and support return to LTC or community with appropriate supports – increasing number of days clients spend at home

In 2015/16, the BSO team will continue to explore education opportunities for front line staff and opportunities to enhance collaboration with other initiatives focused on improving specialized geriatric care.

Senior Friendly Hospitals

The Central East Senior Friendly Hospital (SFH) Working Group leads the regional SFH strategy. The Working Group, comprised of representatives from each of the nine hospitals in the Central East LHIN, the Regional Geriatric Program of Toronto, the Central East LHIN and Seniors Care Network and embodies the collective desire for a regional approach to SFH care and the need for action beyond another "initiative" to an enduring "movement" that makes a senior friendly approach simply the way we do business in our region.

The regional SFH 2014/15 work plan was based on the five components of the provincial SFH Framework which include organizational support, process of care, behavioural and emotional environment, ethics in clinical care and research and physical environment. In addition to the actions/activities identified in the 2014/15 work plan, all of the hospitals in the Central East LHIN have implemented initiatives that support improving the experience and outcomes of seniors when they are hospitalized by preventing their physical and mental decline. Highlights from 2014/15 include:

- Development of a 2014/15 SFH Working Group Scorecard
- Development of a Central East Senior Friendly Hospital Initiatives - Summary
- Establishment of three task groups: SFH Walkabout, Ageism and Gerontological Foundation
- Development of a SFH Walkabout Framework
- Member hospitals participated in the Provincial Senior Friendly Hospital Environmental Refresh Survey
- Seven hospitals participated in the Delirium and Functional Decline Indicators Provincial Pilot Initiative: three participated in both delirium and functional decline: two in delirium and two in functional decline
- Activities at various stages of implementation in different organizations (e.g., SFH Walkabouts, protocols to optimize physical function, and delirium screening, prevention and management protocols)
- All hospitals now report that they have a structure to provide oversight for SFH care
- Inclusion of the provincial priorities of delirium and/or functional decline in the annual corporate plan, goals and objectives, and/or Quality Improvement Plan (QIP) of hospitals

The Central East SFH Working Group members are in the process of developing a 2015/16 work plan. Work on many of the activities listed above will continue in the upcoming fiscal year. To date, the discussion regarding additional key priorities has included the:

- Implementation of a gerontological foundation for seniors' care to support broader capacity for senior friendly care
- Development of a communication/awareness strategy for staff surrounding ageism
- Development of a SFH overview for presentation at staff general orientation
- Implementation of nutrition/hydration/absorption initiatives to prevent de-conditioning
- Development of communication/awareness strategies for staff surrounding elder abuse
- Development of a high level ethics framework

The Central East SFH Working Group will continue to meet to build on the existing work that is currently underway throughout the Central East LHIN as well as develop and implement its 2015/16 work plan. The vision is to move from discrete initiatives to a comprehensive, coordinated approach to seniors' care and to foster a culture where senior friendly care is woven into the fabric of an organization.

Action Plans/Interventions:

Action Plan	2015/16		2016/17		2017/18	
	Status	%	Status	%	Status	%
System Design						
Provincial Senior's Strategy	In progress	50	Continue	25	Continue	25
Seniors Care Network	Implementation complete	100	Maintain	-	Maintain	-
Access						
Expanded Role of CCAC	Complete	50	Maintain	-	Sustain	-
Transitions in Care						
Home First approaches and Transitions in Care	Sustain gains	-	Sustain gains	-	Sustain gains	-
Assess and Restore	Implementation	25	Sustain gains and expand	50	Sustain gains	25
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	
CCAC-CSS Regulatory Amendments & Policy Guidelines	Planning	25	In process	50	In process	25
Primary Care						
Geriatric Assessment and Intervention Network (GAIN)	In progress	80	Continue	20	Continue	-
Capacity and Funding						
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	-

Quality and Safety						
Behavioral Supports Ontario (BSO)	Complete spread in LTC, continue community spread through GAIN Community teams and spread further in hospital sector	60	Continue BSO spread in community and hospital sector	30	Complete hospital sector and sustain gains	10
Senior Friendly Hospitals	Test and spread SFH indicators	50	Continue to embed practices and approaches	25	Continue to embed practices and approaches	25

How will we measure success?

- Quantifiable enhancements in community services to enable seniors to remain at home, in their communities
- Wait time from hospital discharge to service initiation (hospital clients)
- Wait time for home care services – application to first service (community setting)
- Clients with high and very high MAPLe (Method for Assigning Priority Levels) scores, indicating impaired functioning, living in community supported by CCAC
- Clients placed in LTC with high and very high MAPLe scores as a proportion of total clients placed
- Incidence of falls; falls related ED visits
- ALC days
- Median Wait time to Long-Term Placement
- Ratio of Seniors 75 years + requiring long-term care
- Percent of LTCH residents that have been assessed using the Central East LHIN BSO Behavioural Assessment Tool

What are the risks/barriers to successful implementation?

Risks/barriers to successful implementation include:

- Increasing complexity of care, notably behavioural needs and needs having to be met in the community and hospital setting
- Adaptation to HSFR
- Recruitment/retention of professionals with geriatric expertise

For each risk/barrier, describe the plan to mitigate the risk?
• Continued diligence in working with the CCAC and CSS throughout the year to understand and quantify pressures and respond accordingly. • Continued efforts towards seeking and fostering champions of change in the system to align and achieve common goals. • Proceed with Community Health Services Integration Strategy to build community capacity and readiness for further system transformation. • 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.
What are some of the key enablers that would allow us to achieve our goal?
Key enablers include: • Leadership (LHIN and HSPs); • Alignment of goals (provincial, LHIN, HSPs); • Better levers of change in the system e.g. accountability of non-LHIN funded services; and • Recognition of the important role of sustainability to hold the gains made to date.

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

Integrated Health Service Priority

Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.

Vascular Health Vision: Optimize the vascular health of our communities.

Vascular Health Strategic Aim Coalition (VHSAC) Mission: To promote the transition to an integrated vascular health care system within the Central East LHIN.

IHSP Priority Description

Vascular diseases are major causes of illness, disability, hospitalization and death in the Central East LHIN and across Canada. Despite reductions in the number of people who die each year from vascular diseases, it remains the number one threat to the health of Canadians.

Vascular diseases are a broad group of health conditions that affect almost all parts of the body. 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.

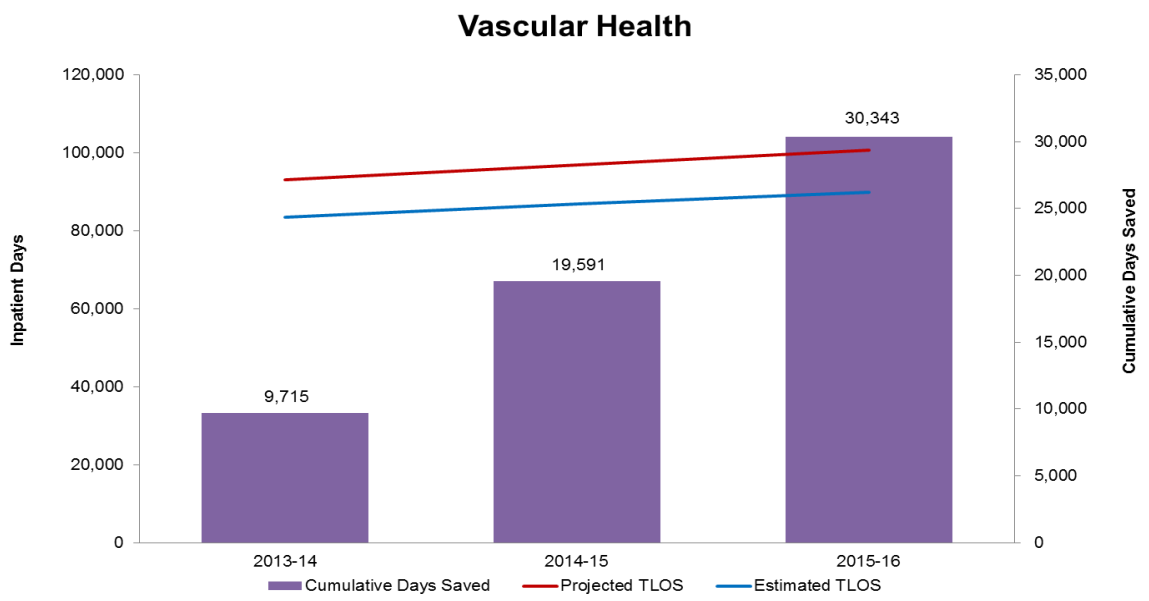
Effectively and efficiently reducing the risk of people developing and managing vascular disease will reduce the impact on individuals and the health care system. Vascular disease and its risk factors are prevalent in the Central East LHIN and result in high numbers of hospital admissions and emergency department visits; therefore they are 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 a main parallel focus under this priority.

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

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

This aim was chosen 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; to expand or initiate collaborations, partnerships, transfer or mergers of services necessary to achieve the aim.

By 2016, the Central East LHIN aims to improve the vascular health of residents so they spend 25,000 more days at home in their communities. The graph below highlights our success to-date; as of 2014/15 the Central East LHIN has saved 19,591 days, with a projection of 30,343 days saved by 2015/16.



Current Status

Five years ago the Central East LHIN set a Strategic Aim to reduce the impact of vascular disease by 10% (10,000 inpatient days). In accordance with the IHSP for 2010-2013, the Central East LHIN has saved 37,870 hospital in-patient days. The current aim to improve vascular health so that residents spend 25,000 more days at home has been exceeded. Currently, over 30,000 days have been saved and this number is continuing to increase. In the Central East LHIN, through vascular health priority projects and investments, there has been increased awareness of and access to:

- Client and caregiver chronic disease self-management training and clinician training in self-management support;
- Acute stroke care;
- Cardiovascular rehabilitation;
- Inter-professional 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, overweight/obese and physical inactivity are all risk factors for vascular diseases and many chronic conditions including diabetes.

Chronic Disease

- Of Central East LHIN residents (aged 12+), 37% 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 the Central East 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.
- Of the population aged 65-74 years, 15% have 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 diabetes-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 rate per 100,000	Hospital days rate per 100,000
	Central East	Ontario
Congestive Heart Failure (CHF)	1310.4	1524.2
Diabetes	866.7	923.9
High Blood Pressure (Hypertension)	58.9	92.6
Ischemic Heart Disease (IHD)	1798.5	2103.7
Stroke	1452.4	1691.9

Source: Environmental Scan (IHSP 2013-16)

Goals

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 & empowerment
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 and secondary prevention services
- Improving access to comprehensive primary care by reducing the number of individuals who are 'unattached' to primary care providers through alignment with Health Links
- 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
- Working alongside the Canadian Diabetes Association to help provide workshops to providers to ensure they have the tools to overcome challenges of managing and caring for patients with diabetes, fostering inter-professional team collaboration throughout the region and identifying gaps in providing diabetes care

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 Plan	2015/2016		2016/2017		2017/2018	
	Status	%	Status	%	Status	%
25,000 days spent at home in the community equates to 25,000 less days spent in hospital. As such, efforts to reduce avoidable hospitalizations will be a core focus, namely: • Reducing readmissions to hospital which could have been avoided if the care in hospital or the care after discharge was optimized; • Preventing initial hospitalizations which could have been prevented with comprehensive primary care focused on chronic disease management and prevention for patients with ambulatory-care sensitive conditions; • Reducing hospital days due to preventable adverse events in hospital.	Complete	100	Maintain	-	Sustain	-
Development of Complex Diabetes Care system including centralized intake for diabetes education & management	Monitor	100	Monitor	-	Monitor	-
Diabetes Education Program Quality Improvements and monitoring	Implement	40	Monitor	40	Monitor	20
Self-Management and Self-Management support (enabler)	Ongoing	-	Ongoing	-		-
Finalize Regional Vascular Surgery Service Level Agreement between Central East LHIN hospitals	Implement	70	Sustain gains and expand	20	Sustain gains	10
Early Chronic Kidney Disease (CKD) Management through primary care	Ongoing	-	Ongoing	-	Ongoing	-
Ontario Telemedicine Network utilized of Teleophthalmology	Implement	70	Monitor	20	Monitor	10

Harmonized Stroke System using stroke QBP for Planning and Implementation for Central East LHIN	Implement	60	Monitor	20	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)	Implement	60	Monitor	20	Monitor	20

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 2015/2016.

Overall Vascular Health Aim:

Metric	Reporting Level
Number of inpatient days saved	LHIN
30-Day Readmission for select CMG (CHF)	Hospital
30-Day Readmission for select CMG(COPD)	Hospital
30-Day Readmission for select CMG (Diabetes)	Hospital
Percentage ALC days (Stroke)	Hospital
Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation	Hospital
Proportion of stroke/TIA patients treated on a stroke unit any time during their inpatient stay	Hospital

The Central East LHIN monitors various metrics reported quarterly from Diabetes Education Programs (DEPs), to support the analysis and establish quality 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.

Through the Stroke QBP planning and roll-out, the Central East LHIN specific scorecard has been created 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 the North East cluster of the Central East LHIN and stroke acute care solutions across overlapping Central East Stroke Network boundaries
- Stakeholder resistance to change/confidence
- Variability in physician specialist (cardiology, endocrinology) models
- Resistance to clinical integrations across clusters by stakeholders (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.
- An enhanced role to support the Regional Cardiac Rehabilitation and Secondary Prevention (CRSP) program focused on congestive heart failure.
- Increased number of sites within the Regional CRSP program that ensures access to all residents within all clusters of the Central East LHIN.
- A Central East LHIN Vascular Health Strategic Aim 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 education, clinical opportunities and support services (i.e. Teleophthalmology).

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 issues 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 days from 2013-16.

This strategy focuses 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 (ED) or hospital-based services, they will receive coordinated care from hospital and community teams so they can return home safely with supporting services. Within this aim, the strategy is targeted to those who are most vulnerable. This includes 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. Another main focus is providing services to those with Concurrent Disorders (CD), as they make up the largest number of returning visitors to Central East LHIN EDs. In addition to ensuring that the mental health and addiction system in the Central East LHIN is CD capable, the LHIN will work to improve the CD capacity of the health system overall. The Central East LHIN will collaborate 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. The Central East LHIN will continue to 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 and maintain stability in the most important spheres of their lives: home, employment, and friends.

The Central East LHIN will work with mental health and addictions and primary care providers in partnership to achieve this aim, which may 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, integration of programs, and access are key enablers 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 both the Peterborough and Durham North East Health Links. The project scorecard provides diagnostic information regarding the mental health or addiction visit, which has been instrumental to continuous quality improvement. The Central East LHIN completed an internal evaluation of the Hospital to Home (H2H) program which 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 challenging. The internal evaluation of Hospital to Home, completed in August of 2014, yielded some positive results in terms of achieving the MOHLTC/LHINs Performance Agreement (MLPA) Outcomes, illustrating the efficacy of the H2H model itself. The H2H initiative at Lakeridge Health Oshawa achieved a 42.9% reduction in unscheduled return visits within 30 days for mental health and a 36.2% reduction in substance abuse revisits.

