Central East **LHIN**

Central East Local Health Integration Network

2009 – 2012 Annual Business Plan

Engaged Communities.
Healthy Communities.

Ontario
Local Health Integration Network

M E M O R A N D U M

To: Ken Deane, Assistant Deputy Minister, Health System Accountability and Performance Division

From: Foster Loucks, Board Chair, Central East Local Health Integration Network

cc: Leela Prasaud, Director(A), LHIN Liaison Branch

Date: July 2009

Re: Transmittal Letter for the Central East LHIN Annual Business Plan, 2009-2012

I am pleased to present to the Ministry of Health and Long-Term Care our Annual Business Plan (ABP) for 2009-2012, in fulfillment of the requirements outlined in Schedules 5 and 8 of the Ministry-LHIN Accountability Agreement.

The Plan was presented to the full Board at our open Board meeting on October 16, 2008, in accordance with the Local Health Systems Integration Act 2006 provisions to demonstrate to our stakeholders that LHIN decision-making is transparent, evidence-based and grounded in the priorities of our Integrated Health Service Plan. Following discussion and review, the Board is proud to approve and endorse the Plan as it will achieve the goals set out in both the Strategic Directions of the CE LHIN, and the Integrated Health Service Plan.

This Plan continues to advance the LHIN's vision of "Engaged Communities. Healthy Communities" with a particular focus on seniors, persons with or at risk of chronic illness such as diabetes, individuals with mental illness and/or addictions, aboriginal persons and their communities, and finally patients and their caregivers.

Our Annual Business Plan initiatives have been checked against the risk framework as well as aligned to the outcome measures of a high performing health system as described by the Ontario Health Quality Council. Such a high performing system is characterized by its accessibility, efficiency, effectiveness, safety, integration, person-centred care, appropriately resourced, equity and delivers good population health outcomes.

Looking forward to the refreshed Integrated Health Services Plan (2010-2013), the initiatives in this Plan are increasingly focused on achieving tangible outcomes for the residents of this LHIN and their health care providers. The CE LHIN has established two broad strategic goals that will have a direct impact on our health system today and tomorrow. Those goals are:

- Save 1 million hours spent waiting by patients in CE LHIN hospital Emergency Departments by 2013
- Reduce the impact of vascular disease by 2013

To achieve these significant goals, the CE LHIN and local health service providers will be pursuing solutions that will:

- Reduce both avoidable Emergency Department (ED) visits and the amount of time patients spend waiting in EDs;

- Reduce the number of Alternate Level of Care (ALC) days and enhance collaboration and flow between health service providers;
- Continue with the Aging at Home Strategy to enable seniors to live healthy, independent lives in their homes by providing health care services such as adult day programs, outreach services, supportive housing, and care giver supports. These services are designed to keep seniors healthy and active, prevent avoidable visits to the ED and hospitalization, and reduce the number of hospital days patients wait for ALC;
- Realize the goal of a "One Acute Care Network" that will ensure greater equity of patient access to an integrated hospital system that delivers the highest quality of care;
- Improve access to primary health care, health assessments, and self-care tools for residents of our LHIN who are without a family physician and are at risk of developing a worsening of a chronic condition such as diabetes and kidney disease;
- Strengthen the CE LHIN Stroke System in order to improve equity, timelines, and quality of stroke care;
- Enhance existing and new mental health and addiction services so that clients and families get the right care at the right time by the right provider in the right setting;
- Bring to life the CE LHIN Board's Strategic Directions, the 2010-13 Integrated Health Service Plan (IHSP), and Performance Management Framework.

The Annual Business Plan also identifies known areas of health service sector growth due to demographic pressures, clinical practice and inflation. They are included in the plan for the purposes of notifying the Ministry of pending growth. It follows that spending in these areas will need to follow a process consistent with LHIN and MOHLTC policies and procedures and funding opportunities.

Our health service providers and CE LHIN Planning Partner groups, (including geographic-based Collaboratives, LHIN-wide priority Networks, issues focused Task Groups and project teams, Health Professional Advisory Committee, Francophone Collaborative, and Aboriginal Health Advisory Circle will be applying their tremendous capacity, knowledge, and experience to bring these initiatives to fruition. Their active partnership ensures that the proposed initiatives detailed in the Annual Business Plan are responsive and reflective of all of our unique communities from Scarborough to Haliburton.

The Board is confident that the following Annual Business Plan represents the necessary steps to establish a truly transformative and appropriately resourced health system rooted in the Central East, and oriented around the residents we serve.

Foster Loucks, Board Chair,
Central East Local Health Integration Network

Attachment: Annual Business Plan

Table of Contents

Executive Summary

The 2009 - 2012 Central East LHIN (CE LHIN) Annual Business Plan provides the public and the Minister of Health and Long-Term Care with key information on how the CE LHIN is meeting its legislated and accountability requirements. It demonstrates our on-going plan to create an integrated public health system that provides safe and high quality of care, is accessible and equitable, and is efficient and sustainable. The activities in this Annual Business Plan are derived from the **2007 - 2010 Integrated Health Service Plan** (IHSP), a plan that was derived through extensive community engagement with local residents and health care providers about what they wanted most from their health care system. The 2010-2013 Integrated Health Service Plan will be available in November 2009.

The purpose of this Annual Business Plan as it relates to LHIN legislation, the CE LHIN Vision, Strategic Directions, Integrated Health Service Plan, and the Ministry-LHIN Accountability Agreement are described in the **Introduction**.

The **Environmental Scan** sets the context in which the LHIN and local health service providers are operating. This includes LHIN-specific information such as our population profile, risks and opportunities that form the base assumptions of this Annual Business Plan.

Activities that operationalize the CE LHIN Integrated Health Service Plan (IHSP) while meeting the accountability requirements of the Ministry-LHIN Accountability Agreement (MLAA) can be found in the **Detailed Service Plan**. Specifically, for each priority established by the IHSP this section will:

- Provide a summary of objectives, planning partners (i.e., community engagement), and environmental factors for that priority
- Demonstrate how activities within this priority support provincial priorities, the Ministry-LHIN Accountability Agreement (MLAA), and the CE LHIN Strategic Directions
- Describe the specific health service initiatives and LHIN planning activities for this 2010-13
- Describe objectives, implementation plan, status, and performance target for each initiative within that priority

The **Financial Summary** describes anticipated expenditures and revenues over a three year period and demonstrates how the LHIN proposes to allocate its approved resources in order to fulfill its mandate. It provides a detailed road map to the achievement of the LHIN and Ministry priorities.

The **Operational Plan** describes the planned operational (e.g. staff, materials) requirements for 2009 - 10 and two subsequent years.

The CE LHIN strategy to share this Annual Business Plan with its stakeholders is contained in the **Communications Plan**.

Introduction

Local Health Integration Networks are non-profit corporations established by the Local Health System Integration Act (LHSIA) in order to plan, fund and integrate the local public health system. The CE LHIN – one of fourteen LHINs in Ontario – has the legislated responsibility:

- to promote the integration of the local health system to provide appropriate, coordinated, effective and efficient health services;
- to identify and plan for the health service needs of the local health system in accordance with provincial plans and priorities and to make recommendations to the Minister of Health and Long-Term Care about that system;
- to engage the community of persons and entities involved with the local health system in planning and setting priorities for that system;
- to ensure that there are appropriate processes within the local health system to respond to concerns that people raise about the services that they receive;
- to evaluate, monitor and report on and be accountable to the Minister for the performance of the local health system and its health services;
- to participate and co-operate in the development by the Minister of the provincial strategic plan and in the development and implementation of provincial planning, system management and provincial health care priorities, programs and services;
- to develop strategies and to co-operate with health service providers, including academic health science centres, other Local Health Integration Networks, providers of provincial services and others to improve the integration of the provincial and local health systems and the co-ordination of health services;
- to undertake and participate in joint strategies with other Local Health Integration Networks to improve access to health services patient care and access to high quality health services and to enhance continuity of health care across local health systems and across the province;
- to disseminate information on best practices and to promote knowledge transfer among Local Health Integration Networks and health service providers;
- to bring economic efficiencies to the delivery of health services and to make the health system more sustainable;
- to allocate and provide funding to health service providers, in accordance with provincial priorities;
- to enter into agreements to establish performance standards and to ensure the achievement of performance standards by health service providers that receive funding from the network;
- to ensure the effective and efficient management of the human, material and financial resources of the network and to account to the Minister for the use of the resources; and;
- to carry out the other objects that the Minister specifies by regulation made under this Act.

The 2009 - 2012 Annual Business Plan is one of several planning and accountability documents that describe how the CE LHIN is meeting its legislated responsibilities and advancing local and provincial health care priorities. Ultimately this Plan supports the actualization of CE LHIN vision of ***"Engaged Communities. Healthy Communities"***

and the priorities outlined in the CE LHIN Strategic Directions and 2006-2010 IHSP. Through the commitment of local health service providers, volunteers, patients, families, caregivers and other interested stakeholders, the implementation of this vision and plan are well underway.

The CE LHIN Annual Business Plan also identifies and informs the public and the Minister of Health and Long-Term Care of some of the known challenges and opportunities to improve the local health care system, either through integration activities and/or priorities for new investment.

Figure 1: The ABP supports the achievement of MOHLTC and CE LHIN priorities and accountabilities.

The Plan demonstrates what the CE LHIN is doing to realize the Strategic Plan and Priorities of the Government of Ontario, and meet our accountability requirements as stipulated in the Ministry-LHIN Accountability Agreement. Finally, the Annual Business Plans, prepared by all of Ontario's 14 LHINs, are important contributions to the preparation of the Ministry of and Health and Long-Term Care Results-Based Plan (i.e., its strategic and operational plans forecasts). Figure 1 summarizes the function of the Annual Business Plan.

While the Annual Business Plan provides information on how the CE LHIN will achieve the priorities of the Integrated Health Service Plan, the results of this process are reported annually in the CE LHIN Annual Report.

Supporting our Vision and Strategic Directions

Underlining the activities outlined in this Annual Business Plan is the foundational commitment of the CE LHIN to its vision, strategic directions and desired outcomes for a high-performing healthcare system as described by the Ontario Health Quality Council (OHQC). The following table illustrates the inherent connection between the Strategic Directions and the OHQC outcomes:

Our **Strategic Directions**:	**System Outcomes** of a high performing health care system
Transformational Leadership *The LHIN Board will lead the transformation of the health care system into a culture of interdependence.*	**Equitable** *People should get the same quality of care regardless of whom they are and where they live.* **Focus on Population Health** *The health system should work to prevent sickness and improve the health of the people of Ontario.*
Quality and Safety *Health care will be people-centred in safe environments of quality care.*	**Safe** *People should not be harmed by the care that is intended to help them.* **Effective** *People should receive care that works and is based on the best available evidence.* **People-Centred** *Health care providers should offer services in a way that is sensitive to an individual's needs and preferences.*
Health Service and System Integration *Create an integrated system of care that is easily accessed, sustainable and achieves good outcomes.*	**Accessible** *People should be able to get the right care at the right time in the right setting by the right health care provider.* **Integrated** *All parts of the health system should be organized, connected and work with one another to provide high quality care.*
Fiscal Responsibility *Resource investments in the Central East LHIN will be fiscally responsible and prudent.*	**Efficient** *The health system should continually look for ways to reduce waste, including waste of supplies, equipment, time and information* **Appropriately Resourced** *The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people's health needs.*

CE LHIN **Vision**: Engaged Communities. Healthy Communities.

