South East
Local Health Integration Network
2008-2009 Annual Service Plan
May 30, 2008

Ontario

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Transmittal Letter

South East
LOCAL HEALTH INTEGRATION NETWORK
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May 30, 2008

The Honourable George Smitherman
Minister of Health and Long-Term Care
5th Floor, Hepburn Block
80 Grosvernor Street
Toronto ON M7A 1T3

Dear Minister Smitherman:

Pursuant to our obligations under the Local Health System Integration Act, 2006, please find attached the final 2008/09 Annual Service Plan (ASP) for the South East Local Health Integration Network (South East LHIN).

This plan marks yet another milestone for health system sustainability and accountability in Ontario. Our ASP demonstrates our commitment to local health system governance and demonstrates clear and achievable ways to support the priorities for change of our IHSP. No doubt, the release of the ministry's strategic plan will trigger further discussions on how to ensure provincial objectives are equitably met across Ontario.

The South East LHIN Annual Service Plan speaks, in part, to the conflict of growing service demand in an era of financial constraint. We know success of the LHINs will not come from our looking at the chess board of health services and re-arranging the pieces, nor from upending the table. The key for our LHIN is understanding the enablers of success: leadership, continuous improvement and leveraged investment.

- Leadership at all points in the health system will drive the success of the South East LHIN and our health service providers.
- Continuous improvement of how services are delivered and supported enshrines a culture of innovation.
- Leveraged investment, tied to continuous improvement and the leadership to drive change, is the catalyst for health system transformation.

Our ASP was developed with these factors in mind. Our first steps in making these principles part of the management culture in our LHIN are included in our ASP, ensuring that resources are being used optimally and that any deficiencies in health services are addressed. Our next steps will be to use these principles when moving forward with new initiatives with our health service providers.

The Board of the South East LHIN is fully committed to ensuring that our local health system provides optimal care to our communities and does so in an environment of shared accountability for performance, access and sustainability.

We look forward to reporting on our progress.

Sincerely,

Georgina Thompson

Georgina Thompson, Chair
South East Local Health Integration Network

Introduction

Annual Service Plans[1] (ASPs) are prepared by Local Health Integration Networks (LHINs) to advise the Ministry of Health and Long-Term Care (MoHLTC) on how each LHIN intends to meet its planning and performance requirements as well as how it intends to fulfill its Integrated Health Services Plan (IHSP).

This ASP speaks to current and anticipated activities as well as expected results for the South East Local Health Integration Network (South East LHIN) for the fiscal years 2008/09 through 2010/11. The timeframe of this ASP extends beyond the current IHSP[2] but supports the intent and objectives of that plan.

What LHINs do

- **Plan the development of a local health system**
- **Give the communities served by the LHIN a voice in the future of their health care system through community engagement**
- **Seek out opportunities to improve the health system through better cooperation and coordination of local service providers**
- **Negotiate agreements with providers and monitor performance**
- **Allocate funding to providers**
- **Report on the performance of the local health system to the community and the government**

LHINs plan for and fund health services within specific geographic areas focusing on opportunities for health service providers to work more effectively together. Over the next few years, LHINs will negotiate accountability agreements with their providers, setting performance objectives and working collaboratively to determine how those objectives will be measured. LHINs will fund providers based on the terms of their accountability agreements. LHINs are responsible for the planning and funding of services provided by long-term care homes (LTCH), hospitals, community care access centres (CCAC), community support services, mental health and addiction agencies and community health centres.

[1] This submission is mandatory, and meets the LHIN's requirements for accountability and transparency under the *Local Health System Integration Act, 2006.*

[2] The South East LHIN IHSP was released in November, 2006.

The Ministry of Health and Long-Term Care's (MoHLTC) vision for the health system is "*a health care system that helps people stay healthy, delivers good care when they need it and will be there for their children and grandchildren*." The South East LHIN employed this vision when developing the IHSP. More recently, a vision specific to the South East LHIN was developed to guide our efforts. The following vision was developed through the use of a citizens and health service providers assembly in spring, 2008:

> "*Achieving better health through proactive, integrated and responsive health care in partnership with an informed community."*

The South East LHIN will use this vision to develop a strategic plan in 2008/09 for rollout in 2009/10 and beyond. This service plan explains how we intend to achieve this vision, as well as our IHSP Priorities for Change:

Improve access to:

- Primary Health Care
- Specialty Care
- Mental Health Services
- Addiction Services
- Long-Term Care Services
- Rehabilitation Services

In addition to these priorities, the South East LHIN is investigating opportunities to assist patients moving from one health service provider to another. In some cases, this may mean the physical movement of patients; in others, it means facilitating greater cooperation and alignment between providers to improve access and transition.

Our IHSP also considered these priorities in the context of ensuring that aboriginal communities were engaged in planning health services for their communities and that health services are provided in both official languages, where designated.

E-health and the continued implementation of information technology are essential to ensuring health system sustainability and to attracting new clinical professionals to our communities. In achieving our priorities for change, we will - where possible - leverage e-health initiatives.

"[Our]...three year plan supports the good healthcare services that are currently available in the South East and identifies several priorities for development that will help health care move from a series of health services to an integrated health system.

Our goal is to make sure that developments are focused on making healthcare a more accessible, easier to navigate journey that helps people stay healthy and helps them recover when illness or injury happen".

- Paul Huras, Chief Executive Officer

How we plan to achieve these priorities is detailed in Section D. Given the well-documented financial constraints on the health system, the South East LHIN has focused on projects with a high probability of success and greatest results for time and effort invested. The review and implementation of future projects is one of the ongoing responsibilities of LHINs.

The work detailed in this plan reflects contributions from our community as gathered during and since development of the IHSP. Implementation will require the South East LHIN and our health service providers (HSPs) to work collaboratively for our collective success.

Of special note, in addition to the operational projects detailed in this ASP, our board has invested and continues to invest considerable time and resources to advance collaborative governance among health service providers within the South East LHIN. This "governance to governance" relationship between provider organizations within the South East LHIN enables discussion about founding principles, modes of governance and strategic priority alignment. A Collaborative Governance Development Team, with representation from all health care sectors within the South East LHIN, is guiding the work of this critical initiative.

Leadership, starting with health service provider boards through to every person working in our LHIN, is what will drive our collective success. We recognize that the objectives of LHINs are not new to health care. But the South East LHIN will be greater than the sum of its individual providers. Integration, done well, is transformative - and that is our ultimate objective. Together, we will transform delivery of health services in the South East LHIN into a cohesive system where patient care is paramount and health service providers operate knowing their collective responsibility to the health care system as well as to their own organization.

Environmental Scan

A full environmental scan was completed for the South East LHIN to support the development of our IHSP. The scan involved community engagement activities such as stakeholder consultations; demographic analysis of our population; analysis of population health and how our health services are used; and a review of key health system and health status indicators and outcomes, where available.

Geography and Population Health

Geographic area

The South East LHIN covers 19,473 square kilometres and is, geographically, the fourth largest in Ontario.

Population distribution and where care is received

Approximately one-half of the South East LHIN's population live in relatively small communities scattered across the South East LHIN's geographic area, with the balance living in the four urban areas along the 401 corridor. This distribution can make accessing health services more difficult than it would be for Ontarians in large urban centres as distance, weather and practitioner preference all come into play. Despite this, over 90% of our residents who need health services are able to receive them in the South East LHIN.

Highest proportion of senior population

With a population of approximately 482,000[3], the South East LHIN has the highest percentage of residents aged 65 years or older in Ontario (16.7% compared to 12.9% provincial average). Our LHIN also has the second highest percentage of residents aged between 50 and 64 years (20.2% compared to 17.7% for the province). As older Ontarians are historically greater users of health services, and we have a greater proportion of older Ontarians in our LHIN, the local health system will need to adapt to changing service demands.

[3] Population Estimates 2006, Ontario Ministry of Health and Long-Term Care, Provincial Health Planning Database.

Substantial burden of illness

Given that our LHIN has more seniors as a percentage of population than the rest of the province, it is not surprising to see that our LHIN reports a higher prevalence of arthritis/rheumatism, high blood pressure, asthma, diabetes, heart disease and chronic bronchitis[4]. The South East LHIN has the highest prevalence of heart diseases in Ontario.

Low life expectancy[5]

This measure is used as an indicator of overall population health. The current life expectancy at birth in the South East LHIN falls within the lowest quartile for the province. The measure is impacted, in part, by the higher prevalence of chronic disease in the South East LHIN, as noted above.

Issues Affecting the Provision of Health Services

Limited access to primary health care

Our residents regularly report difficulties accessing care from primary care and specialty care physicians throughout the South East LHIN. Several communities in the South East LHIN are designated by the province as being "under-serviced" for physicians. A review completed by the Institute for Clinical Evaluative Sciences (ICES) concluded that "when all adjustments are considered, the East's physician supply appears similar to the provincial average". Further work is required to understand this situation clearly.

Greater utilization of inpatient and ambulatory services

Residents of our LHIN have the highest number of Emergency Department (ED) visits per population in the province.[6] Visits due to *Non-Urgent* and *Less Urgent* care (see Table for definitions) account for almost 60% of all ED visits. While the utilization rate for non-urgent visits to the ED is below the provincial average, the less urgent ED visit rate is the highest in the province - 60% above the provincial average - and more than triple the rates in the LHINs in the Greater Toronto Area.

Selected glossary - Emergency Department and In-patient Levels of Care

Hospitals use the Canadian Triage and Acuity Scale (CTAS) to assess a patient's condition when seen in the Emergency Department

Level I: Resuscitation
Conditions that are a threat to life or limb, or imminent risk of deterioration (e.g. heart attack)

Level II - Emergent
Conditions that are a potential threat to life, limb, or function (e.g. chest pain)

Level III - Urgent
Conditions that could potentially progress to a serious problem requiring emergency intervention. (e.g. moderate asthma attack)

Level IV - Less Urgent
Conditions related to patient age, distress, or potential for deterioration or complications that would benefit from intervention (e.g. abdominal pain, earache)

Level V - Non-Urgent
Conditions that:
- may be acute but non-urgent
- may be due to a chronic problem, with or without evidence of deterioration
- and could be delayed or referred to another health care provider

Hospital levels of care help explain the type of care needed as well as the resources required.