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 examples of projects targeted towards 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 has included the creation of a Physician Lead for Mental Health and Addictions. Dr. Ian Dawe was appointed the Central East LHIN Mental Health and Addictions Lead in September 2014. In addition, the LHIN created a Central East LHIN Coordinating Council to oversee and evaluate the strategy intended to achieve the Strategic Aim. This Council consists of members representing community, hospital, and service user perspectives. The Council oversees the high priority projects led by health service providers in partnership with their peers. These projects, which include Assertive Community Treatment Team (ACTT), Housing Now, and the Child and Adolescent Hospital Based Mental Health Services Review, are targeted to the achievement of the MLPA targets and the Strategic Aims.
- Continued development of Hospital to Home teams in the North East and Durham clusters. These integrated community/hospital teams are embedded in the most active EDs 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 (QI) 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 LHIN has developed a strategy to spread the H2H model to include the Scarborough Cluster, and will strengthen teams in the North East Cluster in order to both fully replicate the model and support the achievement of the MLPA targets for Mental Health and Addictions.
- The Durham Mobile Crisis Intervention Team (MCIT), a partnership between Durham Mental Health Services and Durham Regional Police, was reformatted during FY 2013/14. The MCIT is now more closely linked with the system and the H2H Strategy.
- 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, and will implement six additional Community Crisis Beds in Oshawa, which will be linked to the Durham H2H Team.

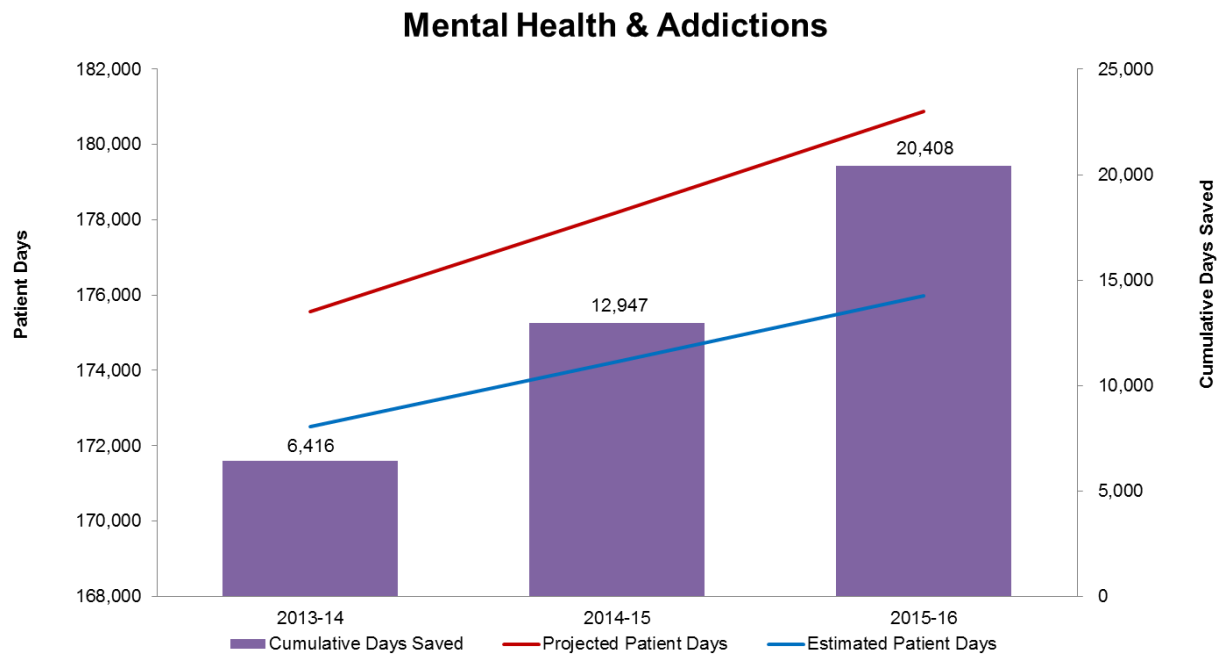
- Ontario Telemedicine Network (OTN) and Telepsychiatry have been used as strategic enablers to this aim. The installation of three new OTN machines in the North East cluster has made both direct treatment and consultation services more accessible. Canadian Mental Health Association, Haliburton, Kawartha, 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. Base funding has been allocated to CMHA HKPR, which will provide an opportunity to increase their OTN capacity on a permanent basis. 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 OTN Network has continued to expand its services under the leadership of Ontario Shores Centre for Mental Health Sciences.
- The Central East LHIN Opiate Strategy was evaluated by the LHIN in FY 2014/15. The evaluation illustrated that most of the initial service targets had been exceeded by over 35%.
- Continued support of the Mental Health “Nurses in the Schools” program led by the Central East Community Care Access Centre, has focused on children who require hospitalization for a mental health and/or addiction issue to return to school. The LHIN has worked with LHIN partners on service protocols that will ensure students receive services at the right place in the right time regardless of the LHIN of their residency.
- 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 Central East 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 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. Meetings were held in September and December of 2014 with the members of the Central East LHIN Aboriginal Health Advisory Circles and all of the mental health and addictions health service providers throughout the LHIN at the Hiawatha First Nation. A follow up meeting is scheduled to take place prior to the conclusion of the FY 2014/15.
- The Central East LHIN completed the development of an implementation plan that will advise improvements to hospital based child and adolescent psychiatric services.

- The Central East LHIN completed a QI process for Central East LHIN ACTT Teams. Among the recommendations was a “Step Down” process for those clients assessed as being able to transition 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 QI recommendations have been implemented as of FY 2014/15 using a QI approach under the oversight of a Steering Committee.

- The Central East LHIN initiated a Community Crisis Review Project which will develop a report on the current state of these services and develop recommendations for improvement.
- The Central East LHIN allocated 12 new Intensive Supportive Housing spaces with attached case management in the North East Cluster of the Central East LHIN.

- The Central East LHIN provided base funding to three new and innovative housing programs that included a partnership between Fourcast, The City of Peterborough, and local homelessness shelters that will result in housing and housing supports for those who are either homeless or at risk of being homeless. The project is closely linked to the Peterborough Health Link.

By 2016, the Central East LHIN aims to 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. The graph below highlights our success to-date; as of 2014/15 the Central East LHIN has saved 12,947 days, with a projection of 20,408 days saved by 2015/16.



Goal(s):

- Reduce unscheduled return visits to Central East LHIN Emergency Departments by 10% by March 31, 2015
- Reduce in-patient psychiatric days by 10% by March 31, 2015
- Increase the number of days spent at home by those with mental health and addictions issues by 15,000 days by March 31, 2016

Consistency with Government Priorities:

These goals are in alignment with the Minister's Ten Year Mental Health and Addictions Strategy, MOHLTC/LHIN MLPA Targets as well as with the Opiate Strategy Framework.

Action Plans/Interventions:

- Implementation of the Central East LHIN Mental Health and Addictions Implementation Strategy
- Development of a Youth Strategy for the newly integrated Community Health Centre serving South Durham
- Hospital to Home Teams in the Durham and North East Cluster with the addition of teams in the Scarborough Cluster, along with Aboriginal Outreach Workers
- Completion of the Community Crisis Review Project and review of the recommendations of this project with an intention to plan for next steps
- Develop and finalize an Engagement Strategy with municipal housing partners that support joint resource planning related to housing and health care strategies
- Increase concurrent disorder capacity in the mental health and addictions system as well as in the primary care system through specific capacity building activities
- Review and implementation of the implementation plan for the Hospital Based Child and Adolescent Psychiatric Services Recommendations Report
- Client centered 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 becoming homeless
- Ongoing monitoring of the Central East LHIN Common Assessment Tool and Schedule 1 Bed Registry

Action Plan	2015/16		2016/17		2017/18	
	Status	%	Status	%	Status	%
Implement Central East LHIN Mental Health and Addictions Strategy throughout the LHIN including Priority Projects: 1.Community Crisis Review Project 2. ACTT Now Project 3. Child and Adolescent Hospital Based Services Project	In progress	100	Monitor	-	Monitor	-
Central East LHIN Housing Strategy	In progress	25	In progress	70	In progress	5
Implementation of Physician Lead position for Mental Health and Addiction	Completed	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	Completed	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. The LHIN will conduct a formative evaluation to ensure fidelity and course correction in light of the implementation of a Provincial 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
- Achievement of the MLPA targets for mental health and addictions at The Scarborough Hospital, Rouge Valley Health System (Centenary) and Northumberland Hills Hospitals
- Community Crisis Beds will be in place in Oshawa
- 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, e.g. 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.
- Complexities of privacy legislation poses difficulties to an integrated model of care for clients, particularly for those who are new, complex, or functionally assessed as having a mental health and/or addictions issue.
- Difficulties securing a location for the Oshawa crisis beds based on municipal zoning and availability of capital funds.

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

- Close monitoring by the Central East LHIN and ongoing adjustment as necessary
- Quality improvement strategies
- Some mitigation strategies are beyond the purview of the Central East LHIN, e.g. data collected, data issues, available solutions
- Monitoring by Aboriginal Advisory Circles
- Specific Memoranda of Understanding between Health Service Provides
- Communications strategy with municipal governments
- Attention to detail through the Capital Projects submission process

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

- Ongoing use of quality improvement principles and development of achievable indicators
- Strong relationships with providers
- Systemic measures of concurrent disorders and secondary diagnoses
- Continued work with the MOHLTC to resolve data issues

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.

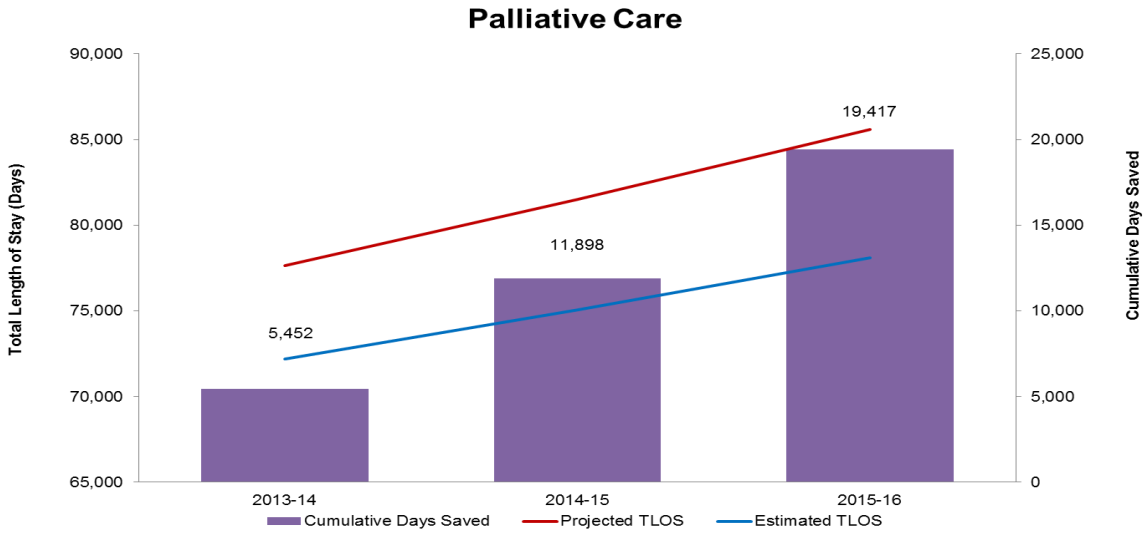
IHSP Priority Description

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 their communities. The below graph highlights our success to-date; as of 2014/15 the Central East LHIN has saved 11,898 days, with a projection of 19,417 days saved by 2015/16.



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 Plan 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 care community teams;
- Enhanced hospice palliative care education and training;
- Integrated hospice palliative care hospital programs;
- Integrated hospice palliative 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 care programs offering specialty clinics and designated beds;
- Community palliative care nurse practitioners;
- Interdisciplinary and physician education;
- Palliative pain and symptom management consultation services; and
- Visiting 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 Care Nurse Practitioners; and
- Long-Term Care Homes.

The CEHPCN 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 MOHLTC/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 comprised 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 families.

Successes of the Past Year

The Central East LHIN has begun initiatives and programs that will enhance 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 the 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 has developed 6 priority indicators related to palliative care performance for use within accountability agreements across LHINs. Through the 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.
- Investment in the creation of 3 Palliative Care Community Teams (PCCT) across the Central East LHIN. These interdisciplinary team-based models provide clinical and non-clinical community-based care to palliative and end of life patients allowing them to die at home.
- Palliative Pain and Symptom Management Consultation Service expansion, equal distribution and access across Central East LHIN community organizations in the Durham, Scarborough and North East clusters. These services have assisted service providers in home care agencies, long-term care homes, community support service 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.

- Community palliative care nurse practitioners continue to serve patients and their families across the Central East LHIN. 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.
- Continued investment in palliative care education. Learning Essential Approaches to Palliative and End of Life Care (LEAP), Fundamentals and Comprehensive Advanced Palliative Care Education (CAPCE) programs are offered throughout the LHIN educating and building expertise within health service providers, including primary care, for the delivery of palliative and end of life care.

Goals

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

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

Consistency with Government Priorities

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 MOHLTC's model for hospice palliative care as outlined in *Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action.* Specifically, adults and children with advanced or end of life chronic disease(s) and their informal support network will receive care and support that is proactive, holistic, person and family-focused, centering on quality of life and symptom management issues, and delivered by a virtually integrated inter-professional team in a coordinated, continually-updated care plan, that encompasses all settings in which the client receives care.

Action Plans/Interventions

Ensuring timely access to quality palliative and end of life care is not only an ethical imperative but a vital component of our health care system. This is why the focus of activities specific to the palliative and end of life aim are centred on supporting individual choice and the option to receive palliative and end of life care in their home and community settings.

Action Plan	2015/16		2016/17		2017/18	
	Status	%	Status	%	Status	%
Education and leadership opportunities for primary care through enhanced collaboration and partnership with Primary Care (PC) Leads, PC Advisory Group and Palliative Care Physician Lead	In progress	50	In progress	50	Monitor	-
Establish Palliative Care Community Teams providing interdisciplinary team-based clinical and non-clinical community-based care	In progress	50	In progress	50	Monitor	-
Education opportunities for front line health service providers, including physicians, to increase expertise in palliative care	In progress	50	In progress	50	Monitor	-
Pursue opportunities for residential hospice	In progress	50	In progress	25	In progress	25
Establish a paediatric palliative strategy in partnership with the Hospital for Sick Children	In progress	50	In progress	50	Monitor	-
Strengthen community hospice through the CHS Integration Strategies (Phase 2)	In progress	50	In progress	50	Complete	-
Utilize eHealth solutions (Health Links) to improve communication between health care providers while caring for patients in their home	Planning	25	In progress	50	In progress	25
Expand and promote integrated hospice palliative and end of life care programs in LTCH and hospitals	In progress	50	In progress	50	Monitor	-

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.