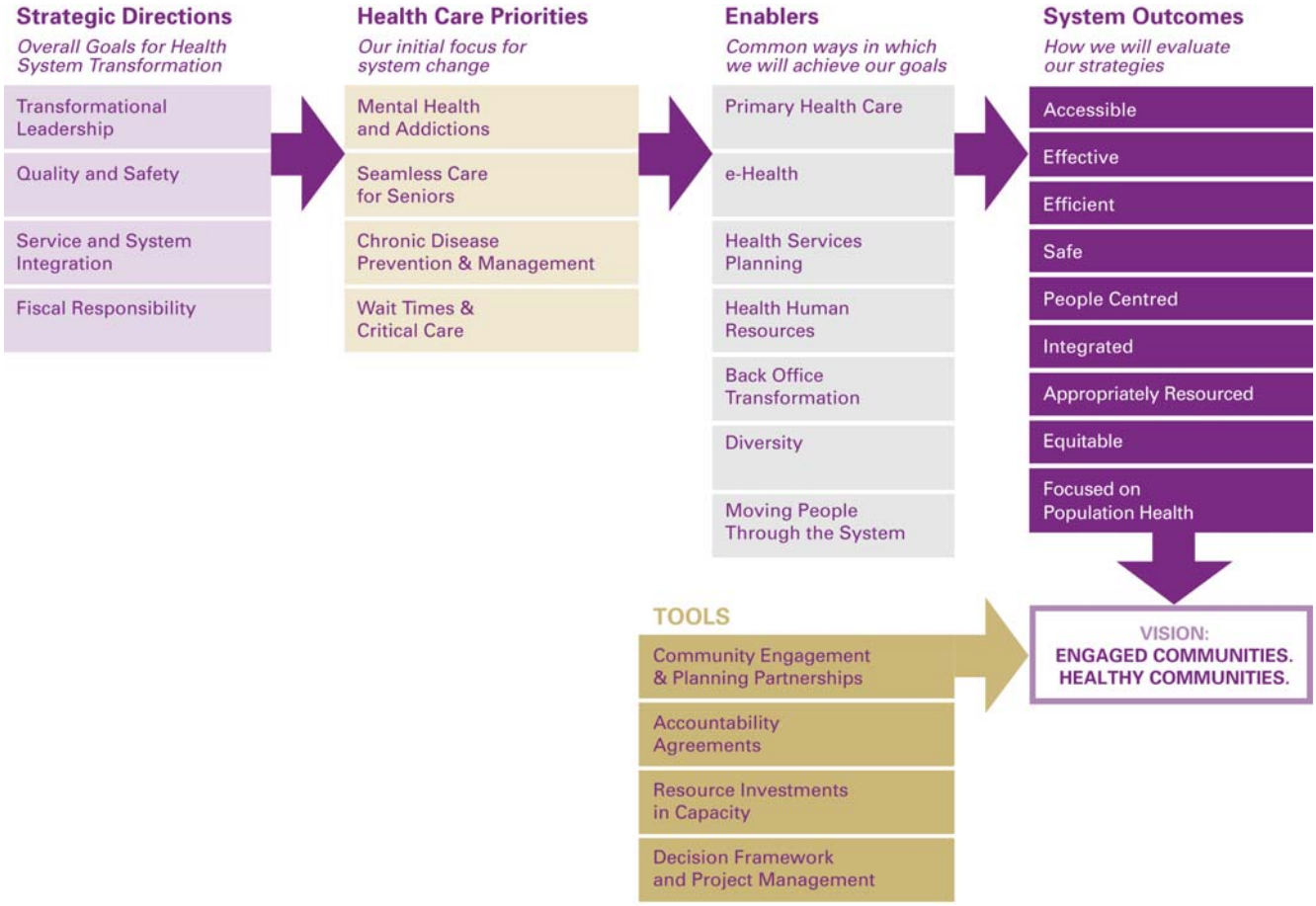
Implementing our Integrated Health Service Plan

The CE LHIN Integrated Health Service Plan identified four areas of focus, or **Priorities for Change**, and some common **Enablers** that will make a direct contribution to the achievement of our Vision and Strategic Priorities. The activities detailed in this Annual Business Plan are aligned to these Priorities and Enablers, which are:

Priorities for Change *Our initial focus for health system change*	**Enablers** *Common ways in which we will achieve our goals*
Chronic Disease Prevention and Management	Health Services Planning
Access and Wait Times	e-Health
Seamless Care for Seniors	Health Human Resources
Mental Health and Addictions	Back Office Transformation
	Diversity
	Moving People Through The System

While the task of transforming the health care system is a complex undertaking, the responsibility of describing our overall strategy should be as simple as possible. To this end, the LHIN has created a straightforward but important **Strategy Map** that depicts the complete transformational story – the strategy, priorities, outcomes and vision – of the CE LHIN.

CE LHIN Strategy Map



In conclusion, 2009-10 promises to be yet another active year for the CE LHIN and its local health service providers as it advances and matures the transformation of the public health care system.

Environmental Scan

The CE LHIN is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario. The LHIN encompasses densely populated urban cities, suburban towns, rural farm communities, cottage and country villages.

Figure 2 shows the population distribution of LHIN residents and its variation across the LHIN. Almost half of the LHIN population is concentrated in the South West corner, and this distribution poses some unique health service and planning challenges. For example, the population in Halliburton is only approximately 15,000 spread over a large geography, compared to the more densely populated Scarborough area. Both areas have identified travel as a service barrier, but for uniquely different reasons that have to be considered in planning new investments.

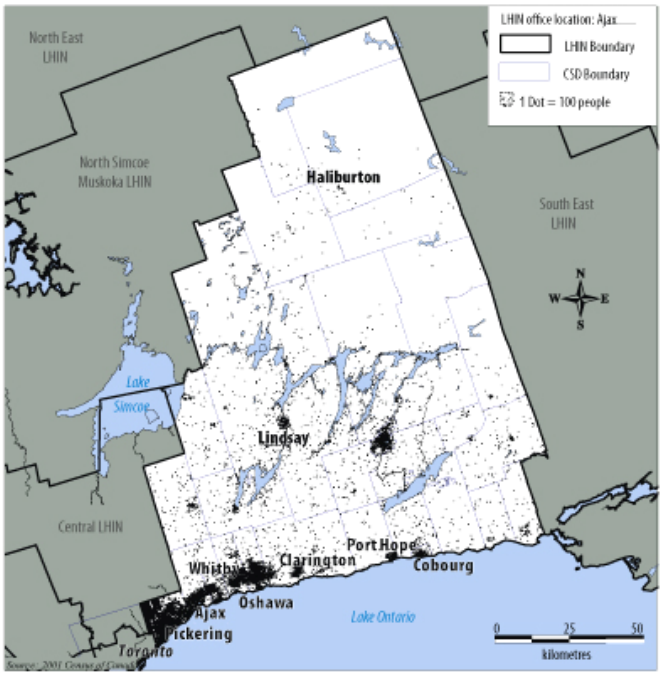


Figure 2: Population Distribution CE LHIN

Summary of Population Demographics

Overall, the CE LHIN is characterized by rapid population growth in certain age groups and great cultural diversity.

Population Growth

The CE LHIN population will increase 19.6% by 2016 overall, but the 85+ age group will increase by over 91%. The high growth in our elderly population has significant planning considerations for the CE LHIN that were identified in our IHSP.

	Base Year (2001)		2006			2016		
	Population	% of Population	Population	% of Population	Percent Increase from Base Year	Population	% of Population	Percent Increase from Base Year
Total Population	1,402,899	100.0%	1,483,126	100.0%	5.7%	1,677,507	100.0%	19.6%
0-64	1,223,404	87.2%	1,287,215	86.8%	5.2%	1,412,764	84.2%	15.5%
65+	179,495	12.8%	195,911	13.2%	9.1%	264,743	15.8%	47.5%
65-74	99,786	7.1%	101,985	6.9%	2.2%	150,064	8.9%	50.4%
75-84	61,405	4.4%	70,744	4.8%	15.2%	79,657	4.7%	29.7%
85+	18,304	1.3%	23,182	1.6%	26.6%	35,022	2.1%	91.3%