Primary: Care provided by a physician, nurse, or another health professional for an uncomplicated condition

Secondary: Care provided by a physician specializing in the treatment of certain conditions

Tertiary: Care requiring the use of one or more medical specialists, with access to specific diagnostic, technical and support services

Quaternary: Highly specialized care requiring several medical specialists, with access to specific diagnostic,

[4] Canadian Community Health Survey, cycles 2.1 (2003), 3.1 (2005), Statistics Canada.
[5] "Life expectancy at birth" measures the average life span of a newborn based on prevailing mortality conditions at that time.
[6] Excluding the North West and North East LHINs, based on 2004/05 age/sex standardized utilization rates.

Many of these less urgent visits are for conditions that should, with proper outpatient care, never occur.

Overall, our LHIN had the fifth highest hospital utilization rate (adjusting for age and sex). Our LHIN had the highest (worst) rating when looking at LHINs with teaching hospitals. Our LHIN also appears to have had a higher than average number of patients needing intense, specialized care (tertiary and quaternary acute care utilization rate is second highest in the province).

Hospital services dependent on few regional institutions

Our residents rely primarily on three hospitals - Kingston General Hospital, Quinte Healthcare Corporation (Belleville site) and Brockville General Hospital - for over 70% of their hospital care. Aligning with the population distribution, the remaining hospital sites serve the remote communities within the South East LHIN.

Long wait times for provincial priorities

The South East LHIN meets most of the targets for hospital services identified by the province as measures of health system performance. Of greatest priority to the South East LHIN is that our residents have the third longest waits[7] for a hip or knee replacement. For 2006/07, the 90th percentile wait time for hip and knee replacement in the South East LHIN was 291 and 361 days respectively. The provincial targets are 182 days for both hips and knees.

Waiting for post-acute care services

Patients in the South East LHIN wait longer for post-acute care services than Ontarians in all but one other LHIN. The provincial measure for this is the number of days patients waited for discharge from Alternate Level of Care (ALC) as a percentage of total patient days. The provincial average for last year was 12.1%; the South East LHIN reported 18.6%. To better understand this, last year:

- 2,700 (7.4%) patients in our acute care hospitals were discharged to a rehabilitation or complex continuing care hospital setting or placed in a long-term care home. Of these, 1,153 patients waited for an alternate level of care before hospital discharge. These patients collectively waited 32,121 alternate level of care days last year (i.e. after their acute stay was completed) - an average of 29 days each - to move within the local health care system.

[7] Wait Time Information System, as reported August 14, 2007.

- Patients who no longer need hospital services need to be moved to the right care setting as soon as possible. It is better for the patient and the family when the patient is in a more residential setting. It is better for the community, because those beds are needed to provide care to others with acute medical need.

Limited availability of long-term care beds

The average number of residents in the community awaiting placement in a long-term care home (LTCH) was equal to 29.5% of the total LTCH bed complement in our LHIN. This result places our LHIN eleventh of the fourteen LHINs. The building of 352 new LTCH beds represents one component toward improving this metric and improving access. The beds are anticipated to be operational in fiscal 2009/10.[8]

Inadequate supply of supportive housing

The South East LHIN is one of two LHINs in the province with no existing supportive housing for the frail elderly. Not having this type of housing increases the demand for long-term care home placement, as they are the only residential care option for this population.

Health service providers under enhanced performance monitoring

The South East LHIN has developed and implemented an enhanced reporting policy which is employed for health service providers that demonstrate failure to fulfill one or more performance obligations as defined within an accountability or other agreement. The South East LHIN may choose to employ this protocol when the failure to fulfill performance obligations is considered to be ongoing, substantial or multiple.

Priorities and Projects included in this service plan - at a glance

Improving...

Access to Primary Care
Integrating Primary Health Care Services

Access to Specialized Medical Care
Wait Times Initiatives
Regional Critical Care Capacity Program

Access to Mental Health and Addiction Services
Mental Health and Addictions Initiatives

Transportation to and from Health Care
Non-urgent/emergent transfer program, a component of Regional Surgical Program and Critical Care Strategy

Availability of Long Term Care Services
Alternate Level of Care (ALC)

Continuum of Patient Care
Critical Care Strategy

Improving access to health care services in French
French Language Initiatives

Moving ahead with the use of an electronic health information system
Advancing IT and Electronic Communication Initiatives

"Centralized" references in this plan

Several references are made to "central intake" and "central registries". Several health service providers have identified this type of function as an enabler of improved access. However, prior to going forward with any centralized system, the LHIN will require agreement among affected health service providers as to the most effective and efficient model.

[8] Pending confirmation of operational funding in the LHIN funding allocation.

The health service provider is responsible for working with the South East LHIN to revise its operations/processes/cost structures to enable the organization to deliver on its performance obligations into the future. The South East LHIN may select from a variety of interventions as deemed necessary.

The health service provider may be requested to submit a Performance Improvement Plan (PIP) in a form deemed appropriate by the South East LHIN. The PIP will identify a remedial action plan that will enable the health service provider to fulfill its performance obligations and provide the health service provider with clear expectations of the South East LHIN including specific actions, deliverables, timelines and performance measures to enable the health service provider to achieve its performance obligations.

The South East LHIN will establish appropriate monitoring and evaluation of a health service provider's compliance to the performance plan or recommendations.

The following table summarizes health service providers currently under enhanced reporting.

Health Service Provider	Main Issue	Progress/ Process to Resolve
Kingston General Hospital (KGH)	• Inability to meet balanced budget requirement. • Access to patient services may be in jeopardy as a result of above.	• Investigator appointed by MoHLTC at request of South East LHIN. • South East LHIN will work with all parties to implement findings of Investigator.
South East CCAC	• Inability to meet balanced budget requirement. • Potential for restriction/ reduced access to patient services if budget issues not addressed.	• South East CCAC to provide a PIP to the South East LHIN by May 30, 2008. • South East LHIN to review and approve the PIP, with modifications as required. • South East LHIN to work with the CCAC to implement and monitor the PIP, with the objective of maximizing appropriate access and leveraging current integration activities (e.g. FLO, Transitions, etc.).

Health Service Provider	Main Issue	Progress/ Process to Resolve
Quinte Health Care Corporation (QHC)	• Inability to meet total margin requirement for 2008/09.	• QHC is aggressively implementing several initiatives, including findings from "work life mapping" analyses, with the objective of increasing employee satisfaction, increasing patient access and addressing cost pressures. • South East LHIN expects initiatives will mitigate budget issues. As such, a waiver was granted, with terms and conditions specified in the hospital's 2008-10 H-SAA which was executed by QHC and the South East LHIN.
Community Care North Hastings	• Inability to meet balanced budget requirement due to a shortfall in revenue from fundraising. • Potential for restriction/ reduced access to client services if budget issues not addressed.	• HSP to provide a PIP to the South East LHIN by the end of June, 2008. • South East LHIN to review and approve the PIP, with modifications as required. • South East LHIN to work with HSP to implement and monitor the PIP.
Canadian Hearing Society	• Inability to meet balanced budget requirement due to a shortfall in revenue from fundraising. • Potential for restriction/ reduced access to client services if budget issues not addressed.	• HSP to provide a PIP to the South East LHIN by the end of June, 2008. • South East LHIN to review and approve the PIP, with modifications as required. • South East LHIN to work with the HSP to implement and monitor the PIP.

Opportunities for Change

The immediate opportunities for health system improvement come from optimizing current health service delivery - working with health service providers as our "experts" in providing care.

Given our LHIN's population characteristics, our focus is to ensure the South East LHIN has the right infrastructure and supports to provide the care needed now and in the future by:

- Identifying options for longer term care for our frail elderly that support a person's independence and dignity and developing a strategy to communicate these options to health service providers, patients and their families.
- Improving the transition of patients from provider to provider - making the continuum of care as seamless as possible.
- Improving access to specialized care, specifically total joint replacements and critical care.

Modelling the future – ReCAP 2008

In March, 2008, the South East LHIN commenced the Regional Capacity Assessment and Projection (ReCAP) Project. The objective of ReCAP is twofold:

- Provide a 'baseline' assessment of the current needs of those using our local system and how well the system is attending to those needs.
- Evaluate the same elements with our population projected out five years.

A dynamic model of population care needs and system response will be developed by using:

- evidence-based approaches
- accepted evaluation methodologies and,
- experts in demography, population trends, health systems operations research and others.

This model will be modified as required to project the most accurate future of the South East LHIN.

ReCAP will enable the South East LHIN to effectively evaluate options and priorities for the 2009/10 Integrated Health Services Plan. This will enable the South East LHIN Board to make appropriate policy and allocation decisions based on a target that considers the needs and requirements of our population and maximizes health service providers' contributions to health care by fulfilling their required roles.

ReCAP is constructed in discrete elements, allowing portions of the methodology to be used while other elements are still being developed, ensuring that the most up-to-date planning data is available for decision-making. The completed model and projection is slated for South East LHIN Board approval in December, 2008. ReCAP, once board approved, will serve as the South East LHIN's definitive planning model and will be a standard by which all planning related proposals are evaluated.

Summary Assessment of Risk

The health care system in the South East LHIN has a number of stress points. Careful analysis demonstrates that these pressures must be faced squarely, as failure to act could result in a number of negative consequences. At best, lack of action may increase wait times for clinical services and alternate care. At worst, it may constrain the system's effectiveness and responsiveness in a time of crisis.

We know that money is not the answer, but investments can be a catalyst for successful system transformation. Improvements to the continuum of care would likely increase the cost profile for the CCAC and community support services, while not resulting in a cost reduction in hospital services[9].

The South East LHIN accepts the challenge of driving system improvement in an environment of needing cost efficiency, understanding that the objectives of system improvement, cost efficiency and effectiveness of delivery may not always align. The South East LHIN will diligently assess any such situations and provide clear options with respect to service provision and available funding.

[9] As an example, while a significant reduction in ALC days are expected, hospital costs could theoretically remain stable or increase as these beds become occupied by more acutely ill patients. Staffing patterns and clinical skills upgrading represent other factors which could come into play. The net result/overall impact will be better utilization of resources and improved patient flow.