The MOHLTC and the LHIN are finalizing a set of palliative indicators for inclusion in the MOHLTC/LHIN Accountability Agreement as well as Hospital and Community Agency Accountability Agreements.

As a result of the Provincial Hospice Palliative Care Data and Performance Subcommittee, all Hospital Service Accountability Agreements in the Central East LHIN include the following performance metric:

- Proportion of patients identified as palliative in hospital that are discharged home from hospital with support.

What are the risks/barriers to successful implementation?

There are a 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.

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;
- Funding for a new LHIN Palliative Care Physician Lead;
- 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; 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 collaboration 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
Access: Improving primary care so that it provides the right care, at the right time, by the right provider.
Integrated Health Service Plan Enabler Description
• Primary health care is the first point of contact a person has with the health system – the point where people receive care for most of their everyday health needs. Primary care providers are integral in facilitating smooth transitions in care. • Guided by the Minister's Action Plan for Health proposal to bring the organization of primary care under the mandate of the LHINs, the Central East LHIN's initial focus is on building and strengthening partnerships with primary care, and their partnerships with other parts of the health care system. • With the support of primary care leadership, efforts are underway to improve the care coordination between primary care and other health services, as well as improving timely access to primary care as an alternative to a hospital visit. 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 the Central East LHIN.
Current Status
• 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. • Provincially, the lowest rate of enrollment (56%) in patient enrolled models of primary care is the 90+ age cohort (Walker, 2011).

- Primary care providers in the Central East LHIN include:
    - 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 key members 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 the establishment of a Health Link initiates with engagement of primary care providers by the staff team and our Provincial Primary Care Lead.
- Seven Health Links are being developed in Central East – The Peterborough and Durham North East Health Links have been established, and planning work is underway in Northumberland County, Haliburton County - City of Kawartha Lakes, and Scarborough North and Scarborough South Health Links. Planning will be underway in Durham West Health Link in FY 2015/16.

Recognizing the need to evolve the four existing hospital based Geriatric Assessment and Intervention Network assessment clinics in the LHIN, a significant community investment was made to establish eight GAIN community outreach teams. These interprofessional teams include a range of primary care providers GP/FP, NP, RNs, Social Workers, Care Coordinators and 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.

Goals

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
- Increase access to primary care within Community Health Centres
- 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

Systems of Care – Health Links

- Identification and support of primary care leaders/champions for each of the seven Health Links

Palliative Care Aim

- Education and leadership opportunities for primary care through enhanced collaboration and partnership with Primary Care (PC) Leads and Primary Health Care Advisory Group
- Establishment of a Palliative Care Physician Lead for the LHIN
- Continued education opportunities for front line health service providers, including physicians, to increase expertise in palliative care

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 Plan	2015/16		2016/17		2017/18	
	Status	%	Status	%	Status	%
Palliative Care						
Education and leadership opportunities for primary care through enhanced collaboration and partnership with Primary Care (PC) Leads and PC Advisory Group	In progress	40	In progress	40	In progress	30
Mental Health and Addictions						
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	40	In progress	40
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	50
Vascular Health						
Early adopters for the Ontario Vascular Health Coalition	In progress	50	In progress	25	In progress	25
Increase access to patient education and self-management support or training for clinicians: Early Chronic Kidney Disease (CKD) Management through primary care Coordinated Intake and Diabetes Education Support for Diabetes Care and Management	In progress	50	In progress	30	In progress	20

Ontario Integrated Vascular Health Strategy – Blueprint: Harmonization of practices across primary and specialty care settings for screening and treatment of vascular disease	In progress	20	In progress	40	In progress	20
Increasing access to diabetes care/education in community and primary care settings to reduce 30 day readmissions	In progress	50	In progress	25	In progress	25
Seniors						
Participate in establishment of 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 implementation	In progress	70	In progress	20	In progress	10
Support primary care awareness, buy-in, and early tests of change of the new GAIN Community teams	In progress	25	In progress	50	In progress	25

How will we measure success?

- Number of people with Individualized Integrated Coordinated Care Plans through Health Links
- Number of unattached patients connected to primary care providers through Health Care Connects
- Patients enrolled in the GAIN Community Teams
- Patient/Caregiver satisfaction with the GAIN Community Teams and collaboration with primary care
- Primary care provider engagement in Health Links and accomplishments of identified metrics/outputs for primary care (e.g. timely access to primary care post hospital discharge)
- Reduced ambulatory care sensitive hospital admissions and re-admissions
- Hospital Patient Discharge Information provided to primary care within 48 hours
- Community Investments made in FY 2014/15 have mandated Mental Health and Addictions Provider to illustrate their relationship with Health Links through their use of Coordinated Care Plans

What are the risks/barriers to successful implementation?

- Poor working relationships and collaboration between CHC sector and other primary health care providers both on the ground and in communities
- Influence/hindrance created by physician compensation issues (and provincial negotiations) on local level collaborations and partnerships (with LHIN, cross Patient Enrollment Model (PEM) or cross CHC-PEM)
- Poor physician buy-in and support of the emerging Health Links and GAIN Community teams

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

Risks identified will be mitigated through:

- Engagement of Central East LHIN and Health Link level primary health care leadership to champion system changes
- New partnership with the Durham Regional Cancer Centre/Cancer Care Ontario for Central East LHIN primary care leadership
- Provincial collaboration with MOHLTC and other LHINs regarding Health Links implementation
- Supporting strong project management and quality improvement focus within primary care programs/initiatives during implementation
- Leverage leadership and peer to peer engagement of primary care leads and community primary care providers
- Provincial collaboration with MOHLTC on various Primary Health Care funding initiatives
- Engage physicians in the design and evaluation of the emerging GAIN Community teams
- Consultation with, advice from and redesign as required of the Central East LHIN's Primary Health Care Advisory Group (PHCAG)

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

- Central East LHIN Primary Care Leads in leading dialogue and change within the Central East LHIN primary health care sector
- Central East LHIN Primary Health Care Advisory Group in place
- Central East LHIN Health Links oversight body (once formed) with inclusion of primary care leadership
- Engagement of the Central East LHIN Mental Health and Addictions Physician Lead and Central East LHIN Palliative Care Lead (once in place)
- Inclusion of primary care representation on the Central East LHIN Mental Health and Addictions Coordinating Council
- 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

Access and Wait Times

IHSP Enabler

Access: Monitoring and Improving MLPA Wait Time Targets.

IHSP Enabler Description

MLPA Wait Time Targets

Maintaining and improving wait times for key services aligns with Ministry of Health and Long-Term Care's (MOHLTC) 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 MOHLTC's goal to create a system of accountability through transparent reporting of wait time information. Achievement of wait time performance targets is also dependent on close monitoring of patient demand, ensuring that volumes meet provider / community resource need.

How is success being measured?

Success is being measured according to the following 2014/15 MOHLTC/LHIN Performance Agreement (MLPA) performance targets:

- Percent of Priority IV Cases Completed within Access Target for Cancer Surgery
- Percent of Priority IV Cases Completed within Access Target for Cataract Surgery
- Percent of Priority IV Cases Completed within Access Target for Hip Replacement Surgery
- Percent of Priority IV Cases Completed within Access Target for Knee Replacement Surgery
- Percent of Priority IV Cases Completed within Access Target for Diagnostic MRI Scan
- Percent of Priority IV Cases Completed within Access Target Diagnostic CT Scan

Current Status

Target Populations

Seven hospitals in the Central East LHIN provide wait time-related or Wait Time Strategy-funded services:

Hospital	Cataract Surgery	Hip Replacement Surgery	Knee Replacement Surgery	Cancer Surgery	CT	MRI	General Surgery	Paediatric Surgery
Campbellford Memorial Hospital					✓		✓	
Lakeridge Health	✓	✓	✓	✓	✓	✓	✓	

Hospital	Cataract Surgery	Hip Replacement Surgery	Knee Replacement Surgery	Cancer Surgery	CT	MRI	General Surgery	Paediatric Surgery
Northumberland Hills Hospital	✓			✓	✓	✓	✓	
Peterborough Regional Health Centre	✓	✓	✓	✓	✓	✓	✓	
Ross Memorial Hospital	✓	✓	✓	✓	✓	✓	✓	
Rouge Valley Health System		✓	✓	✓	✓	✓	✓	✓
The Scarborough Hospital	✓	✓	✓	✓	✓	✓	✓	✓

Community Engagement and Leadership

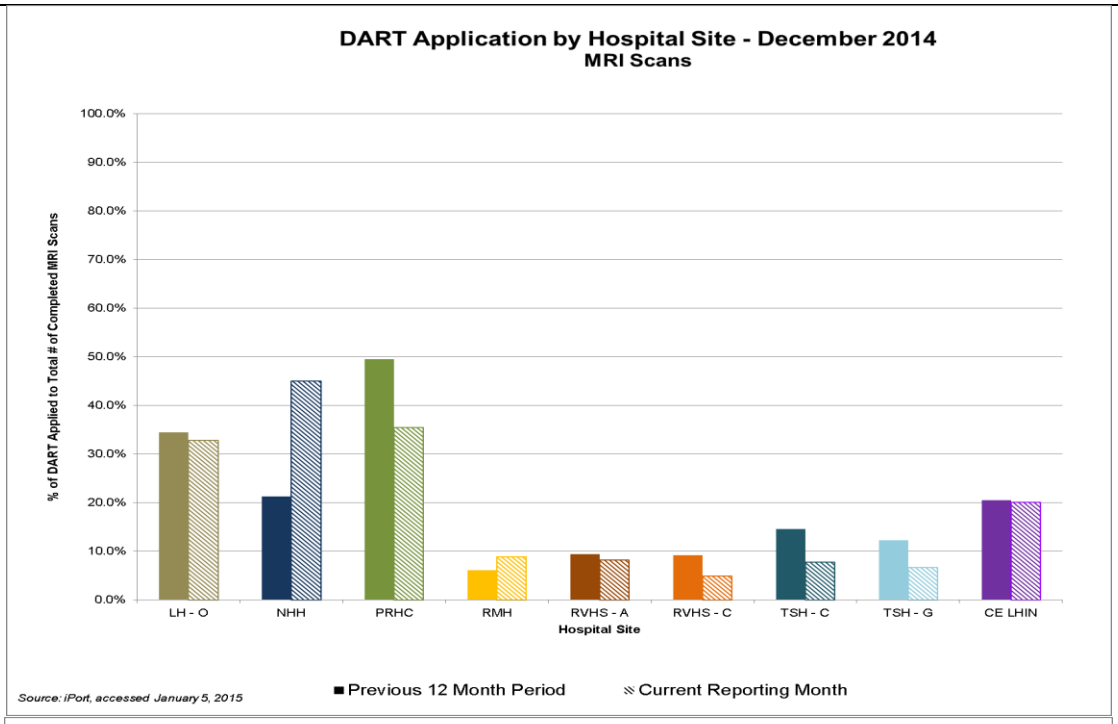
Wait Times Strategy Working Group

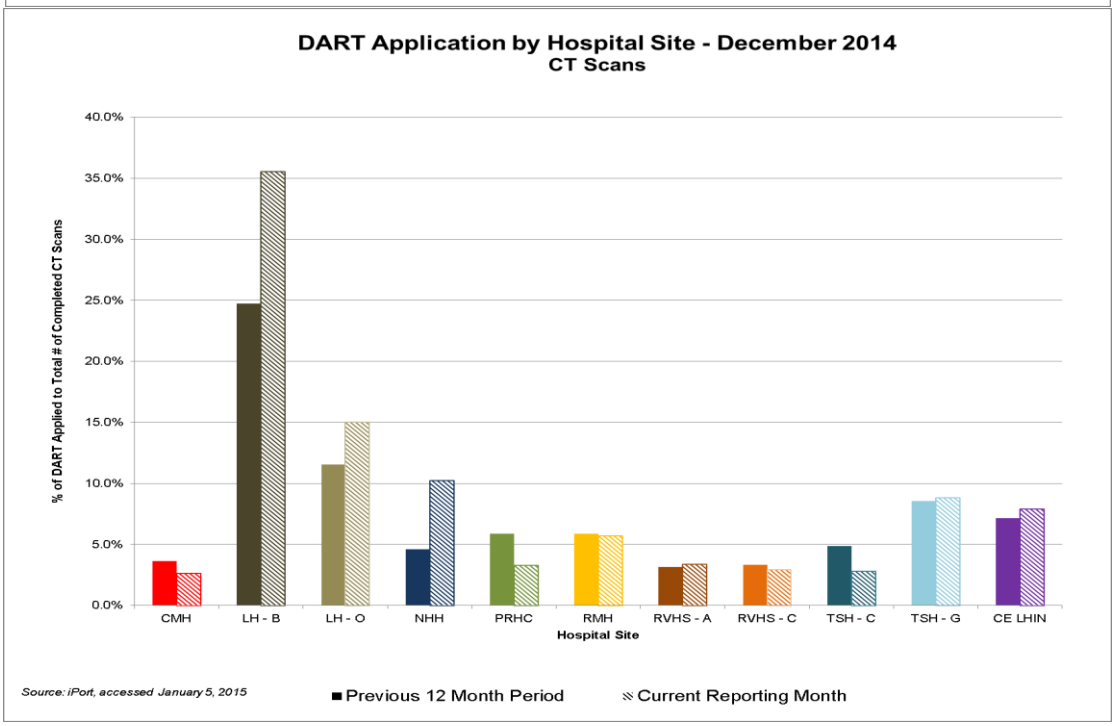
The Central East LHIN has established a Wait Times Strategy Working Group (WTSWG). It comprises representation from the above seven hospitals and meets monthly to discuss issues, risks, and mitigation strategies. The WTSWG also evaluates monthly performance at a system and hospital level, taking into 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 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, which includes reviewing and analyzing submitted data monthly, and addressing any identified issues.
2. Use of standardized best practices in hospitals, including participating in Phase 3 of the MOHLTC's MRI Performance Improvement Plan (PIP3) initiative.
3. 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.





4. Wait time performance indicators have been incorporated into the Hospital Service Accountability Agreements (H-SAAs).

5. The Central East LHIN fully implemented the web-based Surgical Utilization Booking Management Integration Tool (SUBMIT) in June 2012 to assist with the management of wait times and patient wait lists, as well as reporting to the Wait Time Information System (WTIS).

SUBMIT is a strategic and tactical tool of benefit to the local health system in several ways, including:

- Offering a web-based solution to surgeons to electronically manage their wait lists and provide automated rule-based data to the provincial Wait Time Information System without data duplication;
- Connecting the surgeon's wait list management, operation room booking, pre-screening clinics and admissions areas to provide a real-time and transparent view of patient progress;
- Providing electronic transfer of booking packages and supporting documentation;
- Providing access for surgeons to all of their operation room bookings at multiple privileged site(s); and
- Providing aggregate data (viewing and reporting) to improve the data quality and reporting of wait times at a regional level.