Table 1: CE LHIN Population Growth by Cohort 2001-2016

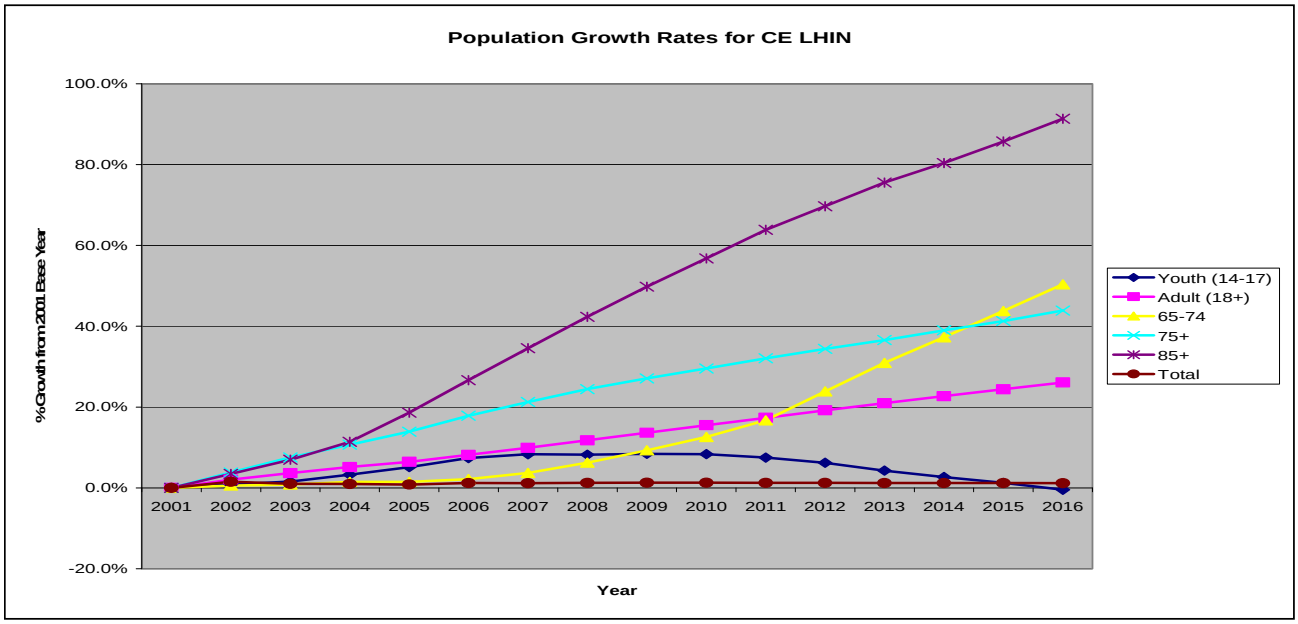


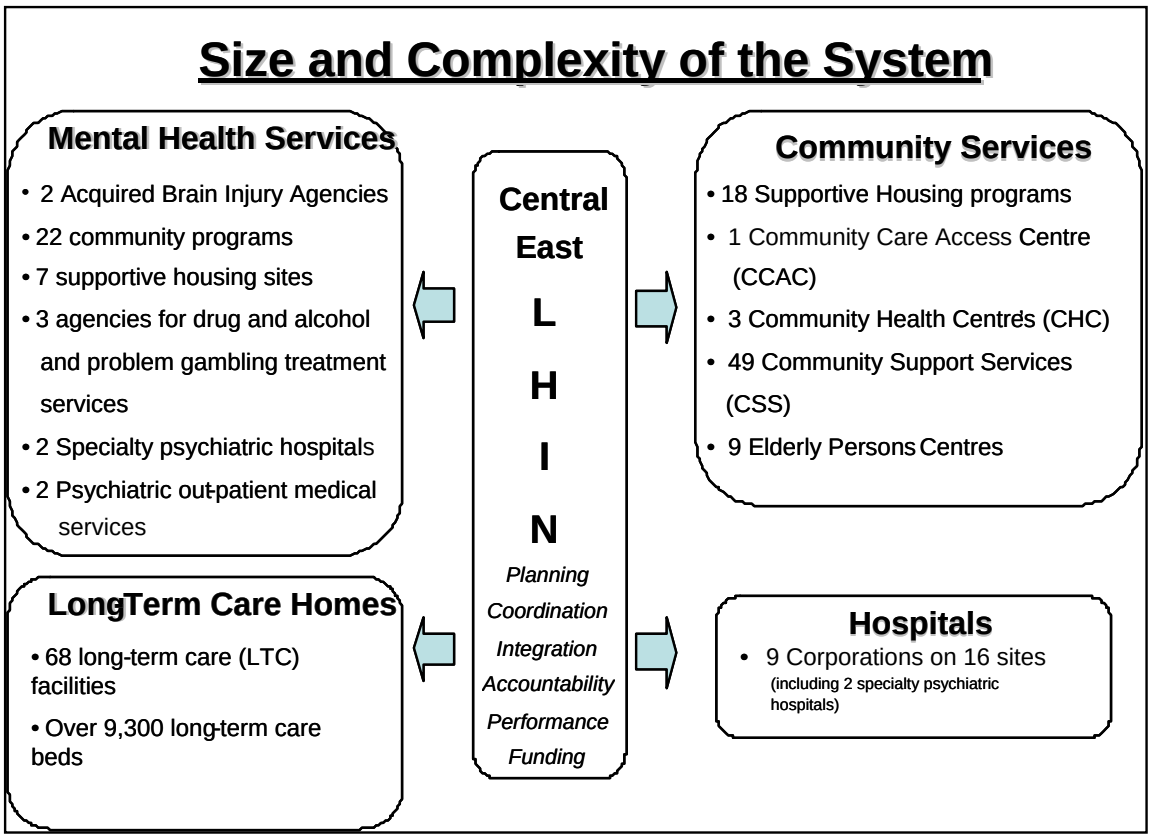
Figure 3: CE LHIN Population Trends

Population Diversity

The CE LHIN has a large immigrant and visible minority population. Scarborough has been cited by the United Nations as one of the most culturally diverse areas in North America. Supporting access to our health care services is one of our LHINs strategic objectives for a high performing health care system and our activities have been aligned with that objective.

Current Health Care Service Capacity

The CE LHIN has over 180 organizations providing health services. These organizations include hospitals, long-term care homes, and housing for the frail elderly, community health programs, home care, social recreational programs like elderly persons centres, and mental health and addictions programs.



Hospital Capacity

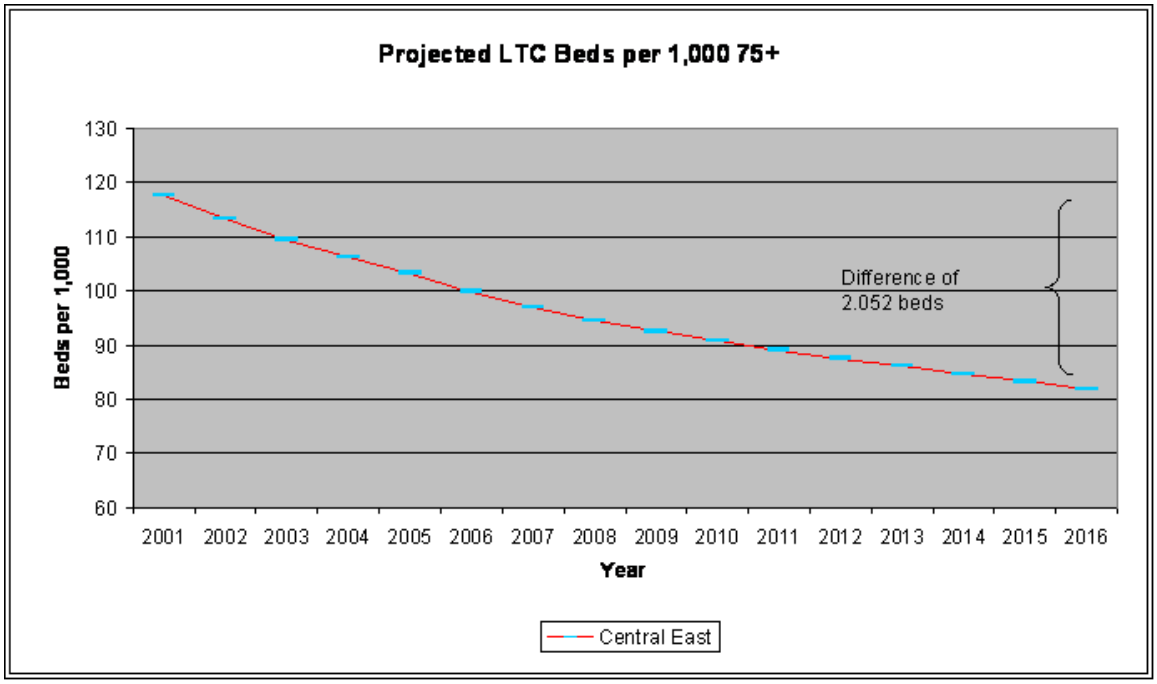
The hospitals of the CE LHIN are experiencing increasing pressures that include:

- Increased percentage of alternate level of care (ALC) days;
- Long average length-of-stays (LOS) in emergency departments (ED);
- Poor MRI and CT scan wait times;
- Access to timely and cost effective non-urgent transportation.

The CE LHIN, along with the providers, has concluded an initial regional Clinical Services Plan that will guide our work to reduce these acute care pressures. The planning process will address the existing state of services and provide advice on future models of service provision, consolidation opportunities and capacity.

LTC Homes Capacity

The CE LHIN has 68 long-term care facilities providing care in over 9,300 beds. The median wait time to long-term care home placement continues to grow and is significantly above the Provincial Target of 50 days. Wait-time pressures reflect the worsening ratio of LTC beds per population aged 75+ in the CE LHIN. Based on current population trending, the projected adjusted additional beds required to achieve the target ratio of 100 LTC beds per 1000 population of people aged 75+ exceeds 2,050 by the year 2016 (see below).



In light of this projected demand and service gap, through the Aging at Home Strategy the CE LHIN and local health service providers are actively pursuing and investing in patient-centred and effective alternatives to residency in long-term care homes. Such strategies include enhancing supportive housing options, stronger community-based geriatric programming, expanding home care supports, and supports for caregivers.

Community Mental Health & Addictions

Funding for mental health and addictions programs is insufficient to support the range of services people need in the CE LHIN. The CE LHIN receives $4.81 per capita funding for community mental health services, which is less than half of the Provincial average, and the CE LHIN has eight psychiatrists per 100,000 population compared to the Provincial average of 17.3. These funding and human resource shortfalls are compounded by high local mental health utilization rates of 18%, equivalent to 216,872 people (see below).

Mental Health Contacts Recorded in Ontario Health Insurance Plan (2004)

	Number of People	Prevalence Rate per 1000 (Pop 15+)	Proportion of the Total Population
Total	1,831,091	164.8	18%
Men	727,580	133.1	13%
Women	1,103,511	195.5	20%
Age Group (years)			
15-19	95,879	116.1	12%
20-39	555,688	156.6	16%
40-64	822,731	199.4	20%
65 Plus	356,793	226.5	23%
Central East LHIN	216,872	173.3	18%

Solutions and investments are required to close this gap, and the CE LHIN will continue to use its Urgent Priority Funding and other sources of revenue to expand mental health and addictions services. In addition, the LHIN and its health service providers are pursuing targeted and integrated solutions that will strengthen the continuum of care that will make the most of available resources.

Community Support Services (CSS)

There are many pressures on the local system ranging from the availability of both acute and LTC beds to a limited supply of community home supports and supportive housing alternatives. The graph below shows the projected need for CSS services to 2016 based on the current utilization rate.