Plans to implement IHSP Commitments and Priorities for the Local Health System

This section details the specific projects and plans being implemented by the South East LHIN.

The projects included in this plan are:

D.1 **Integrating Primary Health Care**

D.2 **Wait Times Initiatives**

D.3 **Critical Care Strategy**

D.4 **Mental Health and Addictions Services**

D.5 **Alternate Level of Care**

D.6 **French Language Services Act in Kingston**

D.7 **IT and e-Health**

D.8 **Health Human Resources**

D.9 **Continuum of Care/Patient Transportation**

D.10 **Seniors Managing Independent Living Easily (SMILE)**

Integrating Primary Health Care

Priorities for change supported	• Improving Access to Primary Care.
MLAA* Indicators impacted	• Rate of emergency room visits that could be seen elsewhere.
MoHLTC Priorities impacted	• Provincial Primary Care Strategy. • Federal/Provincial Health Accord. • Access to physicians, nurses and other health care professionals. • Keeping Ontarians healthy.

***** Ministry-LHIN Accountability Agreement

Project Rationale

- The South East LHIN has identified timely and appropriate access to care - including access to family physicians and nurse practitioners - as a priority for change in the IHSP. The reported inability of residents in the South East LHIN to access primary care physicians and nurse practitioners is the obvious impediment for the provision of effective primary care.
- Building an effective, integrated primary care system within the South East LHIN requires LHIN leadership and consensus building with all primary health care providers.
- An integrated primary care system extends beyond the Community Health Centres (CHCs) currently under the LHIN's auspices. Participation and cooperation of primary care physicians, and those organizations that support them, is essential. No less important is the direct participation of nurse practitioners, midwives and allied health professionals devoted to primary care.

Initiative	Outcomes/Health Service Provider Involvement
CHC Expansion Project	The CHCs under development in Napanee and Belleville/Quinte West require organizational support for service start-up anticipated as early as March, 2009. In addition, the Smiths Falls satellite of the Merrickville CHC requires ongoing transitional support including relocation into a permanent site.
Family Health Team (FHT) Development	The South East LHIN is developing a formal liaison and engagement strategy with local Family Health Teams (FHTs) to ensure their inclusion in primary care system planning, system objectives, and strategy implementation.
Central Patient Registry	The Registry will facilitate the referral of new patients within the South East LHIN through a database of residents seeking a primary care clinician. This project is currently under discussion with MoHLTC.

Key Outcomes	• The development of a consensus based strategy to improve access to primary care within the South East LHIN. • The strategy will be underpinned with commitments to: ▪ Work collaboratively for the benefit of the patient. ▪ Ensure quality and integration are the foundation of change. ▪ Leverage e-health as a conduit to expanded capacity. ▪ Employ chronic disease management strategies to reduce the burden of illness within the South East LHIN.

Improving access to primary care addresses many of the access issues identified in the IHSP and will improve the overall health of our residents.

Wait Times Initiatives

D.2

Priorities for change supported	• Improving Access to Specialized Medical Services.
MLAA Indicators impacted	• Health System Performance.
MoHLTC Priorities impacted	• Ontario's Wait Time Strategy.

Local Performance Obligation Target Setting

Overview

Reducing wait times for key health services is one of the government's top priorities and an important part of its strategy to transform the province's health system. Wait times are a symptom of a broader problem: the lack of consistent management of how patients get access to care. Ontario's Wait Time Strategy is designed to improve access to health care services and reduce the time that Ontarians wait for services. The initial focus is in five areas: cancer surgery, selected cardiac procedures, cataract surgery, hip and knee total joint replacements and MRI/CT scans. These areas are associated with a high degree of disease and disability and are of particular concern to Ontarians.

Consistent with the Provincial Strategy, the South East LHIN has focussed on improving wait times through targeted volume increases, greater efficiencies and standardizing medical and administrative "best practices" so that more people can be treated within the same time period.

In consultation with the hospitals, the South East LHIN developed a methodology to determine hospital specific indicator performance targets for all hospitals in the South East LHIN. These targets are reflected in Schedules B.1 of the Hospital service Accountability Agreements (H-SAAs). A summary of the target setting process, followed by the proposed indicator targets to be achieved in fiscal years 2008/09 and 2009/10, follows.

Target Setting Methodology

Target-setting is part of the joint Ministry-LHIN aim to focus on local health system outcomes and is intended as an iterative process with the opportunity for annual refresh of targets. In 2007/08, the Ministry committed to work with targets proposed by individual LHINs, within the context of a provincial framework. LHINs are now expected to mandate realistic, achievable improvement across health service providers, starting with the hospitals in 2008/09 and 2009/10. These proposed targets aim to reflect the local trends and available resources and capacities but also consider the mandate and initiatives taking place at the provincial level.

Hospital Performance Baselines

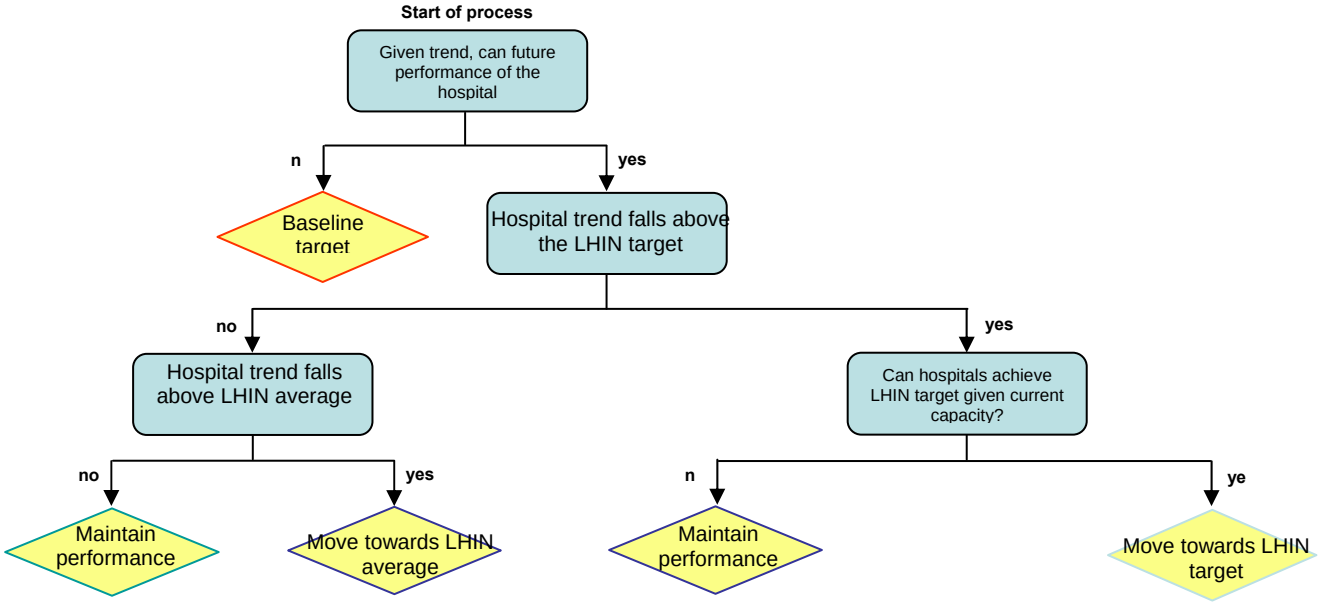
For the purpose of this target setting process, baselines were defined as the average performance for the last four quarters of wait data at the time when the targets were formulated. This ensures that the baselines are representative and considers seasonal variation within a fiscal period. The baseline has been set as the average 90th percentile wait times between Q3 2006/07 and Q3 2007/08. All baselines were calculated using data as reported on the Wait Times Information System.

Performance Corridors

Performance corridors are defined as an acceptable range of results around a target for a performance indicator. A performance corridor may define an acceptable lower limit, upper limit or both, or there may be no range. For the purpose of this agreement, corridors are based on provincial guidelines as set out in the H-SAA agreements. Reporting on performance in the LHIN-Hospital Accountability Agreement will be quarterly by exception only. Hospitals will report quarterly on local health system performance indicators only where variance from targets is identified. Variance is defined as “a result for a performance indicator that falls outside the performance corridor”. Variances will be considered as a “performance factor” and hospitals will report on mitigation strategies and performance improvement plans in their quarterly reports.

Target Setting Process

The process for setting the hospital performance targets is outlined in the diagram shown below.



South East LHIN Performance Targets

South East LHIN Performance Indicator Targets 2007/08 to 2009/10

Performance Indicator	Baseline	Targets		
		2007/08	2008/09*	2009/10*
Data from:	*Q3 2006/07-Q3 2007/08*			
90th percentile Wait Time for Cancer Surgery *(days)*	61	58	58	58
90th percentile Wait Time for Cardiac By-Pass Procedures *(days)*	43	43	43	43
90th percentile Wait Time for Cataract Surgery *(days)*	153	153	135	117
90th percentile Wait Time for Hip Replacement Surgery *(days)*	291	262	232	224
90th percentile Wait Time for Knee Replacement Surgery *(days)*	361	325	300	282
90th percentile Wait Time for MRI *(days)*	30	31	96	28
90th percentile Wait Time for CT * *(days)*	44	39	34	28
*Subject to final agreement with MoHLTC				

Significant Wait Times Initiative – Regional Surgical Services

Project Rationale

- The MoHLTC and the South East LHIN identified significant variances between the average wait for total joint replacement procedures (both hips and knees) and the average wait in the South East LHIN. In 2006/07, the ministry requested proposals from area providers on what could be done to address the waits.
- The Health Care Network of South Eastern Ontario (HCNSEO) submitted and received one-time funding to implement a proposal for a LHIN-wide regional surgical service, starting with total joint replacement procedures.
- The South East LHIN has identified timely and appropriate access to surgical care as an essential component of the health system. Access directly impacts quality of life. Waits for certain surgical services, like total joint replacement, directly impact the community perception of the quality of care provided in the South East LHIN and the sustainability of the health system in general.