The LHIN has explored the expansion of SUBMIT functionality to Diagnostic Imaging. The Central East LHIN will work with health service providers in FY 2015/16 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 1 tracking (date of referral from family physician to date seen by specialist), as well as the capability for appropriateness of the request, validation and acceptance, notification back to the requestor and scheduling of the request. Also, the system of e-request and intake will potentially be developed so as to be applied to other care services including surgical, palliative, and cardiovascular etc.

6. 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 FY 2015/16 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. Directional Plans will 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, 2015. This expert 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 the 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 and other key stakeholders to identify opportunities to improve wait times in FY 2015/16. As of year-to-date (YTD) November 2014/15, the Central East LHIN has met all wait time targets.

Goal(s)

Central East LHIN IHSP AIM

MLPA Targets for Surgical and Diagnostic Imaging

Indicator	2014/2015 Baseline	2015/2016 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%

Please note, the 2015/16 MLPA has not yet been negotiated, therefore, 2014/15 targets have been applied.

Action Plans/Interventions

The Central East LHIN's 2013-2016 IHSP is aligned with the MOHLTC'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:

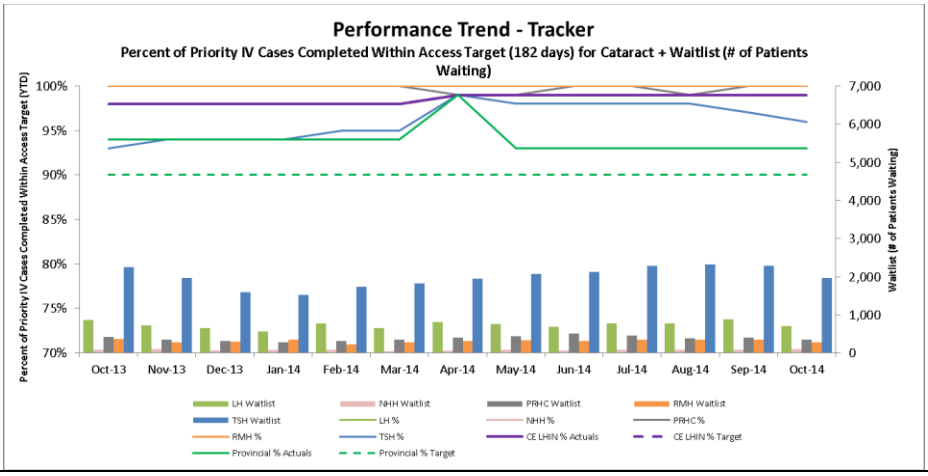
- Engaged communities and partnerships;
- Improvement in the health status of Ontarians;
- Equitable access to quality care and services;
- Continuous improvement in the quality of care Ontarians receive and the resulting impact on health conditions; and
- A sustainable health system framework.

Action Plans	2015/16		2016/17		2017/18	
	Status	%	Status	%	Status	%
Hospitals and the Central East LHIN implemented a **Data Quality Improvement Working Group**. The Wait Time Coordinators group met for two years before disbanding in late 2012, as 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 **WTSWG**. Monthly monitoring of volumes, targets, issues, challenges, and mitigation strategies at the hospital and system level at WTSWG allows for effective management of wait time performance, including expedient in-year reallocations.	Ongoing	-	Ongoing	-	Ongoing	-
One-on-one meetings with each hospital as needed to discuss hospital-specific performance issues, such as additional capacity and integration. **Wait Time performance** is also an integral part of the **H-SAA negotiation process which is well underway for 2014/15**.	Ongoing	-	Ongoing	-	Ongoing	-

Reallocation of a portion of the Central East LHIN's surplus dollars from other sectors, targeting the improvement of key service areas for those hospitals that are able to demonstrate that this one-time funding will improve access to care.	Annual exercise	-	Annual exercise	-	Annual exercise	-
Maintain the Surgical Utilization Booking Management Integration Tool (SUBMIT), 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	-
Engagement sessions at the hospital level with administrators and physicians, through the HSFR Local Partnership (previously the QBP Working Group).	Ongoing	-	Ongoing	-	Ongoing	-
Orthopaedic Planning and Implementation Committee (OPIC): Upon the completion of the Integrated Orthopaedic Capacity Plan (IOCP), the OPICs are now working towards the implementation of the developed cluster specific Directional Plans and Project Charters. The overall Implementation the IOCP will take place until March 2016.	Started	40	In progress	60	Ongoing	-

How will we measure success?

The Central East LHIN utilizes a monthly dashboard system to monitor and manage MLPA Indicators. The dashboard is discussed at a variety of leadership 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 LHIN is working with stakeholders to more fully utilize all area 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 LHIN. 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 LHIN received additional Wait Time Strategy incremental volumes (compared to 2012/13). The Central East LHIN successfully sought approval from the MOHLTC 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 Diagnostic Imaging Software Solution. 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 2015. 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?

- The Central East LHIN has identified potential opportunities 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. Enhanced functionality of current Information Technology software platforms will support success in achieving performance improvements and timely access to care.

Health System Funding Reform

IHSP Enabler

Capacity and Funding: Health System Funding Reform

IHSP Enabler Description

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 Patient-Based Funding (PBF). 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).

Patient Based Funding is intended to serve as an equitable and sustainable funding model that will also standardize care, minimize practice variation, and encourage investments in quality improvement and patient safety.

Current Status

Going forward, hospitals' funding will comprise 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.

The Health Based Allocation Model (HBAM) estimates expected health care expenses based on (i) population profiles and (ii) clinical complexity and type of care. Relative to the provincial funding pool, individual hospital's allocations are adjusted according to differences between actual and expected health care expenses.

Quality Based Procedures (QBP) provide reimbursement to health care providers based on the types (including acuity) and quantity of services they deliver.

As part of Health System Funding Reform, the LHIN 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, and by facilitating clinical, financial, and decision support advice to and from the Central East LHIN and the MOHLTC.

The LP will:

- Proactively discuss local implementation planning and change management imperatives related to all aspects of HSFR;
- Identify and discuss critical implementation issues and the associated strategies to ensure coordination across providers;

- Provide advice and strategies on volume management and alignment to service accountability agreements; and
- Proactively engage and communicate with local providers across sectors, with emphasis on implementation planning and the impact on the health care system as well as health service providers.

Goal(s)

Develop recommendations for an effective volume management strategy for all Quality-Based Procedures as they are introduced.

Consistency with Government Priorities

The Ministry of Health and Long-Term Care has requested the Central East LHIN to develop and implement volume management strategies.

Action Plans/Interventions:

Action Plans	2015/16		2016/17		2017/18	
	Status	%	Status	%	Status	%
Develop an accepted process for establishing volume management strategies for Quality-Based Procedures (QBP)	Ongoing	-	Ongoing	-	Ongoing	-
Develop standards and processes for tracking and forecasting medical QBP volumes	In progress	50	Complete	50	Monitor	-
Effectively manage the new policy direction of shifting low-risk procedures (cataracts) from hospitals to community-based specialty clinics if appropriate	Ongoing	-	Ongoing	-	Ongoing	-

How will we measure success?

Success will be measured by the development of volume management strategies through consensus building.

What are the risks/barriers to successful implementation?

There are a number of risks and barriers to the successful implementation of this aim. These include issues surrounding change management, resources and work.

For each risk/barrier, describe the plan to mitigate the risk?
• To develop a strong communication strategy with members of the Local Partnership and Health Service Providers • To review and operationalize clinical handbooks and best practice guidelines which are embedded in the handbooks • To identify key performance indicators which define the quality of care and expected outcomes • To continue data quality reviews to ensure complete and accurate information is reported • To allocate and re-allocate volumes in a matter that is responsive to the achievement of quality outcomes, cost-effectiveness, and accessibility to care

Health System Design and Integration

IHSP Enabler:

Health System Design and Integration

IHSP Enabler Description:

Health system design and integration activities will improve the quality of client care, performance of the local health system and system sustainability

Current Status:

Health System Design and Integration: Forthcoming Strategies

Housing and Homelessness Framework

In September 2014, the Central East LHIN Board approved the initiation of a significant strategic partnership between the Central East LHIN and Municipal Service Managers to improve housing and support services for homeless and precariously housed residents across Central East LHIN. A Housing and Homelessness Framework was developed and approved in February 2015, which identifies Guiding Principles and a Terms of Reference. These foundational documents provide the basis for initiation of a joint Steering Committee supporting the four Municipal Service Managers in Durham, City of Kawartha Lakes-Haliburton, Northumberland County and the City of Peterborough. Similarly, the Central East LHIN has initiated a partnership with the City of Toronto housing and homelessness teams to focus on Scarborough.

The Central East LHIN and Service Managers have identified the following common needs to support LHIN-Municipal collaboration and partnership:

- Collaborate during organizational strategic planning with intent to identify common priorities;
- Undertake collaborative service level planning to improve coordination of services and ability for residents to obtain and then retain tenancy;
- Identify opportunities to align and maximize investment/funding opportunities to address needs in community.

All parties recognize at the onset of the process that specific details, strategies and tactics supporting collaboration and partnership will evolve throughout the process. A Strategic Aim has been set to guide the partnership.

Housing & Homelessness Strategic Aim

Purpose

To design and implement a Housing and Homelessness Framework to guide partnerships and collaboration between the Central East LHIN and Service Managers in the delivery of housing and homelessness services by 2024.

Outcomes

- Improve access to high-quality, timely, equitable services to support residents in securing and maintaining safe, affordable and accessible housing with health and social support;
- Promote health and social equity across populations and communities;
- Make the best use of the public's investment.

The Framework has already provided guidance to the collaborative identification of priorities for investments of Rent Supplement and associated Intensive Case Management/Support for people with mental health and addictions needs who are homeless or precariously housed.

Through the Community Mental Health and Addictions investment in 2014/15 and planned for 2015/16, and 2016-17, the LHIN and Municipal Services managers will collaborate to identify priority communities for allocation of the following Rent Supplement – Intensive Case Management Resources :

Year 1, (FY 14/15)	Year 2, (FY 15/16)	Year 3, (FY 16/17)	Total Allocation
12	51	21	84

In December 2014, the Central East LHIN Board approved the Year 1 allocations as follows:

Four Rent Supplements and 0.5 FTE Intensive Case Management is provided to support residents in Northumberland County.

- CMHA-HKPR will receive four Rent Supplements for Northumberland County residents. Location to be determined in consultation with the Northumberland Hills Lakeshore Mental Health Program and Northumberland County.
- Northumberland Hills Hospital – Lakeshore Mental Health Program: 0.5 FTE Case Management to be implemented in consultation with CMHA- HKPR and Northumberland County considering current and planned investments in Mental Health Homeless Liaison and Hoarding Initiatives.

Eight Rent Supplements and 1.0 FTE Intensive Case Management is provided to support residents in Peterborough City or County.

- CMHA-HKPR will receive 8 Rent Supplements for Peterborough City or County residents. Location to be determined in consultation with FourCAST and the City of Peterborough.
- FourCAST: 1.0 FTE Case Management to be implemented in consultation with CMHA- HKPR and Peterborough City considering current and planned investments in Housing and Homeless initiatives.

The support/Intensive Case Manager for all 12 units will be FourCAST.

Housing Now Initiatives

Two new Housing Now initiatives were approved for the communities of Peterborough and Durham through the Community Mental Health and Addictions funding for 2014/15 and 2015/16. The Housing Now projects are multiple health service provider and municipal service manager collaborative initiatives that will see improved access to stable, affordable housing with essential health and day-to-day support services to residents who are currently on waiting list for housing or support and/or are experiencing lapses in stable housing due to lack of health or social supports and resources to obtain and maintain tenancy.

Special Needs Strategy

The Special Needs Strategy announced in February 2014 aims to connect children and youth with special needs to the services they require as early as possible and to improve the service experience of families and children. The Strategy intends to develop and implement a new standard developmental screen for preschool children; to put in place coordinated child- and family-centred service planning for children and youth with multiple and/or complex needs; and to work with communities to develop local implementation plans for an integrated approach to the delivery of child and youth rehabilitation services (speech-language therapy, occupational therapy, and physiotherapy).

In the Central East LHIN the following service delivery areas for the Special Needs Strategy are in our geographic catchment area:

- Durham
- Hastings Prince Edward/Northumberland
- Haliburton/Kawartha Lakes/Peterborough
    * *Toronto (Toronto Central LHIN)*

In December 2014, the Durham Special Needs Steering Committee held two Value Stream Mapping sessions to validate the findings of the MacCharles Report (2013). The focus of the Value Stream Mapping sessions was coordinated service planning and integrated delivery of rehabilitation services drawing out system constraints and barriers in the current system to guide future planning and improvement work.

Participants included families, services providers and representatives of Boards of Education. In addition to validating the MacCharles Report (2013), the purpose of the Value Stream Mapping sessions was to identify system constraints and barriers that families and service providers experience locally to guide future planning and improvement work. Numerous opportunities for improvement were identified during the two sessions.

Next steps include the following key deliverables:

- Developing work plans/timeframes
- Determine needs for working groups and identify stakeholder membership
- Determine future engagement strategy (families, youth and stakeholders)
- Prepare and submit the reports as per the following timelines:
    - Coordinated Service Planning, due by June 15, 2015
    - Delivery of Rehabilitation Services, due by October 31, 2015

Health System Design and Integration: Integration Strategies

Health Links

The Central East LHIN is fully engaged in supporting 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:

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

The Central East LHIN Board has approved the creation of seven Health Links covering the entire Central East LHIN. Two Health Links have received approval from the MOHLTC– Peterborough and Durham North East – and by the end of Q1 (2015/16), it is expected that the business plans of the five remaining Health Links will have been submitted and possibly approved by the MOHLTC– Northumberland County, Haliburton County - City of Kawartha Lakes, Scarborough North, Scarborough South and Durham West.

Focus for the Peterborough and Durham North East Health Links has been on three primary patient cohorts:

- 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).

- 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).
- Seniors with exacerbated chronic obstructive pulmonary disease (COPD) and at least one other comorbidity with the possibility of other complicating factors (such as inadequate housing or transportation, isolation, palliation, responsive behaviours, financial issues).

Durham North East Health Link added a fourth cohort for early focus:

- Patients with complex chronic conditions identified through the GAIN community teams

Target populations have evolved to focus on complex patients, although each of the Health Links will have a locally determined initial cohort of patients, which they plan to focus change improvement activities.

Coordinated Care Plan Tool

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. The eHealth Transformation office has 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).

In the summer of 2013, the Transformation Team 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 MOHLTC, eHealth Ontario, Ontario MD, LHINs, physicians, hospitals, community care and mental health and addictions providers and support.

The process ended in December 2013, and a set of requirements and initial data set was identified. Through the end of the FY 2013/14, a series of forums were held to spread the stakeholder awareness and input to provide a comprehensive dataset. Each LHIN 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). 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.

The tool in paper format was available to pilot as of January 2014 and the Peterborough Health Link agreed to work with this tool. Updated with drop down menus, this tool was tested and feedback was 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. There have been subsequent changes to the paper tool and summary template and the team has made the changes to implement the revised tool.