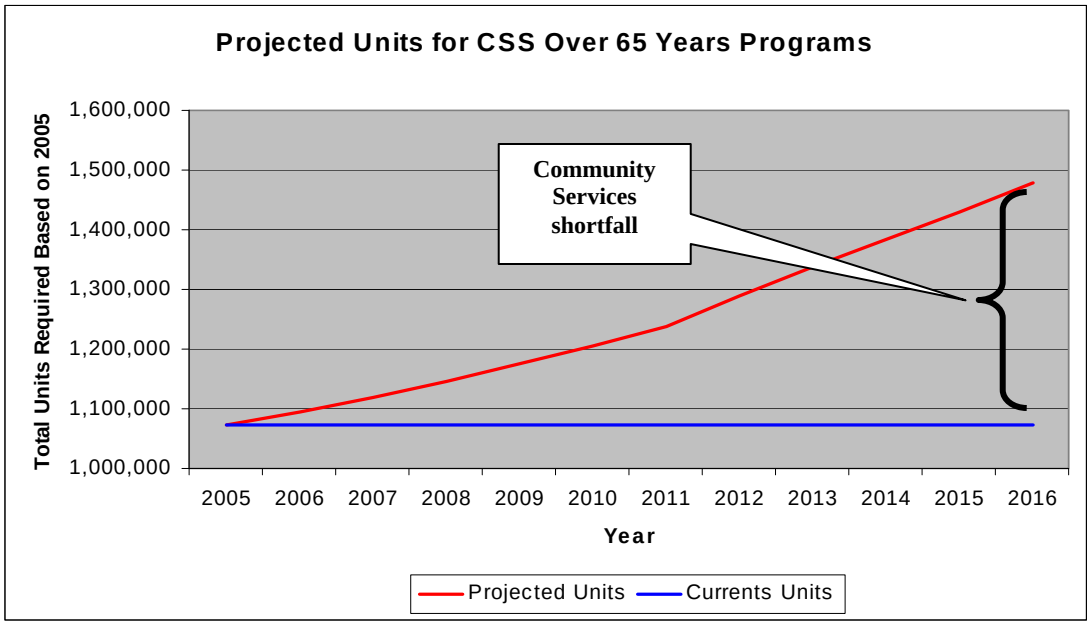


Figure 4: CE LHIN Community Service Shortfall. Note: Not reflective of CE LHIN Aging at Home investments in 2008-09 and 2009-10

Going forward, the CE LHIN will look to mitigate these issues through various multi-faceted initiatives, specifically the provincial Aging at Home Strategy. Within the first two years of the CE LHIN, we have closed the above gap by creating 17,555 new units of service annually.

Risks

The fast growing and aging population is quickly outpacing the capacity to deliver service. Without a combination of targeted new investment and new innovative partnerships for service delivery the level of service provided will begin to decline. Community service capacity has to grow to support growing demand, and to support transformation efforts, maintain people in their homes longer, and reduce ALC pressures. Long-term care home bed capacity is also insufficient relative to population aging, current use rates, and to support the reduction in ALC. The high capital and operating cost of these LTC home beds limits growth options within this sector. Mental health and addictions programs are significantly under-resourced in the CE LHIN, and will continue to decline as age-related mental disorders like dementia and depression increase. Substantial new investments in MH&A are needed to address existing service pressures, and to support the transformation of services to appropriate community and institutional care settings.

Accessible Services

While population growth among certain age groups presents certain planning challenges, there are distinct risks when services are not accessible to new Canadians and visible minorities. The south-west corner of the CE LHIN in particular has a growing and diverse population. Our planning challenges are to ensure that sufficient services are available to all people.

Economic Risk

There will be a direct impact on our ability to maintain and enhance services from the recent economic downturn. All providers have already been struggling to provide stable service levels when provincial/LHIN incremental funding lagged behind inflation. It can be expected that the funding gap will grow if provincial transfers are constrained. The LHINs have a mandate to transform the health care system, and not to simply maintain the previous status quo. Transformation activities like the Clinical Services Plan and creating a regional stroke program are fundamental investments in our health care system needed to promote a new way of providing health care in Ontario.

Opportunities

Recognizing that there are insufficient new investments to offset all risks, the LHIN has targeted initiatives that provide direct improvements in identified priority areas. It is important to note that the initiatives include both investment to increase volume of service activity and funds to support integration, innovation and alternative service delivery. These initiatives or opportunities are described in the next section, the Detailed Service Plan.

Detailed Service Plan

Meeting the Strategic Priorities of the Central East LHIN and Ministry of Health and Long-Term Care

This section of the Annual Business Plan provides details on how the CE LHIN intends to meet the commitments and performance objectives as set out in the 2006-2009 Integrated Health Service Plan (IHSP) and the 2007-2008 Ministry-LHIN Accountability Agreement (MLAA). The activities of the CE LHIN organization and local health service providers are part of a concerted effort to realize the strategic directions and vision of the CE LHIN and the Ministry of Health and Long-Term Care.

This section will provide initiative-level detail for each of the four CE LHIN Strategic Priorities for Change:

1. Chronic Disease Prevention and Management and Primary Health Care
2. Wait Times and Critical Care (including Emergency Department Performance and Alternate Level of Care).
3. Seamless Care for Seniors (including Aging at Home)
4. Mental Health and Addictions Services

For each Priority we provide a **summary** of:

- Alignment to the Ministry of Health and Long-Term Care strategic priorities and the Ministry-LHIN Accountability Agreement (MLAA)
- LHIN level performance goals for the priority
- Partners involved in planning and implementation
- Current status
- Environmental factors

Following this summary, we then provide detailed information for each **health service initiative** and **planning activity** for 2009-10 under that priority.

Broad Central East LHIN Initiatives

In addition to the Integrated Health Service Plan Priorities, 2009-10 will see the continuation of several strategic and operational initiatives undertaken by the CE LHIN. These broad-based initiatives are intended not simply to fulfill our legislated mandate and accountability requirements but, more importantly, to enable the transformational culture and leadership that will underpin the overall success of the CE LHIN.

Board to Board Engagement Strategy

LHIN Strategic Direction	Transformational Leadership
Objectives	Foster a culture of cooperation and coordination of care within the LHIN that will advance the LHIN's Strategic Directions and the IHSP Create opportunities for providers to learn and propose integration opportunities across provider "silos" Create opportunities for the LHIN Board to meet with provider Boards and learn of their strengths, challenges, and opportunities Serve as a vehicle for dissemination of governance best practices to support transformational leadership
Implementation Plans	The Strategy is supported through the establishment of three regional Board to Board Engagement Collaboratives that are to be sustained through the in-kind supports of local health service providers.
Current Status	Commenced in Fall 2007 and activities on going.
Performance Target	▪ Participation of all Board Chairs/delegates in the Board-to-Board Collaboratives; ▪ Submission of jointly developed voluntary integration opportunities, Health Services Investment Proposals or project charters.

Triple Aim: Prototyping Partnership with the Institute for Health Care Improvement

LHIN Strategic Direction	Safety and Quality Fiscal Responsibility Service and System Integration
Objectives	The CE LHIN has embarked on a prototyping partnership with the Institute for Healthcare Improvement (IHI) and over 30 international health care organizations with the objective of accomplishing three critical objectives, or the "Triple Aim": ▪ Improve the health of the population; ▪ Enhance the patient experience of care (including quality, access, and reliability); and ▪ Reduce, or at least control, the per capita cost of care.

Implementation Plans The CE LHIN has selected two current projects to be prototyped under the Triple Aim design:

- Self-Management for Consumers and Care Givers of Chronic Disease;
- Nurse-Practitioner Outreach Teams to Long-Term Care Homes.

Current Status Phase One of the IHI partnership commenced in September 2008 and concluded in June 2009. Phase Two will conclude in the Spring of 2010.

Central East LHIN One Acute Care Network

LHIN Strategic Direction
Safety and Quality
Fiscal Responsibility
Service and System Integration

Objectives The One Acute Care Network is the outcome of the CE LHIN Hospital Clinical Services Plan (Feb 2009). This plan set the foundation for improved and equitable patient access to an integrated hospital system that provides the highest quality of care across the Central East Local Health Integration Network for selected services To achieve this vision, the Clinical Services Plan explored:

- Improvements in ***quality and safety*** by grouping together clinical or medical/surgical specialists, their teams and appropriate physical resources;
- Expanding or creating new programs that would not be ***viable or sustainable*** at multiple sites;
- Creating ***operational and clinical efficiencies*** that would allow hospitals to focus on, and improve, their core programs;
- New **"centres of excellence"** to allow CE LHIN residents to receive services within the LHIN and, as **close-to-home** as possible.

Implementation Plans In 2009 and forward, the findings of the Clinical Services Plan will guide the CE LHIN and local health service providers in determining opportunities for new investments and hospital service configurations for the short to medium term (5 to 10 yrs) that will realize the One Acute Care Network.

The 1% Challenge: Reinvesting Our Resources in the Community

LHIN Strategic Direction

Transformational Leadership
Safety and Quality
Fiscal Responsibility
Service and System Integration

Objectives

The CE LHIN has established the goal of reallocating 1% of the 2007-08 Operation of Hospitals budget to community programs by fiscal year 2009-2010. This means that by December 2010, a minimum of $10.3M of 2007-08 hospital expenditures will have been reinvested/transferred to a CE LHIN funded community health service provider. The overriding objectives of this project are as follows:

- Generate local investments to rapidly expand capacity of community services in order to support the overall transformation of the local health system as found in the CE LHIN Integrated Health Service Plan;
- Better align the provision of health services between hospital and community providers, with a focus on appropriateness of access and quality of care;
- Improve shared accountability for performance between hospital and community based providers by pooling resources for joint outcomes; and
- Enhance the sustainability of health services and expenditures within the CE LHIN.

Implementation Plans

A website (http://www.centraleastlhin.on.ca/Page.aspx?id=6820) to support health service providers explore this opportunity has been established by the CE LHIN.

Current Status

The first round of proposals was received on Oct 2008, and the second round of proposals expected September 2009.

Performance Target

By December 2010, a minimum of $10.3 million dollars of 2007-08 hospital expenditures will have been reinvested / transferred to a CE LHIN funded community health service provider.

2010-13 Integrated Health Service Plan

Objectives LHSIA outlines expectations for an end state, mature system of planning and health care integration in Ontario. This end state will not be achieved immediately and will require careful development of products and processes that will support Ontario's devolved model for the health care system. The 2010/11 – 2012/13 IHSP will be the public presentation of the LHINs priorities and strategies and steps to implementation for the 3-year period starting in April 2010. This second IHSP recognizes the early planning and now focuses on strategies to integrate the local health system.

Implementation Plans Community engagement and planning activities will commence in April 2009 with the final Integrated Health Service Plan presented to the CE LHIN Board in the Fall/Early Winter of 2009.