Initiative	Outcomes
Regional Surgical Services (RSS) (HCNSEO)	A LHIN-wide regionally based surgical model for the south east, beginning with total joint replacement procedures. Program elements include structures to review, assess, develop and implement health service provider driven processes. The elements of the RSS includes (in whole or in part): • Patient Transportation. • LHIN-wide physician credentialing standard. • Common [Patient] Assessment standard and a single point of entry.
	Regional Surgical Demonstration Project (South East LHIN) Given the long wait times reported for total joint replacements, the South East LHIN has taken responsibility for ensuring elements of the regional surgical services project are implemented. The entire project is dependent on the South East LHIN and the member hospitals of the Health Care Network working together. Minimal movement in terms of advancing the development of the RSS has been demonstrated by the health service provider participants in the project. In order to advance the project post-haste, the South East LHIN developed the position of a Physician Regional Surgical Lead and has appointed Dr. Mark Noss to this position. Dr. Noss is charged with responsibility for ensuring that the partner organizations move towards completion of this project. The expectation is that the infrastructure necessary for regional surgical services will be operational in 2008/09.

Initiative	Outcomes
	Patient Transportation (HCNSEO) Optimizing the use of existing surgical capacity across the South East LHIN will necessitate reduced reliance on municipal emergency medical services in order to enable: • Better use of health human resources across the South East LHIN. • Improved satisfaction of patients and health professionals. • Improved responsiveness of the health system. Work continues on linking patient transportation with an advanced patient care logistics model to minimize patient waits, inter-hospital process delays and overall improvements to patient care and outcomes. A regional transportation plan, inclusive of inter-hospital transportation as well as transportation to and from health care for marginalized populations (e.g. seniors), is under development and will be finalized in 2008/09. This plan will incorporate the Ministry Aging at Home Transportation (Van) initiative.
	Physician credentialing (HCNSEO) Finalization and implementation of a LHIN-wide credentialing process with all hospital Medical Advisory Committees and hospital boards ensuring obligations under the *Public Hospitals Act* is in development and is planned for fulfillment by the end of 2008/09. A LHIN-based standard of competence, and mobility of physicians to practise at multiple hospitals within the South East LHIN, is the goal.
	Clinical Outcomes (South East LHIN) An objective standard of care and outcome measures are required to assure patients that good clinical outcomes accompanied by a shorter wait in a smaller community are positive reflections of the high quality of care that is and can continue to be provided by community hospitals across the South East LHIN. A baseline standard, determined by the surgeons in the South East LHIN, will be set by December, 2008 and monitored, initially, quarterly.

	Common Pre-Surgical Assessment (South East LHIN) A study at Queen's University had advanced practice physiotherapists using a standardized screening tool to assess patients referred for orthopaedic surgery. Based on the positive results of that research, an extended trial (with full implementation if results bear out) is in place and is planned to continue and expand, if necessary, in conjunction with this project. Pre-screening of total joint surgical candidates prior to specialist consultation will increase capacity for initial screening, expedite the candidate's procedure based on priority and build in re-assessment capacity for patients falling outside of target waiting periods. The screen does not exclude consultation with a surgeon.
	Referral and E-Referral (South East LHIN) Many individual surgeons are below the wait time targets set for the South East LHIN. A small number of identified surgeons have waiting lists far above the South East LHIN wait time target. The practices and waiting lists of those surgeons who are above the local wait time targets will be targeted for intensive scrutiny and action beginning in June, 2008. The goal will be to bring wait times, as defined within the provincial wait time targets initiative, for these surgeons closer to their peers. To facilitate common assessment, e-referral for total joint referrals will be trialed within the South East LHIN. Improved quality of referral information and faster assessment are first level objectives. E-referral will also enable the implementation of a single point of entry for surgical services.
	Predictive Modelling (South East LHIN) A predictive model is being prepared to estimate the required number of procedures to ensure that all patients in the South East LHIN can receive their surgery by the provincial target. The model will estimate the wait times based on historical data, assess the anticipated "arrival rate", compensate for patients already queued for services and extrapolate procedures required over time to achieve the provincial target. This predictive modelling will be completed in 2008/09 as part of the Regional Capacity Assessment Project (ReCAP) and will be incorporated into planning for surgical resources in the South East as part of the re-do of the Integrated Health Services Plan scheduled in 2009/10.

Key Outcomes	• A rational and common sense approach to managing health system capacity. • A plan to bring wait times for total joint replacement surgeries in line with provincial targets. • A framework for implementation of other surgical specialties.

Leveraging change management in the South East LHIN

The South East LHIN works closely with the Health Care Network of South Eastern Ontario. HCNSEO, which predates the LHIN, is comprised of the hospitals, the CCAC and one public health unit within our geographic area, as well as a representative from Queens Medical School and from the Community Support Services sector.

HCNSEO took a leadership position in proposing the regional surgical services program to the ministry in 2006. One-time funding was received by the network. HCNSEO expressed concern over commencing activities without some form of annualized funding commitment; however, it is imperative that the providers meet the mandate supported by the development funding within 2008/09. This outcome will be the major consideration in consideration of future, annualized funding.

The South East LHIN is using the regional surgical service project as an opportunity to effect cultural change with our hospitals and their network. The South East LHIN has taken a leadership role in some elements of the project to model change management concepts in the LHIN environment. We have appointed Dr. Mark Noss as the Physician Surgical Lead for the South East LHIN.

The South East LHIN's objective is to show that "walking the talk" can and does lead to positive change with minimal risk.

Funding Implications

Initial costs for this project were funded by the Ministry of Health and Long-Term Care through a one-time grant of approximately $0.86M.

Understanding why we have waits for services and how to improve them - making sure the right people are waiting for the right service - will improve quality and timeliness of care.

Critical Care Strategy

Priorities for change supported	• Improving Access to Specialized Medical Services.
MoHLTC Priorities impacted	• Ontario's Critical Care Strategy.

Project Rationale

- For some time, and most recently in January 2007, access to critical care beds within the South East LHIN has been constrained. While this has been recognized by the Ministry with the approval of ICU/CCU expansions in two hospitals' redevelopment plans, approvals to proceed are pending.
- The South East LHIN, under the leadership of the Critical Care Lead, assembled a critical care working group to advise on the requirements of hospitals to create a single critical care system within the South East LHIN (1 LHIN : 1 CCU). That working group comprised of key stakeholders and decision-makers in our hospitals has been asked to:
    - Examine the current critical care system in our LHIN, including support systems (access to long-term ventilated beds, constant care/special care units).
    - Make recommendations for system-based improvements predicated on the 1 LHIN: 1 CCU concept.
- The South East LHIN is responsible for ensuring timely access for the critically ill.

Initiative	Outcomes
Critical Care Strategy: 1 LHIN: 1CCU	Ensure that critically ill patients in the South East LHIN can access the right level of critical care from the secondary or tertiary facility in the South East LHIN best able to provide the care. The 1 LHIN: 1 CCU strategy brings a collaborative and cohesive approach to critical care management in the South East LHIN, and complements the government's Critical Care Strategy. When fully implemented, intensivists and physicians attending special or constant care patients will be expected to manage case loads (to and from their facility) based on a peer assessed "limit of acuity".

Critical Care Leaders Working Group	A working group of critical care practitioners, clinical managers and senior administrators was struck to confirm outstanding issues, identify key elements necessary for the strategy to be successful, recommend ways to meaningfully engage stakeholders and champion change within their organization. The working group will also review and validate the transfer protocols of patients who exceed or do not meet CCU level of acuity corridors.
Patient Transportation	The critical care leaders working group will review and recommend sector implementation of a series of protocols which provide guaranteed access for patients within a "corridor of acuity". Patients are currently assessed as having a "level of acuity". Should a patient's acuity exceed the local CCU acuity corridor, the tertiary care facility will guarantee that the patient can be transferred as soon as deemed appropriate. Conversely, patients in the tertiary CCU who fall below that centre's acuity corridor will be transferred back to the CCU in their community with a similar guarantee.
Critical Care Capacity Assessment	The current and future bed requirements for the critically ill over the next three years will be determined and used to support ongoing capital requirement (and requisite operational funding) discussions.

Key Outcomes	• A LHIN-wide protocol for the care of critically ill patients. • A commitment to ensure that critically ill patients will not be transferred out of the South East LHIN except in extraordinary circumstances. • Greater collaboration and cooperation between the intensive care specialists within the South East LHIN.

Multi-Year Funding Implications

Ontario's Critical Care Secretariat has been working with hospitals and researchers to determine out year requirements based on predicted utilization. The South East LHIN understands this work is ongoing.

A funding risk has been identified for critical care beds, projected to open in 2008/09. The South East LHIN has not been able to confirm if the funding allocation for this approved project will be sufficient to cover operational costs.

A patient being moved from one hospital to another not only assures appropriate care for that patient, but also the ability to care for other, more severely ill patients.

Mental Health & Addictions Services

Priorities for change supported	• Improving Access to Mental Health and Addictions Services.
MoHLTC Priorities impacted	• Access to physicians, nurses and other health care professionals. • Keeping Ontarians healthy.

Project Rationale

Challenges accessing mental health services have been identified for clients in crisis situations and for those requiring medical-psychiatric intervention, especially in our rural communities. Those seeking addiction treatment or counselling have experienced similar challenges across the South East LHIN.

The locations of mental health and addiction services within the South East LHIN are primarily in the larger urban centres. Patients from rural areas consequently face greater transactional costs in order to access care including; longer commuting distances, extended absences from their home community to participate in treatment programs and limited (if any) access to adequate outreach supports when they return home

An additional pressure for those patients that are required to live away from home for treatment is a provider-reported inadequate supply of supportive housing within the communities where treatment programs exist.

In both instances, our LHIN is fortunate that local providers continue to show leadership in identifying these and like issues and in providing solutions. This energy is a valuable resource to the South East LHIN and speaks to the inception of these agencies which was, from a health systems perspective, a more organic and local process than other sectors experienced. Consequently, the development of the multiple organizations and service delivery models within this sector can be seen as an artefact of their evolution. This history has reinforced challenges of service alignment and delivery. The need for supported development of this sector is identified by the South East LHIN as a pre-requisite to improvements in service delivery.