A review of the technology opportunities has been undertaken including the regional SharePoint system to determine viability for use including the functionality:

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

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

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

As of January 2015, the Peterborough Health Link has been selected as one of the sites in the province that can participate in the provincial electronic tool (CCT) pilot. This would require six to eight months' work with the provincial team to test and evaluate the CCT and provide feedback and information that will support a request for full rollout back to the MOHLTC. Work will be undertaken through to fall of 2015.

For the other six Health Links as they are developed and begin work, there is still a need to support the teams through a paper process. There is an opportunity to develop an interim solution for the other Health Links to support their use of the 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.

Community Health Services Integration Strategy

In 2012, the Central East LHIN Board of Directors approved a three year 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 (CHS) Integration Strategy was to design and implement a cluster-based service delivery model 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.

The CHS Integration Strategy focused on Community Support Services (CSS) agencies, Community Health Centres (CHC) and, in the North East Cluster the four small and medium sized hospitals. This CHS strategy commenced facilitated integration planning processes in all Clusters of the LHIN – Scarborough, Durham and the North East (Northumberland, City of Kawartha Lakes – Haliburton County, and Peterborough). The Small Rural Northern Hospital Transformation Fund enabled small hospital and community integration initiatives in both Northumberland and the City of Kawartha Lakes – Haliburton County.

Haliburton County/City of Kawartha Lakes Integration Process

After months of due diligence and stakeholder engagement, the Integration Planning Team, which was comprised of senior administrative representatives from six local agencies, developed an Integrated Governance and Service Delivery Model which was included in the Final Integration Plan - Hospital and Community Health Services Integration – Haliburton County and City of Kawartha Lakes. The Plan was presented to the Health Service Provider Boards in November and early December and the Central East LHIN Board in December 2013 for any final decisions and was approved by all parties

In Haliburton County, Haliburton Highland Health Services (HHHS) and Community Care Haliburton County (CCHC) moved forward with their transition planning to form One Entity, through the voluntary integration of CCHC into HHHS, after the Central East LHIN approved their Transition at its June 2014 Board Meeting.

In March 2014, Ross Memorial Hospital (RMH) and HHHS announced the appointment of their new Director, Integrated Mental Health Services as a joint initiative to create a broader, more integrated and inclusive Mental Health Services program. This had been included in the "Strategic Alliance" recommendations between RMH and HHHS in the Final Integration Plan and is one of a number of new initiatives that is having a positive impact on the residents of Haliburton County and the City of Kawartha Lakes including shared service partnerships in areas such as Laboratory Services, Medical Device Reprocessing, Mental Health Leadership, Diagnostic Imaging Management and much more.

In the City of Kawartha Lakes, the accountability for the delivery of the Acquired Brain Injury Adult Day Service program was transferred from the Victorian Order of Nurses – Ontario Branch, Peterborough, Victoria and Haliburton to Four Counties Brain Injury Association effective August 1, 2014 after the Central East LHIN Board approved the two agencies' Transition Plan. Service volumes remained the same and clients now have access to strengthened expertise in delivering this type of specialized program.

In December 2014, the Central East LHIN Board approved the Transition Plan developed by Victorian Order of Nurses for Canada – Ontario Branch (VON) and Community Care City of Kawartha Lakes (CCCKL), which will see CCCKL become accountable for the delivery of the Adult Day Program in Lindsay. This integration will be completed by April 1, 2015.

Northumberland County Integration Process

Since January 31, 2013, a group of Health Service Providers (HSPs) from Northumberland County has been meeting as part of a facilitated integration process at the direction of the Central East LHIN. This included two hospital corporations – Campbellford Memorial Hospital and Northumberland Hills Hospital. After months of due diligence and stakeholder engagement, the Integration Planning Team (IPT), which was comprised of senior administrative representatives from seven local agencies, had developed an Integrated Governance and Service Delivery Model which became part of the Final Integration Plan - Hospital and Community Health Services Integration – Northumberland County. The Final Integration Plan was presented to the Central East LHIN Board on February 26, 2014 and recommended how hospitals and community-based health services could be delivered in the future 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. In June 2014, the Northumberland County IPT presented an update on their Transition planning as they work together to develop a Rural Health Hub in Trent Hills, establish a coordinated

approach for Assisted Living and Supportive Housing, expand on the work of the Collaborative Palliative Care committee, develop an integrated strategy for diabetes throughout Northumberland, develop opportunities for a strategic alliance between Northumberland Hills Hospital and the Port Hope Community Health Centre, integrate Information Technology across community and acute sectors and develop a Transformation Council to lead the transition work.

In October 2014, Central East LHIN staff presented information to the Board of Directors on the Community Health Services Integration (CHS) Phase Two and recommendations on how to move forward. Recognizing that some of the elements from the Northumberland CHS Integration Plan, specifically "integrating Information Technology across community and acute sectors" could be implemented through a Central East LHIN-wide approach, management recommended to the Board that this recommendation be aligned with emerging solutions and initiatives and be included in a broader IT strategy for the CHS sector in 2015/16.

In addition, the concept of the Northumberland Transformation Council has now been aligned with the work of the emerging Northumberland County Health Link and Campbellford Memorial Hospital continues to work with its local partners on the development of a Rural Health Hub in Trent Hills.

Durham CHS Integration Process

The Durham CHS Integration Strategy has successfully completed the following projects to date:

- Integration of congregate dining services and supportive housing between Community Care Durham and Sunrise Seniors.
- Integration of congregate dining services and supportive housing between Community Care Durham and Faith Place Support Services.
- Integration of volunteer visiting services between Community Care Durham and VON for Canada (Ontario Branch, Durham Region Site.
- Integration to create a “Durham North Zone” partnership and strategic alliance.

During the Central East LHIN Board of Directors meeting in January 2015, the Oshawa Community Health Centre (OCHC) and The Youth Centre (TYC) presented an Integration and Transition Plan that will see their two organizations amalgamate into a single Community Health Centre by October 2015. The creation of an integrated Community Health Centre that builds on the combined strengths and capacities of both organizations will allow a new organization to achieve a continuum of consistent, quality services and resources for clients in South Durham, including Whitby and Pickering. In addition, representatives from Durham Hospice and the Victorian Order of Nurses Canada – Ontario Branch presented a transition plan detailing how accountability for the delivery of hospice services will now be seamlessly transferred from Durham Hospice to VON effective April 1, 2015. With the Board of the Central East LHIN approving the facilitated integrations to go forward and providing the funding to support the necessary transition costs, the four organizations will move ahead to implement the integrations in partnership with their respective volunteers, staff, clients and communities.

Peterborough CHS Integration Process

In June 2014, the Central East LHIN Board endorsed the creation of a Peterborough City and County Community Health Services Leadership Council, a key element of the Final Peterborough Integration Plan. Since that time, the Leadership Council has been established and is preparing a Master Transition Plan for phased implementation of all key elements. The Leadership Council will be providing progress reports at the Central East LHIN's Board meetings in March 2015 and September 2015 to ensure progress of the Peterborough Integration Plan. The Leadership Council will be involved in the implementation of the LHIN-wide CHS Phase Two projects related to Intake and Referral, CSS Program Standards, and IT Enabling Technologies.

Scarborough CHS Integration Process

In October 2014, the Central East LHIN staff presented information to the Central East LHIN Board of Directors on the CHS phase two integration process and recommendations on how to move forward. Recognizing that two of the elements from the Scarborough CHS Integration Plan, specifically "Defining standard Community Support Services (CSS) services through a CSS Program Standards Committee" and "Intake and Referral - Determine standard tools and processes for seamless intake and referral across programs and providers throughout the Central East LHIN" could be implemented through a LHIN-wide approach, management recommended to the Board that the work completed through the CHS Integration Strategy - Scarborough Cluster be moved forward to a process that would begin in March 2015.

The Scarborough and West Durham Expert Panel

An expert panel has been created to address infrastructure needs as well as improve access and integration of acute health care services in the Scarborough and West Durham region. At the direction of the Minister of Health and Long-Term Care, this panel has been struck to develop a plan to address how hospitals in the region can work together to deliver acute health care programs and services in a way that meets the needs of local residents. The Panel will provide recommendations on program and service integration, as well as infrastructure needs. The group will work in collaboration with the Central East LHIN, other neighbouring LHINs, and local health care service providers, including Rouge Valley Health System, The Scarborough Hospital, and Lakeridge Health.

The work of the Panel is supported by a documented Terms of Reference, which lays out four goals: recommending a process for the development of a master plan for the Scarborough/West Durham region; identifying areas where patients can benefit through better integration of services; recommending implementation plans; and identifying how administrative and support services can be better utilized. The plan will articulate the vision for the hospitals' strategic operations, programs/services and operational models, and capital infrastructure under an integrated system.

The Panel is expected to submit their report to the Minister of Health and Long-Term Care and the Central East LHIN in October 2015.

CHS Integration Process – Phase Two

The Final Integration Proposal was presented to the Central East LHIN Board in October 2014. Phase two of the CHS integration strategy is a regional approach to achieving the same aims as in phase one: 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. In 2015/16 Central East LHIN-wide projects for phase two of the CHS Integration process will include the following:

- Defining Community Support Services (CSS) program standards;
- Determining standard tools and processes for intake and referral; and
- Improving the capacity of care delivery through use of integrated information technology.

Immediate recommendations from the Final Integration Proposal included:

- Developing a project charter and business plan for CSS program standards review;
- CCAC/LHIN Project Management Office and HSPs to develop project charter and business plan for CSS intake and referral;
- Aligning technology with emerging solutions (e.g., intake and referral) and initiatives (e.g., Health Links);
- Submitting a broader IT strategy for the CHS sector to the LHIN Board in 2015/16; and
- Identifying one-time resources for Project Management to support project design and completion.

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 Paediatrics; 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. 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"*

2015/16 implementation activities related to the original 2009 Clinical Services Plan include:

- Monitor Hospital Regional Service Agreements for Vascular and 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 has transitioned to the second phase that has developed implementation recommendations that will be submitted to the LHIN on March 31, 2015. These recommendations will be considered by the LHIN for implementation;
- Monitor sustainability of 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 (as part of the common Health Information System (HIS) vision –facilitated integration process); 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 2015/16 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 sustainability of the Life or Limb Policy implementation. 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. Key responsibilities essential to the success of the policy that the LHIN continues to monitor and participate in, 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;
- Utilizing CritiCall Ontario's repatriation tool to track and monitor repatriation requests and processes; and
- 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 MOHLTC.

- The continued focus on provincial critical care strategy implementation and other system improvements. This includes utilizing 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 and Critical Care Lead will continue to:
  - Explore enhancing system capacity to support patients requiring long-term ventilation;
  - Identify opportunities to mitigate health human resource (physician, nursing) challenges at both the local and LHIN level;
  - Better leverage technology, specifically Telehealth, to support rapid resuscitation of critically ill patients, and reduction in unnecessary transfers; and
  - Critical care service delivery, timely repatriation of any transferred patient, surge planning and event management.

The Central East LHIN Lead will continue to:

- 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 Emergency Department Lead;
- Identify opportunities to improve system efficiency and optimization of resources;
- Create or maintain a CritiCall on-call roster for the LHIN to support surge capacity response;
- Work with local and provincial stakeholders to enhance a patient referral framework that will improve patient transfers in the LHIN; and
- Engage critical care leaders from across the Central East LHIN (Central East LHIN Critical Care Network) to support the above deliverables.

Cardiac Care

Regional Cardiovascular Rehabilitation and Secondary Prevention (CRSP) is a regional approach to providing comprehensive care with a centralized, integrated referral process for Cardiovascular secondary prevention services in the Central East LHIN for patients at high risk including those with diabetes, chronic renal disease, stroke, cardiac disease, congestive heart failure and peripheral vascular disease. This “Hub and Spoke” service delivery model provides equitable access to consistent, high quality services.

In December 2014, the Central East LHIN approved funding to support the expansion of CRSP sites across the LHIN to increase capacity to “close the needs gap” and provide service to 5000 patients annually by 2016.

Vascular Surgery

During FY 2014/15 the Central East LHIN with hospital partners successfully established a regional vascular surgery services Memorandum of Understanding (MOU).The Vascular Surgical Memorandum of Understanding seeks to operationalize the LHIN’s vascular surgical service delivery model as agreed to by all parties in the 2009 Central East LHIN Hospital Clinical Services Plan. In the development of the MOU,

the LHIN engaged all stakeholders – administrative and clinical – in further refining elements of the vascular surgical model. In 2015/16 the regional vascular surgical steering committee will participate in planning meetings in efforts to close the gap of current practice to expected practice.

Maternal Neonatal and Paediatrics

For the past two years (2013 - present) the Central East LHIN Maternal, Newborn and Paediatric Advisory Committee (MNPAC) has been functioning 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.

During 2013/14, the Advisory Committee participated in a series of visioning and strategic planning through several stakeholder engagement sessions to collectively determine our vision, mission and values across the entire Central East LHIN.

Emerging from the nine stakeholder engagement sessions covering all three clusters and in alignment with the Central East LHIN vision and mission, the following statements were derived:

Vision:

Building the foundation for lifelong health in our communities.

Mission:

To provide evidence-informed, high quality health care and health promotion for women, newborns and children. To provide accessible care within an integrated, accountable and sustainable system focused on achieving healthy outcomes in the Central East LHIN.

Values:

1. Accountability & Integrity

- We accept responsibility for the integrity of our services and are accountable to our patients, families, community and health care partners to provide efficient and effective care across the continuum. We act openly and truthfully with fairness and equity in all we do.

2. Collaboration

- We work cooperatively to involve and engage partners and families. We recognize that our collaborative efforts will exceed what we can accomplish individually.

3. Quality & Safety

- We are committed to health care excellence by fostering a culture of safety providing high quality and safety, evidence-informed care and create a culture of safety.

4. Patient Centered Focused

- We support families to make informed choices for their care and respect their autonomy in decision-making, and advocacy for those patients and family.

5. Access to Services

- Supporting access to services, right provider, at the right time, at the right place, and to facilitate navigated access.

Building on the work of the Advisory Committee, and through an in-depth stakeholder strategic visioning exercise, the following five Strategic Directions will be further established in 2015 to develop a robust Strategic Plan for the maternal, neonatal and paediatric population in the Central East LHIN.

Strategic Direction #1:

- Coordinate within the Central East LHIN to create a high-quality, integrated system of patient/family-focused care across the continuum of maternal, neonatal and paediatric health that maximizes system effectiveness, efficiency and equity.

Strategic Direction #2:

- Build and support a Central East LHIN wide culture that embraces a systematic approach to quality improvement and patient safety, and support a knowledge-to-action approach to facilitate exemplary maternal, neonatal and paediatric care and health promotion in an environment of safety and best practice.

Strategic Direction #3:

- Build and support a sustainable approach to achieving and maintaining Baby Friendly designation across the Central East LHIN.