Chronic Disease Prevention and Management and Primary Care

Summary

Strategic Alignment (MOHLTC)	▪ Wait Times ▪ Family Health Care ▪ Ontario Diabetes Strategy
MLAA Performance Indicators	▪ ED visits per 1000 population ▪ Proportion of admitted patients treated within target ▪ Proportion of non-admitted high acuity patients treated within target ▪ Proportion of non-admitted low acuity patients treated within target ▪ Percentage of ALC Days
Specific LHIN-Level Targets	▪ Rate of ED visits that could be managed elsewhere ▪ Hospitalization rate for ambulatory care sensitive conditions ▪ % of diabetes clients managing blood glucose, blood pressure and lipids ▪ % of diabetes clients setting behavioural goals for nutrition, physical activity and condition monitoring ▪ Self reported health status ▪ Clients screened at risk clients without a primary care provider who are identified and referred to primary care/specialist care ▪ Increase in # of patients in primary care practices who have been screened for vascular disease and who are managed ▪ # of health service providers implementing self management support tools to enable patient self management ▪ # of consumers and caregivers participating in self management workshops; # of peer leaders trained; # of master trainers trained ▪ # of unattached primary care patients screened ▪ Increase in appropriate referrals from primary health care providers to CE CCAC or other community services ▪ # of dialysis patients who receive care at home ▪ Hospital discharge summaries are accessible to primary care providers within 72 hours
Planning Engagement Partners	▪ CE LHIN Chronic Disease Prevention and Management Network ▪ CE LHIN Primary Care Working Group ▪ CE LHIN Collaboratives ▪ CE LHIN Diabetes Network

- Durham Region Diabetes Network
- Priority Project Teams for
  - Self-Management Training for Consumers and Caregivers
  - Renal Chronic Disease Prevention and Mangement

Status Between 2007-2010 The CE LHIN has committed $5.56M in funding to several priority projects aimed at improving access to Primary Care and resources for persons having (or at-risk of) a chronic condition.

Environmental Factors

- The number of family physicians in the CE LHIN is the second lowest amongst the 14 LHINs, with 68 FP/GPs per 100,000 people compared to the Ontario average of 89 per 100,000;
- 70% of CE LHIN residents aged 12+ reported having at least one chronic condition (Canadian Community Health Survey, 2005);
- The percentage of individuals over the age of 12 in the CE LHIN with chronic conditions is slightly higher than provincial rates for diabetes, heart disease, high blood pressure and arthritis;
- 36% of CE LHIN residents had at least one of cancer, diabetes, heart disease, hypertension, stroke, asthma, COPD or arthritis (2005).
- Of the 36%, 37% had multiple chronic conditions. Prevalence of multiple chronic conditions increased with age:
  - Age 45+: 27% had two or more chronic conditions;
  - Age 65+: 46% had two or more chronic conditions.
- In the CE LHIN, chronic conditions (including diabetes, stroke, hypertension, depression, cancer, COPD, asthma, heart disease, arthritis) accounted for:
  - 1 in 4 inpatient hospital separations;
  - 1 in 10 Emergency Department visits;
  - 1 in 5 General Practitioner/Family Practitioner (GP/FP) visits.

Specific Health Service Initiatives

Access to Unified Stroke System in the Central East LHIN

LHIN Strategic Direction
Health Service and System Integration
Fiscal Responsibility

Objectives
Improved regional delivery and access of stroke services, notably for Durham region.

Implementation Plans
A District Stroke Program at Lakeridge Health Corporation (Oshawa) was established in Durham Region in Fall 2008. Efforts turn to aligning the Ontario Stroke Strategy with LHIN activity and boundaries.

Status
On going

Performance Target
- Median time from stroke symptom onset to mobilization during hospitalization;
- Stroke clients seen in ED admitted to hospital and receive first CT or MRI scan within medically appropriate clinical time.

Self Management Training for Consumers & Caregiver

LHIN Strategic Direction
Transformational Leadership (Population Health)
Quality and Safety

Objectives
A consistent CE LHIN model to increase consumer/caregiver capacity to self manage their chronic conditions; development of tools/skills for health service providers to enable clients to self manage. An Institute of Healthcare Improvement Triple Aim Prototyping Project.

Across CE LHIN HSPs, implement the Stanford Self-Management Model which develops trained teams of peer and professional leaders each having a chronic condition. Teams work with consumers/ caregivers to set reasonable goals for health/lifestyle modifications and build consumer capacity/confidence to achieve their goals.

Individuals, who took the Stanford Self Management Program, when compared to those who did not, demonstrated significant improvements in: exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations.

They also spent fewer days in the hospital, and there was also a trend toward fewer outpatient visits and hospitalizations. Stanford University program data yield a cost to savings ratio of approximately 1:10.

Implementation Plans Project Initiated in Spring 2008.

Status In Progress – intent is to transition from project to full CECCAC program.

Performance Target

- Consistent and coordinated application of the Stanford Self Management model across HSPs and communities in the CE LHIN;
- 1400 clients receive education by 09-10; 36 Master Trainers identified and trained; 100+ peer leaders trained;
- Rate of ED visits that could be Managed Elsewhere;
- Hospitalization Rate for Ambulatory Care Sensitive Conditions;
- Increase in Client self-confidence/efficacy in managing chronic conditions;
- Increase in HSPs employing self management support tools.

Unattached Patient Assessment, Triage and Referral Project

LHIN Strategic Direction Transformational Leadership (Population Health, Equitable)
Quality and Safety
Health Service and System Integration

Objectives Implementation of an unattached patient access, general health assessment and triage team using retiring physicians, late career NPs that would work in partnership with the CECCAC's Health Care Connect program. Follow-up/continuing care expectations and strategies are included in model design.

Rationale The main mobile interdisciplinary team of 2 FPs, 1 NP, 2 RNs and administrative support can cover 8,500 patients at a cost of approximately $90 per patient. Fixed urban sites in partnership can cover patients at a reduced cost utilizing main office support and shared space in the range of $70 per patient.

Status Planning commenced in 2008 with potential for implementation in 2009-10 pending approvals.

Chronic Kidney Disease (CKD) Early Identification & Outreach Initiatives
Renal CDPM Framework for CE LHIN

LHIN Strategic Direction	Transformational Leadership (Population Health, Equitable) Quality and Safety Health Service and System Integration
Objectives	A comprehensive and collaborative initiative to manage growth in demand for chronic kidney disease and end stage renal disease in CE LHIN through development of a consistent Renal CDPM Framework. Framework comprising best/promising practice in Renal CDPM is being developed through three Project initiatives include: ▪ Screen and outreach to five high needs urban communities in Scarborough (The Scarborough Hospital and Carefirst); ▪ Implement a comprehensive Early Intervention and Management initiative within the Durham regional CKD centre (Lakeridge Health); ▪ Outreach to aboriginal populations in the Haliburton Kawartha Peterborough Region. (Peterborough Regional Health Centre).
Implementation Plans	Project Initiated in Spring 2008
Status	In progress with two projects wrapping up in March 2010; third (Durham) project extends to March 2012.
Performance Target	▪ Hospitalization Rate for Ambulatory Care Sensitive Conditions; ▪ Target: 1000 in-centre renal patients; 3200 outreach clients; ▪ Early identification and improved access to Kidney care – CKD prevention clinics; ▪ Delay in progression of CKD and/or avoidance of need to access renal replacement therapies (Hemodialysis or Peritoneal Dialysis); ▪ Meet or exceed provincial target of 40% of End Stage Renal Disease patients using peritoneal dialysis (30%) and Home Hemo Dialysis (10%).

Diabetes Care and Coordination

LHIN Strategic Direction

Transformational Leadership (Population Health)
Quality and Safety
Health Service and System Integration

Objectives

LHIN-wide planning and coordination of diabetes programs, primary care and community resources (e.g. community pharmacy). Coordinated intake, triage, education and clinical support team(s) for diabetics LHIN wide. Develop care teams that function across primary care and specialty care settings.

Identification of consistent biophysical and behavioural indicators that is consistently monitored at client level and reportable on LHIN wide basis.

Support the rollout of the Ontario Diabetes Strategy.

Status

To commence in 2009-10 pending funding.

Performance Target

- Decreased rate of ED visits that could be managed elsewhere;
- Care that is provided by multi-disciplinary teams;
- Improved consistency and coordination of diabetes care;
- Tools to support uptake of clinical practice guidelines (CPGs);
- Resource guide for CE LHIN Diabetes services;
- Profile of diabetes in CE LHIN;
- Increased % of diabetes clients managing blood-glucose, blood pressure and lipid levels;
- Increased % of diabetic clients who have set and pursuing behavioural goals (i.e. nutrition, physical activity, regular condition monitoring).

Comprehensive Vascular Disease Prevention and Management Initiative

LHIN Strategic Direction	Transformational Leadership (Population Health) Quality and Safety Health Service and System Integration
Objectives	Improved vascular health for people of the CE LHIN through the implementation of a comprehensive, integrated approach to screening for risk factors and treatment of vascular disease across the LHIN.
Implementation Plans	Initial CE LHIN investment with contributions from the Heart and Stroke Foundation of Ontario and Astra Zeneca Canada.
Status	18 month demonstration project with strategies for LHIN wide adaptation/adoption.
Performance Target	▪ Rate of ED visits that could be Managed Elsewhere ▪ Increase access to vascular screening; ▪ Assessment and multi-disciplinary team-based management across the CE LHIN; ▪ Increase in # of patients in primary care practices whose blood pressure, glucose, lipid and renal function is well- managed; ▪ Target 1500 attached and 1000 unattached patients.

Timely Discharge Information System (TDIS)

LHIN Strategic Direction	Quality and Safety Health Service and System Integration
Objectives	Project linking Primary Care and Acute Care Services. Require CE LHIN Hospitals to provide 72hr notification to primary care provider when their client has been admitted and/or discharged from hospital. The ultimate goal is to improve the coordination of care between primary health care and hospital settings as measured by the reduction of ALC days and hospital readmissions.
Implementation Plans	Investment in 2009-10 is $XXX with additional resources from eHealth to support LHIN-wide roll-out.

Status Program initiated in 2008 at two hospital sites (Peterborough Regional Health Centre and Lakeridge Health Corporation) expansion in 09/10 to additional sites.

Performance Target

- 100% of primary care physicians provided with notification of admission or discharge in 24 hours and discharge summary delivery to community physician providers within 24 hours of the transcription of dictations that commence within 48 hours after discharge, including weekdays and weekends.
- Reduction in hospital re-admission rate for Myocardial Infarction, COPD, and community acquired pneumonia and other measurable ambulatory conditions.

LHIN Planning Initiatives for 2009-10

Regional Renal Coordination / Network

LHIN Strategic Direction
Quality and Safety
Health Service and System Integration
Fiscal Responsibility

Objectives

- One overarching Network for all three Renal Programs in the CE LHIN. Initial improvement initiatives include:
  - Develop and implement one standard reporting methodology;
  - Develop a contingency plan for dialysis care within CE LHIN;
  - Develop CE LHIN Post Transplant Follow Up Clinic;
  - Develop a demand/capacity plan for dialysis services with the CE LHIN;
  - Comprehensive partnerships with the Diabetic Networks.

Rationale

- Ensure provision of quality renal care within the CE LHIN incorporating unique needs of populations associated with each renal program;
- Foundation for further integration opportunities between the three CE LHIN Regional Renal Programs (TSH, LHC, PRHC).