Initiative	Outcomes
Amalgamation of Lennox and Addington Mental Health and Addictions Services	The South East LHIN supports the newly amalgamated agency and will work to highlight opportunities for improved service delivery models, integration opportunities and foster ongoing business management acumen by modeling leadership at the governance and operations levels. This work will be reinforced through the development of Service Accountability Agreements with the sector and the negotiation of performance targets.
Realignment of Consumer Survivor Initiatives (CSI)	The South East LHIN has successfully worked with CSI agencies in our region, resulting in a negotiated integration of CSI services for two-thirds of our region. We will complete an integration plan for the remaining CSI services in the South East region.
Leeds-Grenville Agency Co-location	Five local mental health agencies have voluntarily co-located their offices to centralize services and improve patient access. The opening of the new joint offices is set for August, 2008. The South East LHIN will make it a priority to work with agencies that take a pro-active approach to care provision and careful stewardship of financial resources, with an emphasis on optimizing administrative efficiencies, streamlining access and reducing overhead expenses.
Centralized Intake Process for Mental Health & Addictions	LHIN-wide expansion of the centralized intake processes continues to progress. Hastings-Prince Edward (HPE) and Lanark are already well established while Frontenac is beginning to launch its process using the one access number from HPE. Leeds and Grenville are in the initial stages of discussion amongst health service providers to develop a process for their catchment population.
Concurrent Disorders Project	A concurrent disorders working group has been established in partnership with the South East LHIN and CAMH to identify gaps in Mental Health and Addictions providers' training (limited to concurrent disorders) and develop a plan to address such gaps, thereby improving client care.

MoHLTC Community Mental Health Common Assessment Project	The South East LHIN has collaborated with ministry colleagues to evaluate software and operating platforms in support of a common provincial mental health assessment tool. FCMHS is a pilot site for the project and provides ongoing feedback to the project lead throughout the pilot process.

Key Outcomes	• Develop means to engage all relevant health service providers, agencies, and consumers as part of a regular planning cycle to review: ▪ Opportunities to improve coordination of services. ▪ Viable alternatives for rural consumers. ▪ Other priorities, as identified. • Leverage the knowledge base within the sector to develop LHIN-wide improvements to service delivery.

Mental health services and addictions services that are accessible to those in need empower clients to manage their care independently and in a coordinated way, reducing reliance on our emergency and acute points of care.

Alternate Level of Care

Priorities for change supported	• Access to long term care. • Continuum of Care improvements. • Access to Specialized Medical Services.
MLAA Indicators impacted	• Health System Performance Indicators.
MoHLTC Priorities impacted	• Link with MoHLTC "Flo" Collaborative. • Ontario's Wait Times Strategy.

Project Rationale

- The timely and appropriate movement of patients from provider to provider is one of the more observable measures of a well integrated health system.
- Patient flow can be described in a macro context - a current example is the issue of patients waiting in hospitals for alternate levels of care.
- Patient flow can also be described in a micro context - providers fixing a problem they see as "unique", resulting in multiple and often uncomplimentary ad-hoc solutions across the health system.
- One of the best opportunities for transformative change is the improvement of patients' journeys through the health system.

Initiative	Outcomes
Eldercare Access Strategy in Emergency Room (EASIER+)	The implementation of this multi-component strategy to improve health care outcomes of the high-risk frail elderly in the Emergency Room is underway. This strategy represents a collaborative partnership between acute care hospitals, specialist services for the elderly and community-based programs. Building on an evidence-based approach, EASIER+ identifies and targets high risk elderly patients and provides a rapid response care plan to avoid hospital admission. The key to success is the improved provider response developed through the program among emergency room staff, primary care practitioners, South East CCAC, community support services and specialist services to the elderly. This initiative is funded through the Emergency Department (ED) Action Plan Funding – Care in the Community/ED Process Improvement Funding.
Enhanced Home Care Service Provision (≤30 days) (Enhanced Bridging Program)	Enhanced bridging provides short-term, high intensity home care services to elderly patients at risk of an emergency department visit and/or potential inpatient admission due to a sudden change in health. The program is geared to support elderly who, with increased support at home, would respond well to treatment and recover quickly – eliminating the requirement of an inpatient stay: • Enhanced CCAC services for up to 30 days (163 clients served November, 2007 – March, 2008). • Enhanced community support services for up to 30 days (16 clients served November, 2007 - March, 2008). This initiative is funded through the Emergency Department (ED) Action Plan Funding – Care in the Community/ED Process Improvement Funding.

"Flo" Collaborative: Quality Transitions for Better Care	Participation and learning from the provincial ALC strategy launched by the Ontario Health Performance Initiative. The South East CCAC has partnered with Kingston General Hospital in this initiative. The aim of this collaborative is to improve patient transitions from acute care hospitals to subsequent care destinations for all patients, not only those designated as ALC. In addition to improving the timeliness and effectiveness of transitions, Flo is designed to help achieve and build long-term capability for quality improvement.
Transition Initiative	A joint initiative of health care partners in the South East (under the auspices of the Health Care Network of South Eastern Ontario) in response to the region's consistently high percentage of total days of stay designated as Alternate Level of Care (ALC) and a longer than the provincial average time to placement. This regional collaborative approach to find solutions to this problem built on and expanded activities under-way in the region. Through a coordinated project approach, a number of sub-projects were agreed upon to address the situation. They include: • Standard interpretation of the definition of ALC. • Discharge standardization. • Educating, informing and supporting clients and families. • Bed stock utilization. • Performance Measurement. • Information Technology Solutions. • Long-Term Care Homes (LTCH) Flexible. Admission Cycle. • System Capacity for Operations Policy Change. The initiative is jointly resourced by the partner organizations and the South East LHIN, using both financial and in–kind contributions. This is a multi-year Initiative, spanning fiscal 2007-2008 and 2008–2009.

Everybody Gets It	Hospital based activation program to keep the frail elderly at their best possible level of functional abilities during their hospitalization to ensure they can return home upon discharge from hospital, with or without community supports. This program has been initiated at one acute care hospital and the first report-back has demonstrated an increase in elderly patients being discharged to home of 10% over the prior year. The launch of a similar program at another hospital is imminent. One-time funding has been provided by the South East LHIN to support implementation of this initiative on a demonstration basis.
GEM Program	A specialized education program to enhance the knowledge, skills and attitudes of CCAC case managers functioning in geriatric assessor roles within emergency rooms throughout the remainder of the South East (e.g. Brockville, Perth/Smiths Falls, Lennox and Addington and remaining QHC sites). Funded through a carry forward of funding from the Emergency Department (ED) Action Plan Funding – Care in the Community/ED Process Improvement Funding.

Key Outcomes	• Reduce the number of ALC days in hospitals. • Improve the transition of patients from hospitals to other providers. • Reduce the days to placement. • Support the independence and dignity of our elderly population by providing knowledge and options prior to a sudden change in health status.

Multi-Year Funding Implications

One-time funding for a number of these initiatives was provided by the ministry through the Emergency Department (ED) Action Plan Funding initiative. These programs are not sustainable and risk discontinuation if funding is not annualized.

Transformation of the local health system requires the South East LHIN and our providers to understand the health care needs of our communities, redeploy current resources to meet emerging needs and improve our populations' health status.

French Language Services in Kingston

Priorities for change supported	• Improving Access to Services provided in French.
MoHLTC Priorities impacted	• *French Languages Services Act.*

Project Rationale

- The Kingston area was designated as being subject to the *French Language Services Act (FLSA)* in 2006. Health service providers in Kingston must meet various requirements regarding the ability to provide services in French.
- The lack of availability of health services in French may affect the health status of francophone residents, who, due to language or cultural barriers, do not access the health system or fail to fully participate.
- The requirements of the FLS Act must be implemented by May, 2009.

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Initiative	Outcomes
Stakeholder Consultations	Increased provision and/or coordination of services in French. Broad consultation and input from affected health service providers and Francophone leaders (including l'Association Canadienne-Française de l'Ontario, Région des Mille-Îles and Le Réseau des Services de santé en français de l'Est de l'Ontario).

Assistance with compliance activities	South East LHIN funded health service providers serving the Kingston area must be identified and become compliant with the FLS Act by May, 2009. A letter from the South East LHIN supporting an FLS coordinator was forwarded to MoHLTC. As planning for FLS in Kingston continues and the likelihood for ongoing input into future South East LHIN planning that may impact on FLS, the FLS coordinator may be best placed directly within the South East LHIN.

Key Outcomes	• Timely implementation of requirements by affected health service providers. • Increased dialogue with the francophone community in the South East LHIN. • Community support for the implementation of French Language Services through participation in re-sourcing and education.

Multi-Year Funding Implications

At this time, it is too early to determine detailed impacts and associated future costs.

IT and e-Health

Priorities for change supported	• Moving ahead with the development and use of health information systems.
MoHLTC Priorities impacted	• Ontario's e-Health Strategy.

Project Rationale

- The South East IHSP identified as a priority "moving ahead with the development and use of health information systems".
- The MoHLTC is implementing an e-Health Strategy in support of delivery of care, specifically around the management of chronic disease.
- A cross-sectoral LHIN e-Health Council has been formed and has reviewed the available provincial plan and started to update the e-health strategy, elements of which are included in this plan.
- Priority projects have been discussed, however detailed planning and implementation will depend on the final release of the MoHLTC e-Health Strategy and identification of project funding.
- The e-health plan identifies projects in four major areas:
  - Robust Core Systems
  - Integration Enablers
  - Development of Regional Electronic Health Record (EHR)
  - Creation of tools to use EHR Information

Initiative	Outcomes
Robust Core Systems	Develop local systems that capture information needed, drive local workflow and link technology amongst providers, such as: • Application for SSHA connections for all providers. • SSHA One-Mail complete rollout. • Community technology update for long-term care. • Primary care systems review and approach (with Ontario MD and Ministry). • Adopt regional implementation of Health Outcomes for Better Information and Care (HOBIC). • Implement CCAC Client Health Reporting and Information System (CHRIS) including integration with other South East LHIN hospitals and community agencies. • Identify Regional Medication Reconciliation Project. • Identify systems needed for storage and access of knowledge base items like sharing of educational materials, care plans, library services and other materials.
Integration Enablers	To enable the sharing of e-health information across providers, regional standards and capacity are required. These projects will seek to develop a regional approach to e-health and to implement regional systems: • Staff Regional Project Management Office. • Approval for Data Centre Consolidation, Implementation and Funding Plan. • Implementation of Regional Interface System for hospitals. • Development of business case for Regional Data Repository. • Implement SAP as shared Supply Chain System for six participating hospitals. • Begin implementation of Regional Surgical Services System and develop plan for complete implementation. • Regional Shared Information Management Services study. • Define regional data standards structure and identify applicable Provincial or Federal projects (e.g. Health Outcomes for Better Information and Care – HOBIC).