Strategic Direction #4:

- Develop best practice, interprofessional education, training, and patient/family resources, to facilitate implementation of evidence-informed practices.

Central East LHIN Motion 1b Collaborative – Service Delivery Model for Maternal, Child and Youth Care in the Scarborough Cluster:

On March 27, 2013, the Central East Local Health Integration Network (Central East LHIN) passed the following motion:

"…in partnership with the Rouge Valley Health System (RVHS), local stakeholders and physician leaders, The Scarborough Hospital (TSH) is to develop a Service Delivery Model for Maternal-Child-Youth (MCY) services (which includes obstetrics, neonates and paediatrics) for the Scarborough Cluster, as well as a plan for a LHIN regional program for advanced neonatal and paediatric care as recommended in the 2009 Hospital Clinical Services Plan and endorsed by the respective hospital boards at that time, with a report back to Central East LHIN Board in no more than 90 days."

Building on the strong work of 2013, a collaborative interprofessional team – the RVHS-TSH Motion 1B Collaborative – has been established and includes staff, physicians, and midwives from RVHS and TSH, as well as representation from the Central East LHIN, health system partners and community members.

The Motion 1B Collaborative will support the further development of an integrated service delivery model for maternal child youth services, which will include the formal establishment of a Central East LHIN-wide centre for advanced level 2c inpatient neonatal and paediatric care.

Upon completion of the workshop sessions, the Working Group deliberated and agreed that three of the initial six models presented would move forward for additional assessment using the agreed upon design criteria. The Central East LHIN Decision Making Framework was used to evaluate the three proposed models. The following four domains were utilized:

1. System Alignment
2. System Performance
3. System Values
4. Population Health

The Motion 1b Collaborative Working Group with support from the Central East LHIN captured the three models of care and the selection criteria in the form of an electronic survey using the Expert Choice tool. The survey results were shared openly and transparently with the Motion 1b Collaborative Working Group.

Ultimately, the survey was not intended to be the decision making mechanism for the Motion 1b Collaborative. It acts as an input mechanism into the decision making process. The survey was recommended by the physician stakeholders' themselves, it was not a LHIN recommendation or requirement.

Next steps involve presenting the findings from the workshop sessions to the Central East LHIN Board in March 2015, followed by a report back from the Motion 1b Working Group Collaborative to the Board to provide an overview of the proposed Governance plan and regionalized model within the next six months.

Integrated Orthopaedic Capacity Plan (IOCP) and Musculoskeletal Rehabilitation Services

In response to a MOHLTC 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) have been 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) developed Directional Plans and Project Charters outlining the plan for implementing all seven of the Key System Changes throughout 2015/16.

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

The Central East LHIN is developing the Central East LHIN Orthopaedic Advisory Committee to ensure oversight, standardization and sustainability of implementation including reporting process and timelines. The Advisory Committee will be initiated at the beginning of FY 2015/16.

The expert Orthopaedic Advisory Committee will be responsible for the following:

- Oversee planning and implementation of the IOCP including delivering on project plans and spread of promising practices
- Implement reporting structure and processes including identification of key process and outcome indicators (anticipated to be semi-annual)
    - Key accomplishments
    - Milestones achieved

- Current barriers and challenges
- 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 to OPICs and Central East LHIN
- Ensure best practice design

- Progress reports will highlight the following information when working towards completing the seven Key System Changes and 32 action items outlined in the IOCP.

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 has utilized the LHIN Decision Making Framework to ensure due diligence has occurred with our stakeholders in reaching consensus on recommendations regarding the most appropriate planning option. See the Vascular Health Strategic Aim on page 28 for additional information.

Development of a Vision Care Strategy

Resulting from the impetus of Health System Funding Reform (HSRF) and the adoption of Quality Based Procedures, new recommendations for Ophthalmology in Ontario have been developed to help with launching the Provincial Strategy Task Force. A Central East LHIN Vision Plan Working Group (VPWG) composed of representatives from across the LHIN had been established. The VPWG has developed a *"Directional Plan – Vision Care Strategy"* that focuses on inpatient and outpatient ophthalmic surgeries currently delivered by Central East LHIN hospitals. This Directional Plan aims to inform future Central East LHIN decision-making with respect to resource allocation, quality improvement, and access to services. The plan has been endorsed by the Central East Executive Committee and the Central East LHIN Board.

To continue the momentum and work completed to date, a similar advisory body will be required. The mandate of the VPWG will transition from a working group to a more strategic or advisory role to support the LHIN in overseeing the implementation, championing the change and ensuring sustainability post implementation.

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 Alternate Level of Care (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 ALC Days

Initiatives like Home First and 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/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. On October 27th, 2014, Fairview Lodge, a 198-bed Long Term Care (LTC) facility located in Whitby, Durham Region suffered a catastrophic fire. The loss of this 198-bed facility and the net loss of over 80 LTC beds came at a challenging time, especially in the LHIN's Durham cluster, which already has the lowest number of long term care beds per population.

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 for the period between January 2013 and December 2013 was 516,290. 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 2009/10 the number of visits represents an increase by 33,645 or a 7% increase.

Fiscal Year 2013/14					
Unscheduled Visits	Q1	Q2	Q3	Q4	Total
High Acuity	89,829	91,210	91,964	90,875	363,878
Low	50,718	54,135	46,690	44,019	195,562
Annual Totals	**140,547**	**145,345**	**138,654**	**134,894**	**559,440**

Fiscal Year2014/15					
	Q1	Q2	Q3	Q4	Total
CTAS I, II, III	95,987	96,991			192,978
CTAS IV, V	49,308	50,691			99,999
Totals	**145,295**	**147,682**			**292,977**

Source: ER Pay For Results Operational Report

The two main causes that contribute to increased ED wait times are a lack of inpatient acute care beds and a lack of integration between community and hospital health care resources. The Central East LHIN is making an investment of $15,345,800 for FY 2014/15 and $18,646,800 for FY 2015/16 as a part of the community investment. The investments will be in the following high impact areas:

- Comprehensive mental health strategy, building on success and including innovations to increase supports within housing;
- Strengthen comprehensive Primary Health Care models for at-risk seniors through new GAIN Community Teams, expansion of Adult Day Programs and Assisted Living Services to helping individuals and their caregivers lead active lives and spend more time in their homes and communities; and
- CCAC Home Care Services.

Funding is being directed to these projects/interventions that will have a positive impact on ED visits and 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:

	2013-14	2014-15 YTD							
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
ED Admitted	31.2	33.0	30.9	27.6	27.5	30.1	29.8	30.1	33.1
ED Low Acuity	6.0	6.3	6.0	6.0	5.9	6.1	6.0	6.0	5.9
ED High Acuity	3.9	4.2	4.0	3.9	3.9	4.1	4.0	3.9	3.8
PIA	2.7	3.0	2.8	2.8	2.8	3.0	2.8	2.8	2.7
ALC Throughput *	0.99	1.08	1.07	0.91	0.98	0.94	0.97		

*Source: ER Pay For Results Operational Report, * iPort ATC*

The Central East LHIN is constantly evaluating the impact of the various strategies 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 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 improves 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 Central East 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:

Indicator	2012/13 Baseline	2013/14 Final Central East LHIN Target
90th Percentile ER length of stay for admitted patients	33.72	30.00
90th Percentile ER length of stay for non-admitted complex patients	6.45	6.45
90th 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%
90th 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 from the FY 2012/13 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. Overall, funding provided to the Central East LHIN for FY 2014/15 was $12,682,625. The Central East LHIN allocation has increased by 17% from the Year 6 (FY 2012/13) total of $10,827,979. 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 2010/11, 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 MOHLTC 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 MOHLTC/LHIN Performance Agreement (MLPA). The objective was to improve alignment of expectations for capital builds between MOHLTC 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.

Health System Design and Integration: Priority Populations

French Language Services

A strong working partnership has been established with Entité 4 (French Language Health Services Planning Entity #4) to support the Central East LHIN in engaging with its francophone stakeholders.

The Central East LHIN and Entité 4 entered into a partnership with the TAIBU Community Health Centre TAIBU CHC), a health service provider (HSP) who provides primary health care, community development programs, and services for the African and Caribbean community in Scarborough, to support the implementation of the Coalition for Healthy Francophone Communities in Scarborough (CHFCS). The primary focus of the CHFCS is on health promotion and secondary prevention to slow or stop the progression of chronic disease and, where possible, prevent adverse events or disability.

The Coalition for Healthy Francophone Communities in Scarborough will specifically:

- Discuss best practices of health promotion, lifestyle modification, and management of chronic diseases;
- Share and present new initiatives, programs, services;
- Identify possible shared initiatives and projects;
- Provide feedback to the Central East LHIN on Francophone needs in Scarborough;
- Promote use of existing programs and initiatives, including self-management of chronic diseases to promote better health outcomes for the diverse Francophone community;
- Advise and provide input on the development of a Health Promotion and Prevention Action Plan for Scarborough;
- Advise on community projects that benefit the Francophone community recognizing diverse ethnicity in in Scarborough; and

- Review information gathered during project consultations, and develop reports and recommendations on initiatives regarding the health and wellness of the French-speaking population of Scarborough.

The Central East LHIN will continue to maintain mechanisms that foster ongoing dialogue with the Entité 4 to ensure that the recommendations, which are aligned with the 2013-2016 IHSP, are taken into consideration, rationally analyzed, and provided with timely responses.

Key activities for implementing the French Language Services (FLS) in 2015/16 include:

- Supporting HSPs in developing their FLS capacity by strengthening the Francophone Coalition table in Scarborough to offer direct services to those who speak French, such as primary care, self-management chronic disease workshop, mental health and addictions services, and health promotion.
- Creating a Francophone health table in the Durham region that aims to advise on issues and priorities for Francophones and to support the development and implementation of the Joint Annual Action Plan, as well as the Central East LHIN IHSP.
- Incorporating French Language services into each Strategic Aim for 2015/16 and considering FLS components in the planning stage of projects and initiatives (e.g. GAIN regional programs, Adult Day Programs, Assisting Living, primary care, mental health and addictions, diabetes/chronic disease and vascular). This will enable the Central East LHIN to strengthen its effectiveness, efficiency, and impact towards the French-speaking population, and accountability to the MOHLTC.
- Working collaboratively with the French Language Health Planning Entity (FLHPE) to continue to provide HSPs with opportunities to learn more about patient-centred care by providing them with tools and training to support the development of health services in French.
- Ongoing communication with 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 HSPs that have identified FLS capacity. Those who are willing to collaborate will be supported in developing and offering services in French in 2015/16.
- Offering cultural competency training to Central East LHIN staff and HSPs.

The Central East LHIN and the FLHPE will also continue to inform Central East LHIN staff, clients, and general public on needs and concerns of Francophone communities, and accountability achievements under the French Language Service Act (FLSA).

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, including:

- Ensuring the cultural safety of Central East LHIN health care services;
- 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;
- The Central East LHIN has continued to support relationships with mental health and addiction providers and with the CECCAC so that the services offered by these providers will be culturally accommodating. Meetings were held with mental health and addictions service providers throughout the year in order to work toward a plan to achieve this aim.

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 FY 2015/16. Both Aboriginal Health Advisory Circles will be engaged early in the process of developing the Central East LHIN's next Integrated Health Service Plan, (2016-19)

Year two of the Central East LHIN Integrated Health Services Plan, marked a number of key developments in moving forward with improvements to health care for Aboriginal people residing in the Central East LHIN area, including:

- In March 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, Niijkiwendidaaa Anishnaabekwewag Services Circle, and the Nogojiwanong Friendship Centre to build the capacity of both on and off reserve Aboriginal health service providers. The relationships formed as a result of this project have resulted in ongoing partnerships between Health Service Providers and Aboriginal Communities in providing Concurrent Disorders treatment to Aboriginal Peoples residing within the Central East LHIN.
- In December 2014, the Central East LHIN Board approved an expansion of the Hospital to Home Program that includes an Aboriginal outreach component in the Durham and North East Clusters of the LHIN.
- In May 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. Aboriginal Health Advisory Circle members have engaged with Health Service Providers to both advise on and provide cultural safety training. Over 50 Health Service Providers in the Central East LHIN have taken part in the IOCC cultural safety training funded by the MOHLTC.
- Meetings were held throughout June, September, and December 2014 at the First Nations located within the Central East LHIN with mental health and addictions service providers to discuss improving relationships between these providers and communities.

- In August 2013, Cancer Care Ontario (CCO) hired their first Aboriginal Navigator with the support of the Central East LHIN First Nations Health Advisory Network. The Central East LHIN has worked closely with the CCO Aboriginal Navigator throughout FY 2014/15.
- In October 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. This program has been fully implemented and has been well received in the community.
- OTN technology was installed at the Mississaugas of Scugog Island First Nation in FY 2014/15.
- 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 that continued into FY 2014/15.
- In January of 2015, Dr. Ian Dawe, the Central East LHIN Mental Health and Addictions Physician Lead met with the Chief of the Curve Lake First Nations.

The Central East LHIN plans to build on these successes during FY 2015/16 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 Service Accountability Agreement 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;
- Members of both Central East LHIN Aboriginal Health Advisory circles will be included in the development of IHSP 2016-19; 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)

The Ontario Telemedicine Network (OTN) is a comprehensive province-wide 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 2015, 19 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 2014/15 the Central East LHIN sites have conducted over 16, 400 clinical events – surpassing the MOHLTC target of 10, 056. Over the last three fiscal years (10 quarters) the most used event type was: Mental Health – this is anticipated to continue as 2014/15 use for Mental Health and Addictions comprising approximately 60% of all use. For 2014 the projected number of events would be 31,821, an increase from the previous fiscal year of 46.0%.

While overall telemedicine use is growing steadily in Central East LHIN, there remains a large degree of variation of use between sites on an annual basis. The Central East LHIN and OTN continue to work with 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 Central East LHIN.

In 2015/16 key areas of focus include equitable distribution of event/access across the Central East LHIN, best practice uptake within various clinical practice areas, activity aligned to Strategic IHSP Aims, extension of support to non-nurse sites and standardized reporting metrics. As programs begin to reach a three year maturity point with initiation and human resources stabilizing, it is expected that sites will begin to focus on standardization and sharing of best practices, and that that use at all sites will continue to increase.

Interim reports were provided to the Central LHIN Board in May 2014 and February 2015. In 2014/15 the Central East LHIN made small investments in replacement of equipment that was end of service, where the HSP had indicated difficulty in managing this need. In addition, through the 2015/16 Community Mental Health and Addictions provincial investment, the Central East LHIN is able to support CMHA-HKPR in expansion of telemedicine nursing and support to assist in addressing high need/demand for services via OTN in this community.