Wait Times and Critical Care (including Emergency Department and ALC)

Summary

Strategic Alignment (MOHLTC)	▪ Wait Times (surgical, diagnostics, ED demand and wait times, ALC).
MLAA Performance Indicators	▪ 90th Percentile Wait Times for Diagnostic Scan ▪ 90th Percentile Wait Times for Cancer Surgery ▪ 90th Percentile Wait Times for Cardiac By-Pass Procedures ▪ 90th Percentile Wait Times for Cataract Surgery ▪ 90th Percentile Wait Times for Hip and Knee Replacement Surgery ▪ Proportion of Admitted patients treated within target ▪ Proportion of non-admitted high acuity patients treated within target ▪ Proportion of non-admitted low acuity patients treated within target ▪ Percentage of ALC Days ▪ Medium Wait Time for LTCH placement
Specific LHIN-Level Targets	▪ Same as above ▪ Improved ED capacity and performance ▪ ED visits that could be managed elsewhere ▪ Ambulatory care sensitive ED visits ▪ Improved bed utilization ▪ Rates of (preventable) patient transfers from Long-Term Care Home to Hospital ED ▪ Appropriate capture of CE LHIN ICU patients who do not require access to specialized services outside of the LHIN (i.e., trauma, neurology)
Planning Engagement Partners	▪ CE LHIN Wait Times Working Group ▪ ED/ALC Performance Lead ▪ Emergency Department LHIN Lead ▪ Critical Care LHIN Lead ▪ CE LHIN ED/ALC Steering Committee ▪ CE LHIN Primary Care Working Group ▪ CE LHIN Collaboratives
Status	The CE LHIN allocated $7,095,206 to designated hospitals for Year 2 Pay-for-Results (09/10). Of the $7,095,206, $2.4M was allocated to community providers to reduce ED wait times in the CE LHIN.

The ED LHIN Lead will chair the ED/ALC Steering Committee with the support of the ED/ALC Performance Lead whose mandate is to provide expert advice to the CE LHIN on matters related to the ED and ALC, focusing on ED diversion, ED capacity and performance and bed utilization.

Throughout 2010-11 the CE LHIN will be continuing the implementation and/or evaluation of the following:

- Wait Times for the following hospital procedures:
  - Cancer Surgery
  - Hip and Knee Replacement
  - Cataract Surgery
  - MRI / CT

- Pay-for-Results Emergency Department Action Plan Designated hospitals:
  - Rouge Valley Health System (Centenary and Ajax/Pickering)
  - The Scarborough Hospital (General Site);
  - Lakeridge Health Corporation (Oshawa and Bowmanville)
  - Ross Memorial Hospital

- Nurse Practitioner Outreach Teams to Long-Term Care Homes
- Transitional Beds
- Geriatric Emergency Management Nurses in the ED
- Mental Health Crisis and Outreach Team
- Mental Health Community Beds
- Urgent and Non-Urgent Transportation

Environmental Factors

Priority Area Wait Time (90th Percentile)	2008/09 Q4 CE LHIN Performance	Annual 2008/09 YE CE LHIN Results	2009/10 Target
Cancer	52	51	48
Cataract Surgery	118	123	140
Hip Replacement	138	184	182
Knee Replacement	153	188	182
MRI Scan	81	83	65
CT Scan	29	32	28

- Wait times are on-track to achieve performance requirements in all Priority Areas except Cancer Surgery;
- Lakeridge Health Oshawa was the recipient of a new MRI machine in May 2009 which will reduce wait times, operational as of September 2009;
- 2009/10 initial incremental allocation is significantly less than 2008/09. CE LHIN will continue to closely monitor CT wait times to ensure that we continue to meet the 2009/10 Target.

Specific Health Service Initiatives

Note: Many of the ED and ALC initiatives are found in related priorities, such as Seniors and Mental Health and Addictions.

ALC Assessment and Coaching Team

LHIN Strategic Direction	Transformational Leadership Quality and Safety Health Service and System Integration Fiscal Responsibility
Objectives	To reduce % ALC days and improve hospital flow and capacity at Peterborough Regional Health Centre.
Implementation Plans	Report developed with recommendations from a local expert, peer-review ALC Assessment and Coaching Team (ALC ACT). Recommendations to be prioritized and implemented by PRHC.
Status	In progress
Performance Target	▪ Reduce percent ALC days (pending implementation of new provincial ALC definition) ▪ Reduce ED LOS for admitted patients in the ED

Transitional Care Beds for ALC Patients

LHIN Strategic Direction	Transformational Leadership Quality and Safety Health Service and System Integration Fiscal Responsibility
Objectives	Reduce the number of ALC patients by providing more appropriate housing/living arrangements and appropriate levels of care. Alter disposition to less intensive, home-based destinations through enhanced therapy/ activation and

appropriate therapeutic convalescence.

Implementation Plans 20 Transitional Care beds have been implemented as of June 2, 2009 in a Retirement/LTC Home. An MOU has been developed between the home and hospital. Length of stay in the transitional bed unit is targeted to 60 days maximum.

Status In progress

Performance Target
- ALC Length of Stay
- # and % ALC patients
- Reduction in ED LOS for admitted patients

LHIN Planning Initiatives for 2009-10

Central East LHIN Emergency Department and Alternate Level of Care Improvement Plan

LHIN Strategic Direction Transformational Leadership
Quality and Safety
Health Service and System Integration
Fiscal Responsibility

Objectives Implement solutions that will resolve ED and ALC pressures and reduce ED Wait Times through ED diversion, ED capacity and performance and bed utilization in accordance with MLAA targets.

Implementation Plans The CE LHIN ED Lead will lead the collaboration of hospital emergency departments in local and provincial initiatives that will improve performance and quality of care.

The ED/ALC Steering Committee comprised of expert stakeholders in the LHIN are responsible for identifying emerging issues related to provision of emergency care and alternate level of care and provide planning and oversight support to initiatives addressing ED and ALC priorities. This group will:
- Prioritize and oversee implementation of the CE LHIN ED and ALC Task Group Report recommendations;
- Oversee Pay-for-Results initiatives including planning, implementation, measurement and reporting;
- Support completion of Stocktake Report.

Status The following will continue to be active in 2010-11

- Emergency Department LHIN Lead
- ED/ALC Performance Lead
- NP Outreach Teams to LTCH
- Mental Health Crisis and Outreach Team
- Transitional Beds
- GEM nurses
- Non-Urgent Patient Transportation

Performance Target

- Proportion of admitted patients treated within LOS target
- Proportion of non-admitted high acuity patients treated within LOS target
- Proportion of non-admitted low acuity patients treated within LOS target
- ALC % days target

Seamless Care for Seniors – Aging at Home

Summary

Strategic Alignment (MOHLTC)	▪ Wait Times ▪ Reduction of ALC
MLAA Performance Indicators	▪ ED visits per 1000 population ▪ Proportion of Admitted patients treated within target ▪ Proportion of non-admitted high acuity patients treated within target ▪ Proportion of non-admitted low acuity patients treated within target ▪ Percentage of ALC Days ▪ Median Wait Time for LTC placement
Specific LHIN-Level Targets	▪ Rates of (preventable) patient transfers from Long-Term Care Home to Hospital ED ▪ ALC cases, ALC LOS and % ALC days ▪ ED wait times ▪ Hospitalization rate for ambulatory care sensitive conditions ▪ # and types of community support services provided (including expanded AND new programs) ▪ # and types of new supportive housing units ▪ # and types caregiver supports (e.g. respite care, day programs)
Planning / Engagement Partners	▪ CE LHIN Seamless Care for Seniors Network and Steering Committee ▪ CE LHIN Primary Care Working Group ▪ CE LHIN Collaboratives ▪ Priority Project Teams for: o Caregiver Supports and Well-Being o Community Support Services Review o Supportive Housing o Specialized Geriatric Services
Status	For Year 2 of the Aging at Home Strategy (09/10), every LHIN across the province was mandated to focus their AAH investments on the reduction of ALC and ED wait times. These priorities are expected to remain for the Year 3 funding as well. Background on the AAH Strategy is provided below. On August 29, 2007, the Ontario government

announced ***Ontario's Strategy for Transforming Community Living to help Seniors Live Independently at Home (the Aging at Home Strategy).*** The **3-year, $700M** will be led by the LHINs and will "offer new lifestyles choices that are reflective of how seniors truly want to live." The *Strategy* has identified overall themes/goals.

- To enable seniors to live healthy, independent lives in their homes
- Impact the way services are delivered and help provide more equitable access to health care by matching the needs of the local senior population and appropriate support services
- Offer new possibilities for Ontario's culturally diverse populations and other community-level organizations like service clubs and groups of seniors to help serve themselves
- Provide supports to help keep seniors healthy and active longer
- Prevent avoidable admissions to Hospitals and help reduce the rates of Alternate Levels of Care (ALC)

Innovation will play a prominent role in service delivery decisions, (including prevention and health promotion).

To help achieve these aims, the CE LHIN received the following annual increases to its base funding:

Based on local community engagement and planning, the CE LHIN identified four priority areas to focus Aging at Home investments. These areas, consistent with the CE LHIN Integrated Health Service Plan, are:

- Care Giver Supports and Well-Being
- Supportive Housing
- Community Support Services
- Specialized Geriatric Services

Environmental Factors

Seniors are one of the fastest growing population groups in Canada. There were about 196,500 seniors living within the CE LHIN in 2006, representing about 13.7% of the population, with the percentage differing between the nine planning zones from a high of 24.6% in the Haliburton Highlands, to a low of 8.7% in

Durham West. The number of persons 65 years or older is expected to increase within the LHIN to approximately 265,000 by the year 2016, for an expected growth rate of +35%. Over this same period, the number of CE LHIN seniors who are over the age of 85 years is expected to grow +90%.

Specific Health Service Initiatives

Nurse Practitioner Outreach Teams in Long-Term Care

LHIN Strategic Direction
Transformational Leadership (Equitable)
Quality and Safety
Health Service and System Integration

Objectives
Three Nurse Practitioner (NP) Outreach Teams will be flexibly deployed across the urban and rural areas of the CE LHIN, each sharing in common performance objectives. It is expected that this initiative will demonstrate results in the short, medium and longer term by helping to reduce avoidable transfers of Long-Term Care home residents to local EDs, hospital admission rates, and the inpatient length-of-stay for admitted residents.

Implementation Plans
The NP Outreach Team project was initiated in the early winter of 2008. Three teams will be deployed:

1. NE cluster of the CE LHIN;
2. Durham; and
3. Scarborough.

Status
In progress

Performance Target
- Decrease patient transfers from LTCH to ED (specifically for CTAS 4 and 5 patients);
- Reduce ED length of stay and expedite admission for patients transferred from LTCH;
- Shorten some ALC length of stay for residents returning to LTCH by allowing for transfer back of higher acuity patients;
- Improve access for community-based seniors without a primary health care provider, resulting in ED Diversion of “unattached” senior clients.