	• Create Regional Privacy structure.
Development of an Electronic Health Record	An Electronic Health Record (EHR) system improves patient care by providing health care professionals with immediate access to the patient's medical history; speeding the diagnostic process and expediting treatment. The South East LHIN's system will be delivered through a series of initiatives including: • Complete implementation of shared Picture Archiving and Communications (PACS) system at regional hospitals. • Implement Provincial Systems at all hospitals - Drug Profile viewer (DPV), Emergency Department Reporting System (EDRS) and Phase 3 of Wait Times Information System (WTIS). • Implement Ontario Laboratory Information System (OLIS) when it is readily available for lab reporting (expected 2009-10). • Develop system for reporting by community agencies using standard Residential Assessment Instruments developed by the InterRAI research network. The InterRAI Community Health Assessment (InterRAI CHA) tool will be used. • Identify other Residential Assessment Instrument tools being implemented in Ontario and develop a means for common access and integration. • Develop business case for regional data repositories to contain information not readily available from MoHLTC provincial repositories. • Identify regional patient identification solution (referred to as Electronic Master Patient Index or EMPI) solution that integrates with MoHLTC systems. • Availability of a registry of patients seeking primary care physicians with processes for update and maintenance of information.

Tools to Access and Use EHR Information	• To improve clinical outcomes, the information in the EHR must be integrated into care or review processes. The South East LHIN will identify means to access information (through a "portal"), share information as part of clinical workflows (e-referral) and report on information in order to improve care and system performance. • Information sharing through a portal. • Develop business case for Clinical Portal that accesses the EHR and is integrated with MoHLTC systems and projects. • Determine information sharing needs in support of developing South East LHIN and MoHLTC Chronic Disease Management Strategies. • Complete Transitions initiative to automate process for placement of Alternate Level of Care (ALC) patients from acute care to other venues. This includes development of electronic referral systems and integration of CCAC information into hospital processes. • Identify standard methodologies for sharing information from hospitals to primary care and implement pilot sites. • Determine need for electronic referral in the community to support Easier +, MH&A Central Intake, SMILE and InterRAI CHA projects and implement pilot sites. • Identify data reporting needs to support LHIN-wide improvements in the delivery of care. Included in this work will be a review of the potential for geo-spatial mapping and reporting. • Identify data sources and standards that exist and develop plan for integrated data repository and reporting.

Key Outcomes	• Action plans to leverage information technology and e-health initiatives to improve data quality and timely access of data for the provision of health services. • IT Implementation strategies that support and enhance the use of information technology across the South East LHIN. • Regional structures and projects that create a true LHIN-wide e-health system.

Multi-Year Funding Implications

Support for the e-health initiatives and for the health service providers will be primarily through provincial e-health initiative funding and through a regional focus on the use of health service providers' own funds. The South East LHIN's e-health initiatives will, by necessity, be adjusted to reflect the e-health initiative funding available within the year.

Information technology improves access to care by making the right information available to health service providers when they need it most.

Health Human Resources

Priorities for change supported	• Developing a regional health human resources plan.
MoHLTC Priorities impacted	• Health Human Resources Strategy.

Project Rationale

- Health service providers in the South East LHIN actively recruit health professionals, in many cases competing against each other.
- Incentives from larger health service providers tend to draw health professionals already in the South East LHIN away from their current employer, providing a net loss to the system (same level of health human resources, but with additional cost).
- Recruitment and retention efforts for physicians, while somewhat coordinated, do not factor population need/future utilization into physician HR requirements.
- Short term strategies to address pressing issues fail to solve the underlying issues.
- HHR recruitment and retention may be impacted by levels of job satisfaction and inappropriate work-life balance.

Initiative	Outcomes
Health Human Resources Profile **Future HHR Evaluation**	• Health Human Resources (HHR) Profile for the South East LHIN. • Methodology to project out year HHR requirements. • Strategy to align recruitment initiatives (i.e. municipal programs, health service provider initiatives). • Alignment of local HHR needs with provincial initiatives (UAP, Incentive Grant Programs, Free Tuition, etc).
Aligning HHR Capacity with Physical Capacity	Creating a structure and process to enable the movement of health human resources in high demand between providers. Potential alignment of health service provider incentive programs. May include physician specialists, nurse specialists, as well as other health professionals.

Alternate Resource Sharing	Investigate opportunities to engage health service providers not participating, or with limited participation, in the South East LHIN.
Work-Life Mapping	Quinte Healthcare Corporation has taken a leadership role for quality, work-life balance and optimal utilization of resources. The process will ensure that hospital staff are being effectively employed in their area of expertise. Self-evaluations are completed by staff and then are evaluated against job requirements and a dataset of similar positions. Outcomes address "false economies" of clinical staff performing clerical or porter duties "because they are there". Realignment of job tasks ensures scarce HHR resources are effectively engaged in their profession. Correct alignment of resources improves access to services and the quality of those services. Four other hospitals in the South East LHIN are also engaged in this activity.
"Region of Choice" for Health Professionals	L&A Health and Community Services Coalition 2007/08 is developing a comprehensive marketing/information package to showcase their health employment opportunities and the community and its benefits. Targeted to educational facilities with whom relationships are already established (Colleges, Universities, Mitchner Institute, etc.), it is intended to encourage training opportunities in the area. This supports existing staff and provides the student with an opportunity to evaluate the community as a place to practice following graduation.

Key Outcomes	• A definitive document outlining the HHR positions within the South East LHIN (staffed and vacant). • A consistent methodology for predicting future HHR needs in terms of succession planning, clinical utilization and population health demands. • Development of a LHIN-wide HHR recruitment and retention strategy. • Development of a framework to share HHR in short supply and high demand. • Better understanding of the non-clinical workload demands on our health professionals.

Multi-Year Funding Implications

Direct costs associated with any HHR projects, which are not health service provider based are contained within the South East LHIN Operations Section of this ASP.

Continuum of Care/Patient Transportation

Priorities for change supported	• Access to long term care. • Improved patient transition through continuum of care. • Access to Specialized Medical Services. • Improved transportation to and from health care services.
MLAA Indicators impacted	• Health System Performance Indicators.
MoHLTC Priorities impacted	• Link with MoHLTC "Flo" Collaborative. • Ontario's Wait Times Strategy. • Ontario's Aging at Home Transportation (Van) Initiative.

Project Rationale

The South East LHIN's IHSP identified improving patients' journeys through the continuum of care as a priority for change. This ASP has addressed many elements of the process through work in other projects.

The scope and magnitude of the process issues associated with this area warrant a summary project plan to consolidate elements and objectives.

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Initiative	Outcomes
Known Events Modelling	Most industries have events occur where: • The event is known to the organization and has occurred before. • There is high degree of confidence that the event will occur again, but little or no certainty as to when.

	• Predictive modelling has been applied in such circumstances to manage the event (i.e. making them less costly per instance, pre-preparing elements in advance). • Research into the application of this modelling methodology to similar circumstances in hospitals may identify opportunities for efficiency gains.
Inter-HSP Non-Urgent Transportation	Hospitals have identified the non-urgent transfer of patients as a cost pressure. Non-urgent transportation options can facilitate the timely discharge of patients from hospitals as well as ensure access to specialized care where it has been centrally located. Research is required to evaluate the relative costs of non-urgent transportation in the context of the South East LHIN's priorities for change and the potential of such a concept in a broader-based health service provider deployment.
Link with Central Intake	Centralized intake and assessments are identified as enablers of improved access and efficiency. Logistics of scheduling, planning, evaluating capacity and managing for random variation are concepts well known to other industries for whom "time is money". For the South East LHIN and the patients, "time is health". Coordination between and among providers is required to ensure that care is provided in sequential order to minimize non-value added consultations and follow-up appointments. The opportunity exists to embed a logistics framework into many of the "optimization" projects.
Aging at Home Transportation Initiative	In May, 2008 the Minister of Health announced a provincial transportation initiative under the Aging at Home Strategy. Under this initiative, the South East LHIN will be receiving a pre-determined number of highly identifiable Dodge Caravan vans. The South East LHIN has indicated its intent to develop a regional, integrated program to incorporate these vans into its current community transportation services. The initial concept is to allocate all vans to a single, existing health services provider who will undertake to locate these vans across the region and provide regular "bus-like" service along routes to major hubs of health care services in the south east. An initial allocation of the vans has occurred but will be reviewed within the context of development of a regional transportation plan for the South East LHIN. This plan will be finalized in 2008 and implemented immediately.

Key Outcomes	• Validation that the application of non-health industry business processes can be leveraged to drive process improvement in the organization and delivery of services in a local health system. • Stakeholders buy-in to trial such methodologies. • Evaluation of potential savings, in terms of health service provider staff and resources, patients (transactional costs of engaging the health system) and estimation of quantifiable benefits (cost savings, cost avoidance, improved efficiency, improved quality of work life). • Meeting required mandate(s) of the Provincial Aging at Home Transportation Initiative.

Multi-Year Funding Implications

Costs which are not health service provider based are contained within the South East LHIN Operation Section of this ASP.