The Ministers Action Plan identifies the expansion of the OTN Telehomecare program. In 2015/16, the Central East LHIN will identify opportunities to introduce Telehomecare to support achievement of the Strategic Aims and priority projects. Telehomecare is a time-limited intervention (about six months), which provides in-home monitoring for clients through technology. This remote monitoring is supported by a registered health care provider (RN or RT) with specialized training in coaching and self-management. Telehomecare can support primary care providers to provide needed monitoring and self-management coaching that they currently do not have the time or capacity to provide. Early areas of interest include use of Telehomecare to support frail seniors enrolled in the GAIN program, alignment of Telehomecare with the Chronic Disease Secondary Prevention program, COPD/CHF initiatives and Diabetes Education Programs. Telehomecare empowers patients to better manage their chronic condition in their homes and communities.

OTN Teleophthalmology

In Central East LHIN, there are about 51,233 unscreened individuals with diabetes. In an effort to improve access, a teleophthalmology program has been developed and will be implemented in 2015/16 to overcome barriers to eye care for people with diabetes. The objective of this initiative is to engage individuals with

diabetes in Central East LHIN communities for the purpose of preventing complications and vision loss. The identified at-risk individuals will be engaged to receive retinal screening in a timely and convenient location in Scarborough with clear follow up access to eye care specialist for clients who may have difficulty accessing and navigating through the health and eye care system. This initiative is not to replace or interfere with those clients who already access similar services, but to provide screening closer to the client's home, which will reduce the travel and communication burden for patients and their families.

Emergency Preparedness

As part of recovery phase for the 2009 H1N1 pandemic, the 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 MOHLTC 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.

At the present time, the internal team is focused on Ebola preparedness and health system readiness for the Pan Am/ParaPan Games.

Independent Health Facilities

Effective in January 2014, the relocation policy of Independent Health Facilities (IHFs) were amended to reflect the LHINs mandate and role in local service planning. The policy change allows for greater IHF movement to address community needs. IHFs are community-based, licensed clinics providing publicly insured non-emergency, condition-specific single or episodic patient care services (diagnostic testing or therapeutic procedures). They are funded by the MOHLTC to cover the cost to the facility for performing the insured service. The Central East LHIN will continue to formalize evidence based recommendations to support the approval of relocation in or out of the LHIN.

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 MOHLTC has requested 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	2015/16		2016/17		2017/18	
	Status	%	Status	%	Status	%
Health Links Plan and implement seven Health Links across the Central East LHIN	In progress	70	Continue	20	Sustain gains	10
CHS Integration Strategy	Complete	50	Initiate Phase 2	25	Spread and monitor change	25
Hospital Regional Program Service Agreements Finalize Service Agreements with respective hospitals (Vascular Surgery) implement and monitor	Complete	100	Monitor	-	Monitor	-
Implement Provincial Life and Limb Policy Policy implementation including (a.) ensuring compliance with hospital use of the Critical service; (b.) updating hospital mild and LHIN moderate surge plans.	Complete	100	Monitor	-	Monitor	-
Central East LHIN Advanced Centre for Maternal and Newborn Paediatric Services As per the recommendations of the Central East LHIN Clinical Services Plan, the LHIN will consider the above pending review and community consultation.	In progress	60	In progress	40	Monitor	-

Central East LHIN Motion 1b Collaborative	In progress	40	Ongoing	30	Monitoring	30
Regional Delivery Model for In-Patient Adolescent Mental Health and Addiction Services As per the recommendations of the Central East LHIN Clinical Services Plan, the LHIN will consider the above pending review and community consultation.	Report submitted and considered	40	Implementation planning	30	Implementation	30
Explore Technology Solutions to Enable Better Patient Care Expand the spread of Ontario Telestroke model, and consider other technology solutions (e.g. Telemedicine) that will improve patient care and reduce avoidable patient transfers.	In progress	20	In progress	30	In progress	50

How will we measure success?

- Wait times for Cardiac and Vascular Services
- Program Specific Service and Quality Volumes (Cardiac, Vascular, Thoracic)
- % ALC with another hospital as destination
- Total number of inter- and intra- LHIN hospital transfers
- Critical Care Occupancy Rate (%)
- Total number of transferred Life or Limb cases
- Total number of Life or Limb consults declined/accepted
- Life or Limb acceptance rate
- Time to referral/acceptance/transfer/treatment for CritiCall 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)
- 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
- CritiCall
- Central East LHIN physician leadership
- Health System Funding Reform
- Ontario Telemedicine Network and eHealth Ontario
- Resource Matching and Referral
- Hospital Governance and Senior Leadership

Transitions in Care & Electronic Health Information Management

IHSP Enabler

Electronic Health: The Electronic Health Record Strategy to support improvements in delivery of care, and the health system in the region through information management and information technology.

IHSP Enabler Description

Continued development of the electronic health record has been broadened to incorporate all sectors of the health care system in the region including primary care, acute care, long term care, mental health and addictions, community and multi-services care. It has also been broadened to support the IHSP in its delivery of quality and safe care while also supporting continued integration, better value for the public dollars and efficiencies in the system. The broader range of the enabler is now being developed as a Regional Integrated Health Information System that will support the patient and provider through IMIT, with an overall Health Information System (HIS) Vision, and in collaboration with all HSPs, develop a Roadmap and plan to implement the vision that can guide the implementation and success of the strategy in the region into the future.

Current Status:

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 eHealth steering committee. Projects being supported and aligned to the strategy are well underway including the projects that are identified as key eHealth enablers.

The 2013/14 initiatives have been incorporated into this single enabler:

- Timely Discharge Information System (TDIS)
- Ontario Laboratory Information Systems (OLIS)
- Standardized Discharge Summary Template
- Surgical Utilization Booking Management Information Tool (SUBMIT)

In 2014, a refresh of the strategy that addresses the recent changes to provincial and regional strategies and looks at a more regional integrated approach by an inventory of the various technology initiatives (including Health Links, CGTA, OLIS) that not only aligns to the LHIN IHSP, but also the cluster and provincial initiatives. The region has identified four Vision Elements which are being socialized with all sectors and additional initiatives (identified in the Cluster ETI plan 2014 – 2017) are in progress. The work will result in a regional technology roadmap with collaboration and input from all sectors.

Goals:

Support the work of the IHSP through a broader planning initiative that incorporates the electronic patient record towards a Regional Integrated Health Information System and resulting Roadmap. 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.

Action Plans/Interventions

Action Plans	2015/16		2016/17		2017/18	
	Status	%	Status	%	Status	%
Complete the RIHIS vision with engagement and input from all sectors including the methodology and detail on initiatives.	In progress	100	Monitor		Monitor	
Update Communication Plan derived from the eHealth system strategy to increase awareness and understanding of the LHIN strategy and its alignment to the IIHSP 2013-2017 and cluster strategy.	Not started	100	Monitor	-	Monitor	-
Planning: Work with the cluster to complete and implement the approach for shared cluster priorities (e.g. IM Strategy)	In progress	100	Monitor	-	Monitor	-
Planning: Develop current state of infrastructure and assets with the LHIN and cluster to determine future planning and collaboration (e.g. utilizing or sharing of assets, consolidation of applications etc.) and the related gap analysis	In progress	100	Monitor	-	Monitor	-
Planning: Complete the 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	In progress	100	Monitor	-	Monitor	-

Planning: Identify any major initiatives that require new funding and develop business cases	In progress	100	Monitor	-	Monitor	-
Planning: 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	100	Monitor	-	Monitor	-
Governance: 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	-
Governance: 2. Establish and report on key performance indicators using a balanced scorecard	In progress	100	Monitor	-	Monitor	-

How will we measure success?

- Completed RIHIS vision in the Central East LHIN based stakeholder input and endorsement
- Completed decision making framework and operating principles including development of an approach or framework to the sharing of information between multi-sector / multi-organizations with respect to privacy, security
- Completed update of communication strategy and HIS vision elements and initiatives within the region according to survey
- Completed roadmap approved by sector stakeholders and Board of Directors to implement strategy showing alignment to the strategy within the provincial, cluster and LHIN.
- Formal documentation (business plans and decision making documents) presented as appropriate for new initiatives
- Proposed governance model that has been agreed upon by the HSPs to the Board
- Completed dashboard to provide regular performance indicator using a balanced scorecard

What are the risks/barriers to successful implementation?

- Lack of consensus for approval on roadmap, initiatives, or detailed plans put forward
- Initiatives identified under the strategy fails
- Limited resources
- Lack of awareness or understanding of the privacy / security issues and constraints; education and approval

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

- 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.
- Ensure dedicated and capable leadership is in place to drive each initiative.
- 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.
- 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 Commission).
- Utilize formal project management processes and tools to minimize and mitigate risks (i.e. initial risk planning, monitoring and change control).
- Wherever possible, leverage existing resources (e.g. tools, templates, individuals/committees) and minimize redundancies; this increases the capacity available to all parties in the LHIN and cluster.

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

- Key supporting processes that must be in place to ensure success in both implementation and adoption
- 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
- 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
- Use of current and develop future working groups and collaborative committees to support the initiative
- Principles of collaboration for technology that will guide collaboration and integration; developed out of the restructuring and framework for committees

IHSP Enabler

Transitions: Resource Matching and Referral (RM&R)

IHSP Enabler Description

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, Resource Matching and Referral (RM&R) and related Assessment and Business tools are considered a critical technology enabler to manage patient flow between sectors and organizations.

The Alternate Level of Care (ALC) RM&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&R will result in more efficient, equitable and client-centered care. Supported by the MOHLTC, this initiative is considered a priority for all 14 Local Health Integration Networks.

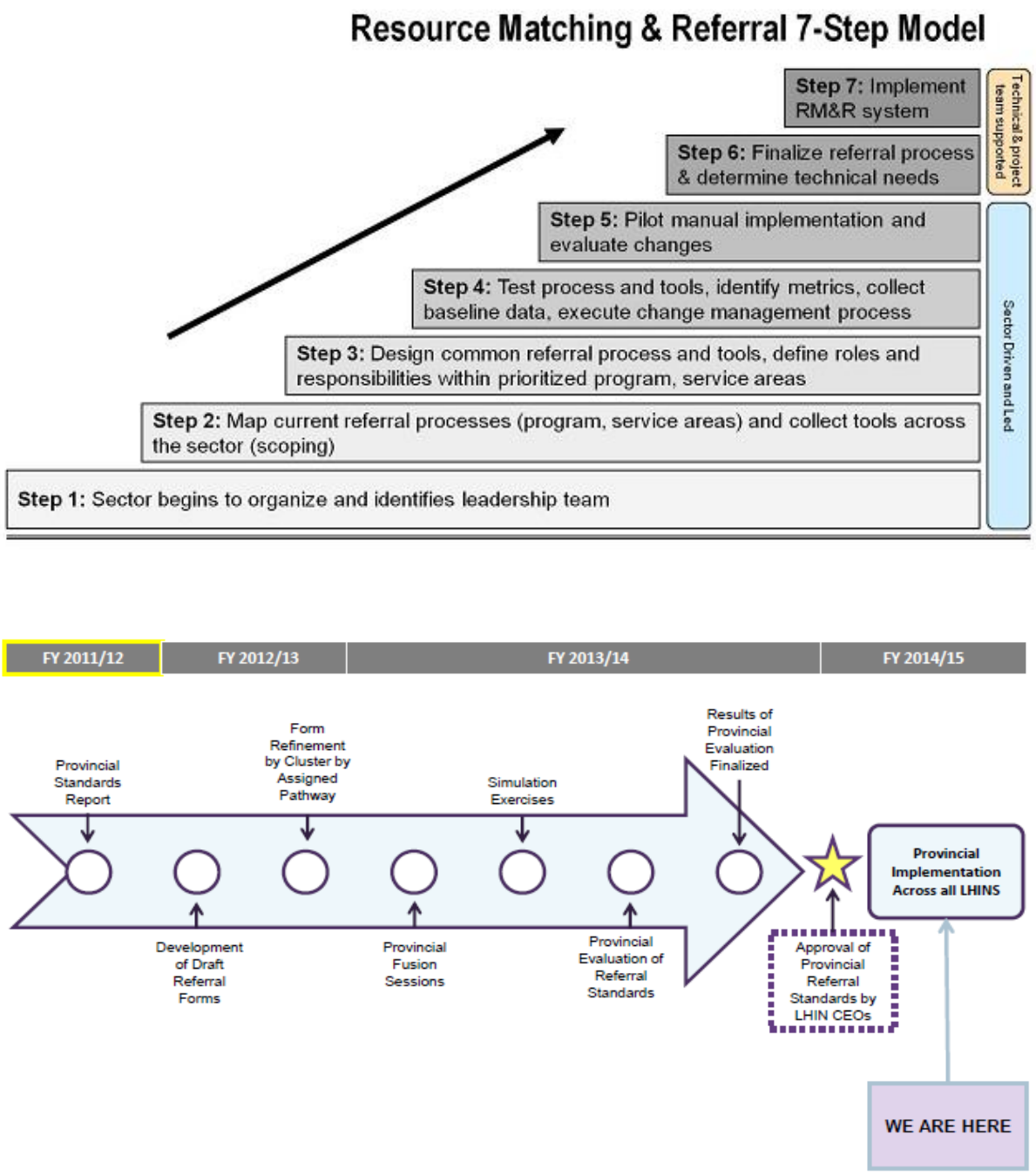
The implementation of the Provincial RM&R is focused on the following four referral pathways, which offer the greatest potential opportunities for improving ALC wait times, with the objective of having one provincial form per care pathway:

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

ALC RM&R supports the MOHLTC ER/ALC Strategy, the Senior's Care Strategy, the Excellent Care for All Strategy, and the Ontario eHealth Strategy. The Central East LHIN has completed the implementation of the 'Acute (Medical and Surgical Inpatient) sending referrals to Long-Term Care through CCAC' and 'Acute (Medical and Surgical Inpatient) sending referrals to CCAC In-Home Services' pathway.

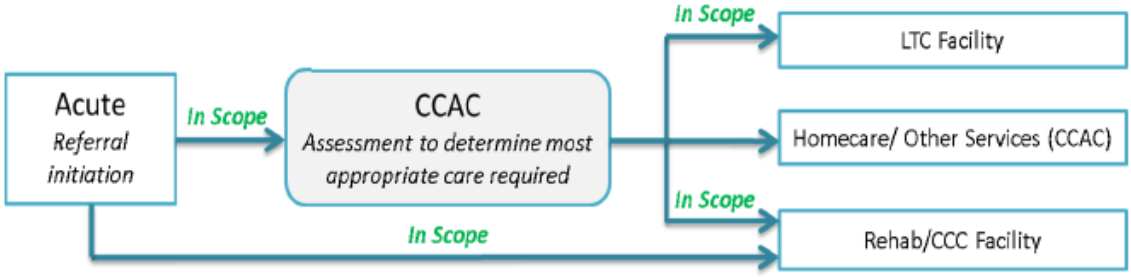
Current Status

The RM&R solution is being implemented provincially and all the LHINs. LHINs divided into three clusters (Central East LHIN is in the Central Ontario Cluster with five 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 seven (see diagram below).



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 Centre 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 the lessons learned will be used as a basis to determine the electronic solution.

Referral data has now been standardized and are being utilized for implementation of the in-scope pathways.