Specialized Geriatrics Services: Community Comprehensive Geriatric Assessment (CCGA)

LHIN Strategic Direction
Quality and Safety
Health Service and System Integration

Objectives
Through the Aging at Home Strategy (2009-10), the CE LHIN will be implementing a model of Community Comprehensive Geriatric Assessment (CCGA). While a LHIN-wide model is desirable, the initial implementation will occur in Scarborough Durham-West, amongst four hospital sites.

This model is considered an improved model to that offered through the Regional Geriatric Programs of Ontario and is suited for the CE LHIN that currently is not serviced in total, and thus inadequately, by any one RGP. The model is multi and trans-disciplinary in its approach to:

- Providing "in-reach" to the hospital sector to assist with the identification, assessment, and support of the adult/senior population that is either already designated ALC and/or pre-ALC designation;
- Working with existing community agencies including the CCAC to case find those "at risk" individuals;
- Developing a coordinated and integrated care plan for treatment AND follow-up;
- Linkages to and building on existing capacity in community and facility-based services including the Geriatric Emergency Management Nurses and NP Outreach Teams; and
- Providing expertise and education on care of the elderly.

The CCGA Model(s) will:

- Be as standardized as possible across the LHIN, respecting unique regional factors (transferability of models/approaches);
- Assist in preventing the senior moving to a higher level of care;
- Assist the senior in maintaining their independence and dignity within a non-ageist philosophy and a healthy appreciation of the concept of reversibility;
- Build capacity in the system as well as build on the capacity that already exists in the system (using

existing resources differently or better);
- Be culturally appropriate and sensitive;
- Utilize evidence-based practices;
- Have measurable outcomes.

Implementation Plans Investments will be made through the 2009-10 Aging at Home Strategy.

Status Given this is a leading-edge innovation in senior's care, the CE LHIN is currently working with the Ministry of Health and Long-Term Care on securing final approval for the CCGA project.

Performance Target Specific targets are under development, however, they will support MLAA performance goals related to ED volumes/wait times and ALC reduction.

LHIN Planning Initiatives for 2009-10

Access to LTC and Supportive Housing

LHIN Strategic Direction Health Service and System Integration
Fiscal Responsibility

Objectives To develop a method by which Long-Term Care Home capacity is considered within the context of other supports including supportive housing and community based services.

Explore and demonstrate increasing the availability of housing and support options by partnering with retirement homes to provide enhanced care for patients with light to medium level of health care needs. Objectives are to address alternatives to both short term (ALC) and long-term housing needs of clients.

Implementation Plans To be supported through LHIN operations in 2009-10.

Project will engage Long-Term Care Homes, retirement home operators, municipalities, developers and the Central East Community Care Access Centre.

Status To commence in 2009-10. It is acknowledged that there is MOHLTC policy work currently underway related to supportive housing as well as the involvement of the retirement home sector in fostering sustainable solutions to the current challenges of ALC and ED.

Performance Target To implement a process that will result in a phased action plan to improve the mix of services and supports within communities that will reduce ALC.

Falls Prevention Strategy

LHIN Strategic Direction Transformational Leadership (Population Health)
Quality and Safety

Objectives To develop a LHIN-wide Falls Prevention Strategy with the *"Stay on Your Feet"* evidence-based program originating from Australia as a framework.

The Strategy will define and align, across the LHIN, programs and services that relate to various aspects of falls prevention such as:

- community awareness and education;
- home safety assessments and checklists;
- exercise and physical activities;
- medication management etc.

Based on the above information, gaps in the overall umbrella strategy will be defined and associated solutions will be developed.

Implementation Plans To develop an overarching Falls Prevention Strategy that not only aligns with the CE LHIN's IHSP and Seamless Care for Senior's priority but also supports the recommendation in the CE LHIN's ALC Task Group Report related to *"facilitating the early intervention of community supports and services to prevent hospitalization*."

Potential to be supported through Aging at Home Strategy funding.

Status The community has rallied around this project and has produced an initial inventory of falls prevention programs across Central East. Gatherings of partners including community and facility based providers, public health representatives; the LHIN and the Ontario Neurotrauma Foundation have taken place. An Aging at Home Year 2 HSIP was submitted for the planning component. However, due to the directing of the Year 2 envelope on ALC and ED, this project was not able to be funded.

Performance Target To reduce the number of falls within the community and facility sectors that in turn will reduce the impact of fall related injuries and conditions on the client, their family and the system overall. Explicit indicators will be established as part of the project. The Ontario Neurotrauma Foundation has expressed interest in evaluating the process.

Senior Friendly Hospitals Initiative

LHIN Strategic Direction Transformational Leadership
Quality and Safety

Objectives To develop and implement a Senior Friendly Hospital Initiative within the "One Acute Care Network" framework of the Clinical Services Plan.

The initiative will define and align, across all hospitals, across all programs and in all units, the expectations, philosophy, accountability and care processes required to ensure quality care for the elderly population.

Implementation Plans While this initiative is still being discussed and is in its early stages, there will likely be a need for a three or four pronged approach:

- Development of the Senior Friendly Hospital framework ;
- The establishment of a multi-disciplinary coaching team to work with the various hospitals in the initiation of the approach;
- A mechanism to ensure sustainability of the framework.

Status Initiative is currently under development in terms of scoping.

Performance Target

- To reduce ALC and ED wait times through the introduction of a LHIN-wide best practice in the care of the elderly in the hospital sector;
- To save conservable bed days in both the acute and ALC stays for seniors who can go home with or without support;
- To maintain or better the "at time of admission" functional status of seniors upon their discharge from hospital;
- To ensure the satisfaction of seniors and their caregivers with the hospital experience.

Mental Health and Addictions

Summary

Strategic Alignment (MOHLTC)

- Wait Times

MLAA Performance Indicators

- ED visits per 1000 population
- Proportion of admitted patients treated within target
- Proportion of non-admitted high acuity patients treated within target
- Proportion of non-admitted low acuity patients treated within target
- Percentage of ALC Days

Specific LHIN-Level Targets

- Decrease in wait time for psychiatric assessment
- The LHIN will monitor the following Clinical Utilization and Outcome measures (OHA Report):
  - Hospitalization for psychotic diagnoses
  - % discharge with LOS at 3 days or less (LOS<3days)
  - % ALC days
  - OHIP care within 30 days post discharge
  - ED visit within 30 days post discharge (not admitted)
  - 30-day readmission rate (RR)
  - Repeat inpatients
  - Numbers of assessments
  - Numbers of Community Treatment Orders Issued

- The LHIN will monitor the following System Measurement and Change indicators (OHA Report):
  - Inter-organizational Networking (ION)
  - Notification of Hospitalization (NH)
  - Discharge Plans with Client Involvement (DP-CI)
  - Discharge Plans with Family Involvement (DP-FI)
  - Discharge Plans with Provider Involvement (DP-PI)

- # of emergency assessment, crisis services, intensive ambulatory programs and psychiatric services;
- # of clients accessing residential addiction

treatment and out-patient services;
- # of clients accessing outpatient addiction programs including assessment, referral, case management, outreach, treatment and counselling;
- Rates of (preventable) patient transfers from Long Term Care Home to Hospital ED.

Planning Engagement Partners

- CE LHIN Mental Health and Addictions Network and Steering Committee;
- CE LHIN Primary Care Working Group;
- CE LHIN Collaboratives.
- Priority Project Teams for:
  - Early Youth Intervention
  - Disordered Eating
  - Culture, diversity and Equity Project

Status

The CE LHIN faces several significant challenges in providing accessible mental health and addiction services as a result of historical under funding and lack of attention paid to mental health and addiction services capital redevelopment.

Community mental health funding in the CE LHIN is $22/person compared to the provincial average of $39. This differential results in great hospital admission/re-admission and poorer health outcomes.

Environmental Factors

A positive sense of emotional and social well-being is fundamental to the health of individuals, families, communities and society as a whole. Mental health and addictions problems (including problem gambling) affect a significant portion of the Canadian population. Additionally, research has shown that 30% of people with a mental illness will also have a substance use disorder in their lifetime (a concurrent disorder), and 37% of people with an alcohol use disorder (up to 53% if it is a drug disorder) will also have a mental illness. In 2006-2007, 16,069 individuals visited the emergency department for mental and behavioural disorders and according to the Ontario Health Insurance Plan (OHIP), billings for 2004, 18% of the population over the age of 15 accessed a physician for mental health concerns in the CE LHIN which adds up to 216,872 people.

In the CE LHIN, there are 8 psychiatrists per 100,000 populations, compared to the provincial average of 17.3/100,000.

The population of the CE LHIN is becoming more diverse with newcomers to Canada taking up residence in Scarborough and West Durham.

Specific Health Service Initiatives

Mental Health Health ED Coalition

LHIN Strategic Direction

Quality and Safety
Health Service and System Integration
Fiscal Responsibility

Objectives

Provide crisis prevention and intervention services from the ED that will appropriately divert people from the ED and ensure that those who require ED services receive them.

These objectives will be met through a mix of integrated service delivery systems:

- Community Mobile Crisis Response integrated with Hospital Crisis Teams
- Enhanced Community Treatment Order Support
- Enhanced access to Urgent Assessments
- Establish Community Crisis Beds
- Enhance Police/Nurse Community Response Team
- Peer Support Warm Line
- System-wide Mental Health Triage and Common Assessment Tools

Implementation Plans

The Coalition consists of a variety of health service providers and social services along the Mental Health continuum:

- Lakeridge Health Corporation and Rouge Valley Health System
- Ontario Shores Centre for Mental Health Sciences
- Durham Mental Health Services
- CMHA Durham
- United Survivors Support Centre
- Durham Regional Police Services

Status

The project is supported by the Provincial ED Pay for Results Strategy along with existing investments. The Coalition is also taking part in the international Institute for Healthcare Improvements (IHI) Triple Aim initiative on Avoidable ED Visits.

Performance Target

- Reduce ED visits and wait times
- Reduce % ALC days

Planning for LHIN Operations

The operational plan describes the CE LHIN's specific business goals, objectives and associated plans and planned operational expenses per budget category for the 2009 fiscal year, and the two subsequent years.

LHIN Operational Goals or Objectives

An appropriate level of resources is critical to the success in achieving the LHIN's mandate of:

- Executing the strategic directions outlined in our Integrated Health Service Plan
- Developing effective relationships with our 130 plus health service providers
- Effectively monitoring our Health Service Provider Accountability Agreements
- Managing the performance of our local health system
- Managing local issues as they arise
- Providing the support to our Board so they can in turn make good informed decisions
- Developing new service accountability agreements
- Financial management of our Health Service Provider's allocations and audit requirements, and
- Ensuring that we have the communication capacity to keep all of our stakeholders informed in a timely fashion.