Aging at Home/SMILE Program

Priorities for change supported	• Improve the availability of long-term care services (not limited to long-term care homes)
MLAA* Indicators impacted	• Rate of emergency visits that could be seen elsewhere • Alternate level of care • Ambulatory care sensitive conditions
MoHLTC Priorities impacted	• Reducing wait times in emergency rooms (Aging at Home Strategy is now part of that priority/ER Strategy) • Reducing number of alternate level of care patients in hospitals

***** Ministry-LHIN Accountability Agreement

D.10

Project Rationale

- The Aging at Home Strategy is part of two major government priorities for health care announced by Minister of Health and Long-Term Care, George Smitherman, on April 23, 2008. They are aimed at reducing emergency room (ER) wait times and connecting patients to family health care. The Aging at Home Strategy in the South East represents a $17.4-million investment in community-based services for seniors over three years.
- Further to community consultations involving seniors and health service provider representatives, the outcome of the aging at home planning effort in the South East to implement the government's Aging at Home Strategy is a new regional, long-term functional support program for seniors in the South East: SMILE (Seniors Managing Independent Living Easily).
- The SMILE program will make it possible for more seniors who are frail and elderly and most at risk of premature institutionalization, to receive help with activities that are essential to daily living so they can remain in their homes. Because dignity is a matter of choice, SMILE will offer them options in managing their care, in selecting services, in choosing who comes into their home and when.
- VON Canada–Ontario will be accountable to the South East LHIN for program development, administration, funding and rollout over a three-year period.

Initiative	Outcomes/Health Service Provider Involvement
SMILE (Seniors Managing Independent Living Easily)	This new long-term functional support program will make it possible for more seniors who are very frail and elderly, and most at risk of premature institutionalization, to receive help with activities that are essential to daily living – known as instrumental activities of daily living (IADLs) – so they can remain in their homes. Services covered for seniors who are admitted to the program include: meals; routine housekeeping; shopping; laundry (including wash and fold services); running errands; transportation to and from health care appointments and seasonal outdoor chores. The program also enables recipients to leverage community support services that are available locally, or variations on these services. Because dignity is a matter of choice, SMILE will offer them options in managing their care, in selecting services, in choosing who comes into their home and when. Local service providers and community groups will contribute by becoming access portals, entry points into the program, providing standardized information and/or needs' assessment or by delivering services. Seniors can choose to select services from existing services and/or non-traditional providers. Non-traditional providers include individuals (e.g. neighbours) and community-based groups including ethnic and community groups representing marginalized or unique populations. SMILE will be managed regionally (and funded) through VON Canada–Ontario. Implementation is being phased in over three years and begins in 2008.

Key Outcomes	• Regional and standardized service offering (i.e. core basket of services) across the South East for seniors who are admitted to the program. • Improved regional access to SMILE services through improved coordination (i.e. regional management centre) and multiple access portals (i.e. at points in the system where people seek care and have contact with their community). • Economic benefits through hiring non-traditional sources of services. • An initial selection of performance indicators designed in large part to measure the program's impact at a regional level includes the following: – A high level of satisfaction with services received among SMILE program recipients and their caregivers.

	– A higher age of admission to long-term care facilities (five-year trending) for SMILE program recipients compared to non-SMILE program recipients. – A higher level of functional disability at the point of admission to long-term care facilities (five-year trending) for SMILE program recipients compared to non-SMILE program recipients. – Reduced presentations to hospital emergency departments in the region for patients assessed with level IV and V conditions (annual trending) for SMILE program recipients compared to non-SMILE program recipients. – Reduced hospital emergency department visits in the region for conditions that may be treated in alternative care settings for SMILE program recipients compared to non-SMILE program recipients. • SMILE is being phased in over a period of three years, as follows: – *A development phase in year one (2008/09)* – beginning in spring, 2008 to test and evaluate the program using a reduced number of recipients (200) in order to make any necessary adjustments; recruitment of approximately six portals. – *Partial implementation in year two (2009/10)* – to account for added numbers of recipients (715-925) and the involvement of additional service providers and community organizations, as access portals. – *Full implementation in year three (2010/11)* – to coincide with full funding being made available to the South East LHIN by the Ministry of Health and Long-Term Care for aging at home initiatives throughout the province. Anticipate serving up to 1,760 clients within the estimated 2,000 elderly and very frail population in the South East.

Multi-Year Funding Implications

Costs associated with this program are anticipated to include the following:

- $2,211,479 in 2008/09;
- $5,495,822 in 2009/10; and
- $9,706,466 in 2010/11 (ongoing).

Financial Summary by Sector

South East LHIN Financial Summary by Sector	2007/08 Actual (000's)	2008/09 Funding Allocation (000's)	2009/10 Funding Target (000's)	2010/11 Funding Target (000's)
Total Health Service Provider (HSP) Transfer Payments by Sector:				
Operation of Hospitals	584,042.6	594,939.2	603,055.1	603,055.1
Grants to compensate for Municipal Taxation - public hospitals	188.5	188.5	188.5	188.5
Long Term Care Homes	129,672.8	133,936.0	133,936.0	133,936.0
Community Care Access Centres	84,537.9	85,638.9	89,064.4	93,517.6
Community Support Services	14,117.9	14,322.0	14,644.3	14,973.8
Acquired Brain Injury	2,798.7	2,861.7	2,926.1	2,991.9
Assisted Living Services in Supportive Housing	1,901.9	1,944.7	1,988.4	2,033.2
Community Health Centres	12,410.4	12,608.0	12,608.0	12,608.0
Community Mental Health	29,786.1	30,872.3	31,566.9	32,277.2
Addictions Program	5,910.0	5,985.2	6,119.8	6,257.5
Initiatives	1,444.7	4,823.4	8075.6	12,286.3

Includes funding for Aging at Home, Urgent Priorities and the Flo Project.

Allocating Urgent Priorities Funds (Initiatives)

Approach

Over 40 Health System Improvement Pre-proposals (H-SIPPs) were submitted for consideration of funding. In order to select those which best met criteria, including alignment with the South East LHIN IHSP, a structured approach was

used based on the Analytic Hierarchy Process (AHP) decision making Methodology. The AHP approach addresses complex decision making by structuring or "framing" the objectives into hierarchies to break down complex ideas into their component parts. Hierarchies are natural systems of ideas, objectives or criteria that represent the subject under consideration as completely as possible. AHP includes all relevant objectives, isolates and ranks the most important ones and compares benefits derived from each alternative to determine the optimal combination of projects (the "efficient frontier").

The South East LHIN used "Expert Choice" software to implement the AHP process. Expert Choice employs the AHP approach to drive effective collaboration and synthesize intuition, expertise, and quantitative data. This results in improved project selection, resource allocation and decision-making.

Detailed Methodology

The South East LHIN used Expert Choice software to aid in the selection of successful H-SIPPs, based on several criteria including alignment with the South East LHIN's IHSP. Expert Choice is designed to help synthesize data, aid intuition, leverage expertise and address resource scarcity among competing objectives. The methodology was implemented in five steps as follows:

- Structure a Decision Model: Construct a decision model consistent with the Analytic Hierarchy Process using Expert Choice software.
- Derive Weights for the Criteria: Define the relative importance of each criteria and sub-criteria to the decision result.
- Rate the Projects: The projects being considered for prioritization were individually rated for how well they contribute to each of the criteria.
- Resource Allocation and Optimization: Expert Choice software was used to select the optimal blend of projects given complex resource and budget constraints including forced funding of projects (e.g. committed to in previous allocation) and funding pools, as appropriate.
- Iterations and Decision: Several iterations of the decision were reviewed to examine the effect of changes to variables (criteria, funds, resources, constraints).

After the initial review was conducted, health service providers that submitted the highest ranked H-SIPPs were requested to submit a Business Plan Proposal (BPP) for further consideration, using guidelines provided by the South East LHIN. Once the submitted BPPs are reviewed, staff will make recommendations to South East LHIN Board for approval.

Key Dates for 2008/2009 Urgent Priorities Funds Initiatives (subject to change):	
First Submission deadline for H-SIPP Form	April 30, 2008
Selection of pre-proposals for proposal development	May 21, 2008
Deadline for invited BPP submissions	June 13, 2008
Notice of successful (Board approved) BPP selection	August, 2008
Release of funding to successful applicants	September, 2008
Second Submission deadline for H-SIPP Form	August 11, 2008
Selection of pre-proposals for proposal development	September 3, 2008
Deadline for invited BPP submission	October 6, 2008
Notice of successful (Board approved) BPP selection	December, 2008
Release of funding to successful applicants	January, 2009

LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2006/07 Actuals	2007/08 Actuals	2008/09 Pending Allocation	2009/10 Planned Expenses
Salaries and Wages	1,023,599	2,012,734	2,409,243	2,730,597
Employee Benefits				
HOOPP	83,201	201,848	289,109	247,939
Other Benefits	109,843	228,830	353,202	404,532
Total Employee Benefits	***193,044***	***430,678***	***642,311***	***652,471***
Transportation and Communication				
Staff Travel	56,153	86,182	105,040	106,121
Governance Travel	33,689	29,031	39,780	40,576
Communications	40,230	58,548	67,693	69,047
Other	9,569	50,792	7,000	3,500
Total Transportation and Communication	***139,641***	***224,553***	***219,513***	***219,244***
Services				
Accomodation	265,797	177,020	134,100	136,752
Advertising	92,780	1,334	100,800	107,800
Banking	687	519	500	1,000
Consulting Fees	383,384	261,817	170,800	243,209
Equipment Rentals	9,321	4,961	5,304	5,410
Governance Per Diems	177,164	130,767	200,000	200,000
Insurance	44	16,182	16,280	18,727
LSSO Shared Costs	299,349	300,000	300,000	312,120
Other Meeting Expenses	44,935	53,056	107,229	80,340
Other Governance Costs (net)	18,700	18,224	33,000	33,160
Printing & Translation	295	22,087	87,000	59,162
Staff Development	26,922	69,687	69,000	67,760
Total Services	***1,319,379***	***1,055,654***	***1,224,013***	***1,265,440***
Supplies and Equipment				
IT, Equipment & Software	23,190	92,912	63,000	42,288
Office Supplies & Purchased Equipment	86,681	52,624	61,120	84,064
Total Supplies and Equipment	***109,871***	***145,536***	***124,120***	***126,352***
Capital Expenditures	***237,759***	***4,500***		
LHIN Operations: Total Planned Expense	**2,785,535**	**3,873,655**	**4,619,200**	**4,994,104**
Special Project Funding Envelopes:				
e-Health		268,869	120,000	-
Aging at Home		171,023	-	-
Emergency Department		35,832	31,200	-
Aboriginal		15,000	15,000	-
Wait Times List		70,000	-	-
LHIN Operations: Total Special Projects Funding	**-**	**560,724**	**166,200**	**-**
09/10 and 10/11 Special Projects TBD via MOHLTC				
PENDING REVIEW AND FINAL APPROVAL BY SE LHIN FINANCE COMMITTEE AND BOARD				

Planning for South East LHIN Operations

Background

The South East LHIN is now in the fourth year of operations and has been operating with a full staff complement for twelve months. As a start up organization in fiscal 2005/06, LHIN budgets were developed without a full understanding of specific LHIN resource requirements. While unavoidable given the lack of relevant historical data, it is important to note that a go-forward assessment of LHIN requirements or performance based on *pro-forma* start up allocations would be imprudent.