Acute to CCAC	Referral data sent by Acute in-patient (medical /surgical) units to the CCAC in order to trigger a patient assessment for CCAC services.
Acute to LTC (through the CCAC)	Referral data in the application cover sheet set by all CCAC to LTC Homes to help the LTC Home in making acceptance decisions. All other attachments are standardized through either the ministry or the CCAC sector.
Acute to Rehab and CCC	Referral data sent by Acute in-patient (medical/surgical) units to Rehab and CCC facilities to help the Rehab and CCC facilities in making program/service acceptance decisions.

What we are trying to accomplish in the Central East LHIN:

- Implement electronic pathways only (based on results from pilot implementation)
- Use standardized definitions for bedded levels of rehabilitative care (i.e. hospital-based inpatient beds that are not coded as acute care as well as convalescent/restorative care beds within LTCH) as developed by the Definitions Task Group of the Rehab Care Alliance. These will be used as standards for rehabilitative levels of care across the continuum and will limit the need to move patients between bed types.
- Implement the CCAC Expanded Role
- Complete Complex Continuing Care (CCC) and Rehab pathways using provincial referral standards (PRS) by April 2015 for all in scope organizations

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 seven with other tools is being identified in the Central East LHIN.

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 Plan	2015/16		2016/17		2017/18	
	Status	%	Status	%	Status	%
Communication and education around lessons learned from 2012-13 early implementation pilots	In progress	100	Monitor	-	Monitor	-
Validation of two pathways already implemented electronically to confirm they meet provincial standards and dataset	In progress	100	Monitor	-	Monitor	-
Detailed planning to implement the remaining pathways according to the provincial requirement	In progress	100	Monitor		Monitor	-
Implement the future state process for Rehab/CCC in all Central East LHIN hospitals	Planning	100	Monitor	-	Monitor	-
Implement an automated system for resource matching and referral at Central East LHIN	Planning	75	In progress	25	Monitor	-

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 average length of stay 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
- Standardization of Assessment/Referral. Allows for measurement of completeness, response timelines, volume, and regional service placement/waitlist
- Reduction in inappropriate utilization for Rehab/CCC via CCAC Gateway – consistent with Home First practices
- Meets LHIN RM&R implementation objectives and Enhanced CCAC Role

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 they 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 2015 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 health service provider 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

IHSP Enabler: Transitions in Care and Electronic Health Information Management

Transitions and Electronic Health: 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.

IHSP Enabler Description

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.

Current Status

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.

Goal(s)

- Develop a method to define the physician community (i.e. names, contact and geographic information), specifically those that are not captured through EMR funding.
- 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.
- Improve the adoption of provincial electronic tools for physicians through engagement, support in coordination etc. including:
    - Making use of the EMR funding window by Ontario MD
    - OLIS access to the EMR
    - CGTA Connectivity
    - Intake and referrals
    - HRM and TDIS
    - Connectivity to the provincial CCT (coordinated care tool)
    - Proposed project for Physician Credentialing
- 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.

Action Plans/Interventions

Action Plans	2015/16		2016/17		2017/18	
	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 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 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 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 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 started	100		-		-

How will we measure success?
• Identification of physicians in the region and method of tracking updates • Feedback by physician community on engagement and communication methods – building of awareness • Participation % met of adoption of provincial initiatives including EMR, OLIS and automated OLIS query
What are the risks/barriers to successful implementation?
• Difficulty identifying appropriate physicians • Engagement and participation on programs with physicians • Support and follow-up along with Ontario MD and eHealth to support implementation to completion • Potential funding and resource constraints for participation
For each risk/barrier, describe the plan to mitigate the risk?
• Survey and data gathering from Ontario College and Health Force Ontario (HFO) to identify physicians and determine the tracking method • Look to support from HFO, physician champions and regional advisory council to support and engage physicians
What are some of the key enablers that would allow us to achieve our goal?
• Physician Advisory Council • Communication tools available through Ontario MD, College of Physicians, and Health Force

Quality and Performance Improvement

IHSP Enabler

Quality and Safety

IHSP Enabler Description

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

- *Fiscal responsibility and organizational health*: Resource investments in the Central East LHIN will be fiscally responsible and prudent
- *Transformational leadership*: The LHIN Board will lead the transformation of the health care system into a culture of interdependence
- *Health service and system integration*: Create an integrated system of care that is easily accessed, sustainable and achieves good outcomes
- *Quality and safety*: Health care will be person-centred in safe environments of quality care

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

The Central East LHIN's focus on quality improvement has been proven to successfully implement and spread new pathways of care, facilitate engagement of inter-disciplinary teams, design tools, and describe standard work. Emphasis on quality improvement methodology will continue as a critical enabler for the four current Strategic Aims. In addition, methodology to engage patients in planning and design processes, such as Experience-Based Design, will be developed and used to support activities to achieve the Strategic Aims.

Current Status

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

- Percent of stroke/TIA patients admitted to stroke unit during their inpatient stay - between FY 2011/12 and FY 2012/13 was a 6.9% increase in proportion of stroke or TIA patients treated on a stroke unit any time during their inpatient stay. A Vascular Aim Coalition priority was creating a coordinated stroke system by district and increased communication among hospitals with MOUs. This resulted in enhanced utility of stroke units, as demonstrated by this indicator.
- Central Line Infection (CLI) rate (per 1000 patient days) - Central East LHIN has been consistently below the Provincial rate and will continue to monitor to ensure continued positive performance.

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 2013/14 and outcome targets have been included in Hospital Service Accountability Agreements, including reductions of readmissions for select case mix groups.

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

Behavioural Supports Ontario (BSO)

Quality improvement will continue to be the change methodology used to ensure spread and sustainability of the Behavioural Supports Ontario (BSO) initiative as it moves into its fourth full year (2015/16) and spreads throughout all long-term care homes. The BSO Design Team has been 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 2015, 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 2010/11 as a LHIN high priority project and is focused on enhancing the care and reducing the risk of functional decline of seniors. The Central East Senior Friendly Hospital (SFH) Working Group leads the regional SFH strategy. The Working Group, comprised of representatives from each of the nine hospitals in the Central LHIN, the Regional Geriatric Program of Toronto, the Central East LHIN and Seniors Care Network and embodies the collective desire for a regional approach to SFH care and the need for action beyond another "initiative" to an enduring "movement" that makes a senior friendly approach simply the way we do business in our region. See page 24 for additional information regarding the Senior Friendly Hospital Initiative.

Order Sets/Order Entry Initiative

In 2015, the Central East LHIN supported improvements to patient care and quality-based funding reform through by supporting the adoption of standardized order sets and, where applicable, order entry.

- Three hospitals in the Central East LHIN received funding for Order Set/Order Entry Readiness Assessment. Through this initiative, the organizations committed to undertake a formal Readiness Assessment for implementation and spread of order sets/order entry, including:
    - Change Management: Physician and clinician readiness, champions in Medicine, Surgical and/or Mental Health departments;
    - Development of an implementation and sustainability plan that will be supported by administrative and clinical leadership;
    - IT interface Options Analysis: Utilization of order entry options including web enabled solutions and/or interface with the hospital's existing information system
    - Anticipated plans for data capture and monitoring plan to support change management and evaluation; and
    - Issue identification and resolution that has hindered uptake of existing/previous clinical order set options.
- Five hospitals in the Central East LHIN received funding for Order Set/Order Entry Implementation. The organizations agreed to develop an implementation approach for the uptake of order sets and order entry that addresses how order entry will be implemented, including:
    - How forms will be accessed, completed and processed;
    - Adoption and integration of e-forms, and (if applicable) interfaced with existing HIS;
    - Integration of order sets with existing HIS systems;
    - Quality improvement initiatives aimed at creating process efficiencies;
    - Data capture plan, including data reporting and reporting to internal stakeholders; and
    - Change Management and Sustainability Plan.

A final outcomes report will be provided to the Central East LHIN by April 30, 2015. Organizations funded for order set/order entry implementation will provide an order set utilization report by targeted in-patient program in Q1/Q2 of FY 2015/16.

A LHIN Order Sets Coordination Work Group will be formed. The main goal of this group will be to:

- Identify mechanisms for knowledge exchange between hospital partners;
- Recommend areas for future clinical standardization in alignment with QBP implementation;
- Report to the Local Partnership, VP CNE or other tables charged with broader QBP implementation;
- Support the RFP for Order Sets/Order Entry for 2015/16 going forward

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
- Introduce training on patient motivational interviewing and experience-based co-design for LHIN and provider staff
- 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 Plan	2015/16		2016/17		2017/18	
	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	45	Completed	15
Integration of QI tools and methods in HSP initiatives for all sectors.	In progress	35	In progress	35	Completed	30
Standardize and develop a repository of Central East LHIN quality Improvement toolkits and protocols	In progress	90	In progress	5	Completed	5

How will we measure success?

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

What are the risks/barriers to successful implementation?

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

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

- Collaborate with Health Quality Ontario in providing training for system planning teams such as Health Links and Behavioural Supports Ontario
- Provide training in smaller parcels (theory bursts) and online and at convenient times
- Provide in-house training whenever possible

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

- Leadership support
- Staff expertise
- Facility with Eclipse and presentation software

Central East LHIN Staffing Plan

Central East LHIN Staffing Plan (Full-Time Equivalents)				
Position Title	**2014/2015 Actuals as of March 31/2015 FTEs**	**2015/2016 Forecast FTEs**	**2016/2017 Forecast FTEs**	**2017/2018 Forecast 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
Total FTEs	**42**	**42**	**42**	**42**

Central East LHIN Operations

LHIN Operations ($)	2014/15 Actuals	2015/16 Allocation	2016/17 Planned Expenses	2017/18 Planned Expenses
Operating Funding (excluding initiatives)	***4,534,130***	***4,534,130***	***4,534,130***	***4,534,130***
Initiatives Funding (including eHealth, A&MH, ED, Wait Time, etc.)	***1,872,301***	***1,872,301***	***1,872,301***	***1,872,301***
Salaries and Wages	2,785,836	2,785,836	2,785,836	2,785,836
Employee Benefits				
HOOPP	278,584	278,584	278,584	278,584
Other Benefits	334,300	334,300	334,300	334,300
Total Employee Benefits	***612,884***	***612,884***	***612,884***	***612,884***
Transportation and Communication				
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	-	-	-	-
Total Transportation and Communication	***118,400***	***118,400***	***118,400***	***118,400***
Services				
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				
Total Services	***961,130***	***961,130***	***961,130***	***961,130***
Supplies and Equipment				
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		-	-	-
Total Supplies and Equipment	***45,880***	***45,880***	***45,880***	***45,880***
Capital Expenditures	10,000	10,000	10,000	10,000
LHIN Operations: Total Planned Expense	***4,534,130***	***4,534,130***	***4,534,130***	***4,534,130***
Annual Funding Target	***6,406,431***	***6,406,431***	***6,406,431***	***6,406,431***
Operating Surplus (Shortfall)	***-***	***-***	***-***	***-***

Integrated Communications Strategy

Objectives

Business Objective

The Central East LHIN's 2015/16 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 continuing to be 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 2015/16 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 specifically in the areas of seniors care, vascular health, mental health and addiction supports and palliative and end of life care;
- Ensuring that the voice of patients and their families is captured and reflected in the implementation of the initiatives;
- 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, coordinated, effective and efficient services based on funding available and tracking performance against signed accountability agreements;
- Providing accurate and timely information to all audiences using materials that reflect the updated LHIN visual identity.

Context

- Ontario's Patients First: Action Plan for Health Care, announced by the Minister in February 2015, strengthens the province's commitment to put people and patients first by improving the health care experience. This next phase builds on the progress of the 2012 Action Plan for Health Care, which was consistent with the principles of the Excellent Care for All Act (2010). The new Action Plan focuses on improving access to health care, delivering better coordinated and integrated care in the community, informing and supporting patients, and making decisions based on value and quality to promote a sustainable health care system. These areas of focus put the LHINs at the centre of health system transformation.

Additionally, the Premier's Mandate Letter to the Minister of Health and Long-Term Care highlights the priorities placed on home and community care, the LHINs' role in delivering more efficient and coordinated care to patients and the ongoing focus on accountability and transparency.

And the Minister's Patients First: A Roadmap to Strengthen Home and Community Care report, released in May 2015, includes 10 steps toward higher quality, more consistent and better integrated home and community care laying out clear timelines to achieve these goals over the next three years.

- As such, LHINs continue to have a critical role to play in key provincial initiatives 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 MOHLTC 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 MOHLTC, 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
    - Consumer/Patient Support Groups
    - Healthcare Associations (OHA, ONA, OMA, etc.)
- Government
    - Municipal
    - Regional
    - Provincial – including MOHLTC stakeholders
    - Federal
- Central East LHIN Planning Partners
- Patients/Clients/Consumers/Residents/Caregivers
- 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, and 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.

- Demonstrate how patients/caregivers/general public can participate in improving their own health and support the development of plans to support care delivery in the LHIN's seven Health Links.
- 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 evidence-based practices, 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?

- Putting people and patients first by improving the health care experience
- Providing information to make decisions, and tools to live healthy and stay healthy
- Providing better access to quality health services, and protecting those services for generations to come
- Patients First:
    - a caring, integrated experience for patients
    - faster access to quality health services
    - for all Ontarians at every life stage
- Access:
    - Providing faster access to the right care
- Connect:
    - Providing better home and community care
- Inform:
    - Providing information to make the right decisions about your health
- Protect:
    - Ensuring our universal health care system is sustainable for generations to come

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, and is patient focused.
- 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.
- Patients and caregivers need to become more accountable for their own health and actively participate in the development of plans that support care delivery in the LHIN's seven Health Links.

Tactics – high level

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 and incorporate their feedback as appropriate.
- 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 2015-16, the Central East LHIN will fulfill its commitment to community engagement in the following ways:

Engagement Strategies and Best Practices

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

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

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

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

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

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

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

Identification of Stakeholders & Assessment of Impact and Outcomes

The Central East LHIN 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
- Central East LHIN Self-Management Program Advisory Council
- eHealth 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
- Central East LHIN Diagnostic Imaging Working Group
- Central East LHIN Regional Decision Support Group
- Central East LHIN Wait Time Strategy Working Group
- Clinical Vice Presidents and Chief Nursing Officers from Central East LHIN Hospitals
- Medical Leadership Group - Chiefs of Staff from Central East LHIN Hospitals
- Vascular Health Strategic Aim Coalition
- Central East LHIN Communications Sub-Committee
- Central East LHIN Communications Network
- BSO Advisory and Design Teams
- BSO Education Committee

- CCDC Diabetes Committee
- Central East 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
- Health Links Durham West
- Health Links Scarborough (South and North)
- Health Links Northumberland County
- Health Links Haliburton/City of Kawartha Lakes

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, and 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 French Language Services Act (FLSA).

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

To do so, the Central East LHIN engages with its Francophone community in partnership with the French Language Planning Entities (April 2011). 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; and the integration of French language health services.

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