Current Status

The current status of the activities either underway or planned is listed in our detailed services plan. The status for the planning for French Language Services, Aboriginal Health and eHealth are incorporated below:

French Language Services

In 2008-09 the CE LHIN established a Francophone Health Services Planning Collaborative. This multi-disciplinary group consisting of members from across the CE LHIN is of central importance to the overall success of CE LHIN process for community engagement and health system planning for the Francophone community.

The Collaborative will advise the CE LHIN on the health care needs of their linguistic and cultural community, priority setting, planning and evaluation – including the identification of opportunities for the integration/coordination of French language health care services.

Aboriginal Health Planning and Engagement

The *Local Health System Integration Act* (LHSIA), stipulates the Minister of Health and Long-Term Care establish a provincial First Nation, Métis and Inuit advisory body. The *Act* also requires that LHINs engage local First Nation, Métis and Inuit people in its planning processes. The CE LHIN is committed to fulfilling this mandate by working in

partnership with the Nishnaabe[1], Métis and Inuit people to establish a regional health "Advisory Circle" that respects Nishnaabe, Métis and Inuit peoples' rights to self determination and to their to health care and culture.

The CE LHIN estimates that the Nishnaabe, Métis and Inuit peoples residing in the region represents about one percent of the total regional population. Nishnaabe, Métis and Inuit people face a number of health issues and challenges and their health status is below that of the general population. Nishnaabe, Métis and Inuit people receive health services through a combination of federal, provincial, and Nishnaabe, Métis and Inuit run services, as well as other programs and services. In many cases, this complex approach to service delivery has resulted in a lack of coordination between levels of government and Nishnaabe, Métis and Inuit community agencies. Nishnaabe, Métis and Inuit people have identified a number of barriers to receiving equitable access to health services including jurisdictional and funding issues, lack of sensitivity to their culture, and a lack of targeted programs that focus on their particular health needs. One of the main goals of the CE LHIN is to work with the Nishnaabe, Métis and Inuit peoples residing within the region to improve their overall health status. The CE LHIN is committed to working with the Nishnaabe, Métis and Inuit people to align health services with existing Nishnaabe, Métis and Inuit regional, provincial and federal health planning, health programming and service delivery systems to improve health outcomes.

To advance our common goal of improving the health and coordination of health services, the LHIN, Nishnaabe and Metis leaders have agreed to establish a health planning "Advisory Circle" that will advise the CE LHIN on the health care needs of their communities, local priority setting, planning and evaluation – including identification of opportunities for the integration/ coordination of health care services. The Advisory Circle is inclusive of all the Nishnaabe, Métis and Inuit peoples and organizations and provides an opportunity for members to share information and build relationships with their communities, health service providers and the CE LHIN.

The terms of reference for the Advisory Circle will be ratified by all parties in the Summer/Fall of 2009. Of first priority will be an environmental scan of federal, provincial and community health services, coordination of those services, and implementation of an aboriginal diabetes/vascular health strategy.

eHealth

A number of significant eHealth projects are underway in the CE LHIN which aligns with the eHealth strategic plan. Completing the necessary infrastructure and improving functionality required for eHealth throughout the LHIN is necessary to support integration.

The Diagnostic Imaging Picture Archiving and Communication System (DI-PACS) project, which will provide secure electronic sharing and storage of x-rays, MRI test results and other diagnostic images, is reaching completion in our LHIN. This project

[1] "Nishnaabe" is a North American Aboriginal term that is simply translated as "people of the Creator of Turtle Island." First Nations leaders have chosen this term to describe their community, including those persons living on- or off-reserve.

which included 23 hospitals in four LHIN's was led by the CE LHIN. It was primarily funded by the Ministry of Health and Long Term Care and Canada Health Infoway.

Currently, our LHIN is also leading a multi-LHIN project to consolidate hospital data centers in 33 hospital sites to a secure site with a backup for disaster recovery. This data centre will greatly improve the efficiency and effectiveness of the infrastructure for these facilities. Our LHIN we will use this improved infrastructure to complete a consolidated hospital information system (HIS) that will be shared by all the Central East hospitals, and other agencies as required. This consolidated HIS will provide a single, shared, but secure, health record that details all information available in every hospital in the LHIN. In addition to providing comprehensive information this approach will also allow for shared workflows and business processes, enabling us to accelerate the integration of our health system.

CE LHIN is also participating with a project in the 5 GTA LHINS that will allow us to share clinical information with other hospitals and agencies in the Greater Toronto Area.

Other projects underway include:

- Securely linking hospitals to family practitioners, in a way that protects the privacy and confidentiality of personal health information, to ensure that hospital information regarding patients is available to the appropriate physician when patients are admitted and discharged from the hospital,
- A shared project management software system,
- In partnership with the e-Health Ontario, improvements to the wide area network within the LHIN,
- Common procurement of both hardware and software to lower our costs and increase integration, in a number of areas, including desktops, encryption software to protect privacy, NRS software, Operating Management software, video communication software etc.
- We are working with the Clinical Services Planning (CSP) group, and the Medical Leadership group to support the procurement of systems to support common credentialing, on call scheduling, and access to operating room scheduling.

In partnership with the eHealth office of the MOHLTC, we are working on the provincial implementation of programs to support diabetic patients and the practitioners who treat them, wait time management systems, registries of providers, patients, and patients who have no physicians. Another major project, supported by the MOHLTC, is the development of drug information systems to improve the safety and efficiency of our prescribing systems, and the overall management and coordination of the eHealth system to better support health care in the CE LHIN and Ontario.

Implementation Plans

In order to carry out the 2009/10 Annual Business Plan, the CE LHIN requires appropriate funding. Each year since their existence, the LHINs have taken on added responsibilities, for example, negotiation and signing of Accountability Agreements for hospitals, community service providers, and in 2009/10 Long Term Care Homes. This is

accomplished at the same time as ensuring ongoing community engagement with all service providers, patients, elected officials, other ministries, etc., and monitoring the performance of the CE LHIN. We are also cognizant of our responsibility to lead the integration of our health care system and to deliver on what we promised we would do in our Integrated Health Service Plan (IHSP).

The following tables outline the planned operation expenses and staffing plan for 2009/10 to 2011/12. A move to larger office space is anticipated for 20010/11, the costs are spread over a two year period, 2009/10 and 2010/11. We plan to begin our community consultation for our refreshed IHSP in April 2009 with the final plan presented to our CE LHIN Board of Directors in the Fall/Early Winter of 2009.

Table X: CELHIN Staffing Plan (2009/10 to 2011/12)

	2008/09 Actuals	2009/10 Actuals	2010/11 Planned	2011/12 Planned
Number of FTEs				
Position Title:				
Chief Executive Officer	1	1	1	1
Senior Director	2	2	2	2
Portfolio Lead	4	4	4	5
Chief Information Officer	-	1	1	1
Team Lead Finance	1	1	1	1
Team Lead Performance	1	1	1	1
Communications Lead	1	1	1	1
Community Engagement	1	1	1	1
Business Support Manager	1	1	1	1
Project Coordinator	1	1	1	1
Office Administrator	1	1	1	1
Performance Analyst	2	3	3	4
Financial Analyst	2	3	3	4
Integration Consultant	1	1	1	1
Planner	2	3	4	5
Executive Assistant	1	1	1	1
Administrative Assistant	5	6.5	7	8
Receptionist	1	1	1	1
Webmaster	-	.5	.5	.5
	28	**34**	**35.5**	**40.5**

Performance Considerations

Additional staff and other resources as outlined above will allow the CE LHIN to successfully address the following objectives:

- Continue the monitoring of new service accountability agreements for 77 community-based programs.
- Negotiate ten refreshed service accountability agreements with hospitals and, for the first time, service accountability agreements with 66 Long-Term Care homes in 2009/10.
- Identify and manage planning, integration and performance management opportunities in an active community engagement process.
- Develop and improve the focus of financial, service and clinical data toward local health systems.
- Develop our research capability and enhance existing or new performance indicators.
- Enhance our overall ability to identify health care trends to assist in planning proactively for future years.
- Continue collaboration with health service providers and other community resources and thereby leveraging resources currently existing in the CE LHIN area.
- Initiate new partnerships and alliances when opportunities emerge at the local, inter-LHIN or provincial settings.
- Oversee the integration activities that will be undertaken within the CE LHIN, specifically through continued Clinical Services Planning and the Board to Board Engagement Strategy
- Manage the projects that are growing exponentially on an annual basis.

Risk and Mitigation Strategies

The CE LHIN has performance agreements with all of its providers, which includes quarterly submissions of both financial and service level performance. The Boards of all those providers are directly responsible for both quality of services and ensuring a balanced budget. The monitoring system in place at the CE LHIN ensures that there is an early review of risks. Through its quarterly reporting to the Ministry, the CE LHIN identifies all potential risks for joint consideration.

The CE LHIN is actively engaged with our Health Service Providers and ensures that they keep the CE LHIN informed of any unfavourable outcome regardless of reporting timeline. If necessary, increased reporting will be initiated for closer monitoring of a situation, and appropriate action taken. The Board and Ministry staff is advised as necessary.

Communications Plan

The Annual Business Plan (ABP) operationalizes the Integrated Health Service Plan and informs the ministry's Results-based Planning process. LHINs are required, through their Annual Business Plans, to provide the basis of support for any regional transformation objectives and associated funding realignments (if required). These plans for the local health system will assist the public to understand how the LHIN is planning to address the needs of their community.

The Annual Business Plan will become a public document as an appendix to the ministry-LHIN accountability agreement.

Timing:	To be determined
Objective:	To demonstrate responsiveness to community needs and to communicate transformation activities and initiatives to stakeholders and the community.
Primary Audience:	Broader health sector
Secondary Audiences:	Local community
Messaging:	The ANNUAL BUSINESS PLAN will assist the public in understanding how the LHIN is planning to address the needs of their community. ▪ The plans are based on discussions the LHINs have had with thousands of members of the public, providers and stakeholders.
Strategy:	▪ Highlight the focus of the CE LHIN plan and any special considerations required in meeting the identified needs of the local health system and community members/stakeholders.
Tactics:	Coordinated, same day release for all LHINs (date tbd). ▪ Morning – LHINs to notify their provider/stakeholder groups ▪ Afternoon – LHINs post on individual web sites. LHINs could issue local news release (optional) – template to be provided by LHIN Communications Team o Discuss at board meetings and meetings with stakeholders o Highlight in newsletters o Stakeholder events hosted by LHIN

Note**: Board Chair/members, staff, planning partner volunteers to be informed in advance of the rollout.*