With three years of experience in operations and the opportunity to fully evaluate required resources in light of local health system commitments and obligations undertaken with the MoHLTC, we now have a more accurate understanding of our business requirements, our mandate and our community's expectations.

Primary LHIN Objectives

- To achieve successful outcomes in the Priorities for Change articulated in the South East LHIN's IHSP.
- To achieve the negotiated targets detailed in the Ministry-LHIN Accountability Agreement (MLAA) and foster innovation and integration within the South East LHIN.

LHIN Operations Objectives

- Leverage the human and technical resources of the LHIN operations office to enable the South East LHIN to achieve these objectives.
- Assess, analyze and make recommendations regarding:
  - Ability of the South East LHIN to operate within the parameters of its funding.
  - Best deployment of human and physical resources to support the achievement of the primary LHIN objectives.

- Advise on ways and means, in conjunction with Performance, Contracts & Allocation and Planning, Integration & Community Engagement leads, to maximize investments in community engagement activities without restriction.
- Support Human Resources functions as required to ensure the smooth operations of the corporation.

Key Components

The South East LHIN has identified required LHIN Operation funding requirements in the *LHIN Operations Spending Plan* table.

These requirements include the following assumptions:

- **Compensation Considerations**
  - Cost of Living Allowances and Inflation at 2%.
  - Merit Increment range of 0% - 5%.
  - Benefits 25%.
- **Community Engagement**
  - Increased tempo of community engagement activities including development of new committees, issue-specific liaison groups and ad-hoc targeted forums as well as startup support for new initiatives.
- **Ongoing staff development**
- **Equipment replacement based on estimated lifecycle**

The South East LHIN is committed to:

- Modeling behaviour for other health service providers through the application of sound fiduciary judgment, business acumen and applying best efforts in the use and monitoring of the funding for LHIN Operations.
- Working with the MoHLTC to set reasonable funding levels for the work required.
- Using good judgment and common sense should a realignment of our priorities and engagement activities be necessary to meet our balanced budget obligations.

Management Plan to Deal with Risks

Understanding our health service providers was the first step in assuming our roles in allocating funds and managing performance. The South East LHIN has embedded a risk framework into the Planning, Integration & Community Engagement and Performance, Contracts & Allocation teams when evaluating program expansion, new programs or increases in cost factors not linked to service provision.

Scenario	Likely Sector(s)	Risk Potential	Order of Magnitude	Is the risk profile manageable?
HSP breach of fiduciary trust and/or fiscal mismanagement	**CSS/MH&A**	**Low to Moderate**	**Low**	**Yes**
• The potential exists as we transition these smaller agencies from a high level of ministry control to a model of low central control with LHINs. A lack of reporting for daily expenses may give the impression of a lack of oversight. • The budgets in these agencies are quite small. Financial mismanagement would likely be identified almost immediately, if not from the agency itself then from clients, employees or volunteers who did not receive required services, payment, etc. • Sector providers are being integrated into the Ontario Health Reporting System (OHRS) in the next several months; which will further enhance reporting. • Funding is provided to agencies in semi-monthly increments, so risk mitigation is limited to the period from the commencement of any "mismanagement" to the date of notification. • No agencies were identified as high risk by the MoHLTC in the transfer of operations. • A loss in this area would likely be manageable within the local funding allocation.				These health service providers operate with small budgets, little flexibility or discretionary funding. Cash flow concerns would flag issues prior to quarterly reporting.

Scenario	Likely Sector(s)	Risk Potential	Order of Magnitude	Is the risk profile manageable?
HSP failure to meet performance obligations	**Hospitals/ CCAC**	**Moderate/High**	**Moderate/ High**	**Yes in partnership with the MOHLTC re: KGH** South East LHIN has engaged in enhanced performance management with a number of its hospitals and the CCAC. Process includes requirement for a Performance Improvement Plan as well as more frequent and involved oversight of achievement against the approved plans in 2008/09. The South East LHIN will work in partnership with the MoHLTC and the hospital to successfully implement the investigator's recommendations in 2008/09. Potential recoveries due to non-performance are anticipated with these providers. Generally, funds not used for their intended purposes are recovered and redirected.
	A number of hospitals and the CCAC failed to meet the performance obligations of a balanced budget in 2007/08 and are at risk of same in 2008/09. The Kingston General Hospital (KGH) has demonstrated the largest and most persistent negative financial performance. The Minister of Health and Long-Term Care recently appointed an investigator for this hospital. A final report is due to the Minister and the South East LHIN by the end of May, 2008. Recovery of unspent allocations for specific services is a common event for these large providers. In addition to internal controls, public audits and board governance, financial and volumes related performance indicators are assessed quarterly. Inconsistent results are flagged for immediate attention. Similar processes used by the MoHLTC for this purpose have been provided to LHINs for their ongoing due diligence monitoring.			

Based on this analysis, the South East LHIN is confident that:

- The financial management of health service providers is well within its span of control.
- It will detect any irregularities reasonably early and will act quickly.
- Any information provided by stakeholders regarding irregularities will be investigated under our statutory authority.

The overall risk of irregularities with use of public funds is low as the majority of funds are provided to hospitals and the Community Care Access Centre, which have significant financial and audit controls embedded in their operations.

Communications Plan

The South East LHIN's Annual Service Plan (ASP) explains how we will achieve our Priorities for Change and how we intend to meet the negotiated targets in our Ministry-LHIN Accountability Agreement (MLAA). The ASP is, as most documents are in LHINs, available to the public and will be posted to our website.

This results in three key communications goals:

- Ensure all reasonable steps are taken to fulfil the South East LHIN's commitment to making this document readily accessible and providing media outlets with additional context of what the ASP means.
- Additionally, it is important that the information contained in the ASP is known to stakeholders who may be affected by any projects being considered.
- The residents in the South East LHIN will understand, in large measure, what we intend to do. This is a substantial departure from historical planning approaches, and is welcomed by the LHIN.

And one challenge:

- The natural risk with furnishing information to the public is ensuring it is understood contextually. The risk of individuals, organizations, lobby groups and others interpreting elements of the ASP as being favourable (unlikely) or unfavourable (more likely) is significant.

Key considerations when talking about the ASP

- The projects contained in the ASP are in varying degrees of implementation. As a result, some outcomes are clear and well articulated, while others provide information on what is known and not known about a subject and lists developing next steps and activities.
- The ASP references other powers or authorities the LHIN uses and works with. In these cases, the ASP would not serve as the "authority to act". The approval and dissemination of information related to policies, standards, integration activities, service alignment etc. must then occur within the parameters of the relevant power or authority.

Strategy

- Use the ASP as a the foundational document to champion initiatives of networking and integration across the region, illustrating the South East LHIN's key message that gains and progress do not necessarily require new money.
- Position any decisions that may disappoint a health service provider (such as a rejection or non-commitment to deficit financing) within the balanced picture, i.e. the total context of gains and advances made to meet the residents' needs and wants as stated in the IHSP.

Tactics

The Annual Service Plan (ASP) contains many elements for announcements and rollouts but does not, by itself, require a separate strategic or tactical communications plan. The South East LHIN ASP will be posted to our website by summer, 2008 in order to make it available to the public, stakeholders and health service providers. Printed copies of the ASP will be made available by request.

Separate from the ASP but encompassing elements from the ASP, the South East LHIN will develop an annual communication plan that will support the South East LHIN's business plan and:

- Identify target audiences.
- Link stakeholders (agency clients, partners, public groups etc.) to anticipated positive and negative reactions.
- Develop key messages.
- Explain the communications tactical rollout (with expected timelines) and communications tools.

Acronym Table	
AHP	Analytical Hierarchy Process
ALC	Alternate Level of Care
ASP(s)	Annual Service Plan(s)
CCAC(s)	Community Care Access Centre(s)
CCU	Critical Care Unit
CEO	Chief Executive Officer
CHC(s)	Community Health Centre(s)
CIO	Chief Information Officer
CSERP	Community Services for Emergency Rooms Project
CSI	Consumer Survivor Initiative(s)
CSS(s)	Community Support Service(s)
ED	Emergency Department
EDAP	Emergency Department Action Plan
EDI	Electronic Data Interchange
ER	Emergency Room
FHT(s)	Family Health Team(s)
FLSA	French Language Services Act
HCNSEO	Heath Care Network of Southeastern Ontario
HHR	Health Human Resources
HSIPP	Health System Improvement Pre-proposal
HSP(s)	Health Service Provider(s)
ICES	Institute for Clinical Evaluative Sciences
ICU	Intensive Care Unit
IHSP	Integrated Health Services Plan
ISP	Integrated Service Plan
IT	Information & Technology
L&A	Lennox & Addington
LAP	Local Area Planning
LHIN(s)	Local Health Integration Network(s)
LTC(H)	Long Term Care (Home)
MLAA	Ministry-LHIN Accountability Agreement
MoF	Ministry of Finance
MoHLTC	Ministry of Health and Long-Term Care
OLIS	Ontario Lab Information System
OHRS	Ontario Health reporting System
ONA	Ontario Nurses' Association
PACS	Regional Picture Archiving and Storage
PCA	Performance Contracts & Allocations
PCCPR	Primary Care Central Patient Registry
PICE	Planning Integration & Community Engagement
SE	South East
SMILE	Seniors Managing Independent Living Easily
SE LHIN	South East Local Health Integration Network
SSHA	Smart System for Health Agency
TBD	To Be Determined
TEN	Toronto East Network
UAP	Under serviced Area Program