MINISTRY/LHIN PERFORMANCE AGREEMENT (MLPA)

Central East LHIN MLPA PERFORMANCE INDICATOR DASHBOARD

PERFORMANCE TREND - TRACKING REPORT

May 2013

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CENTRAL EAST LHIN

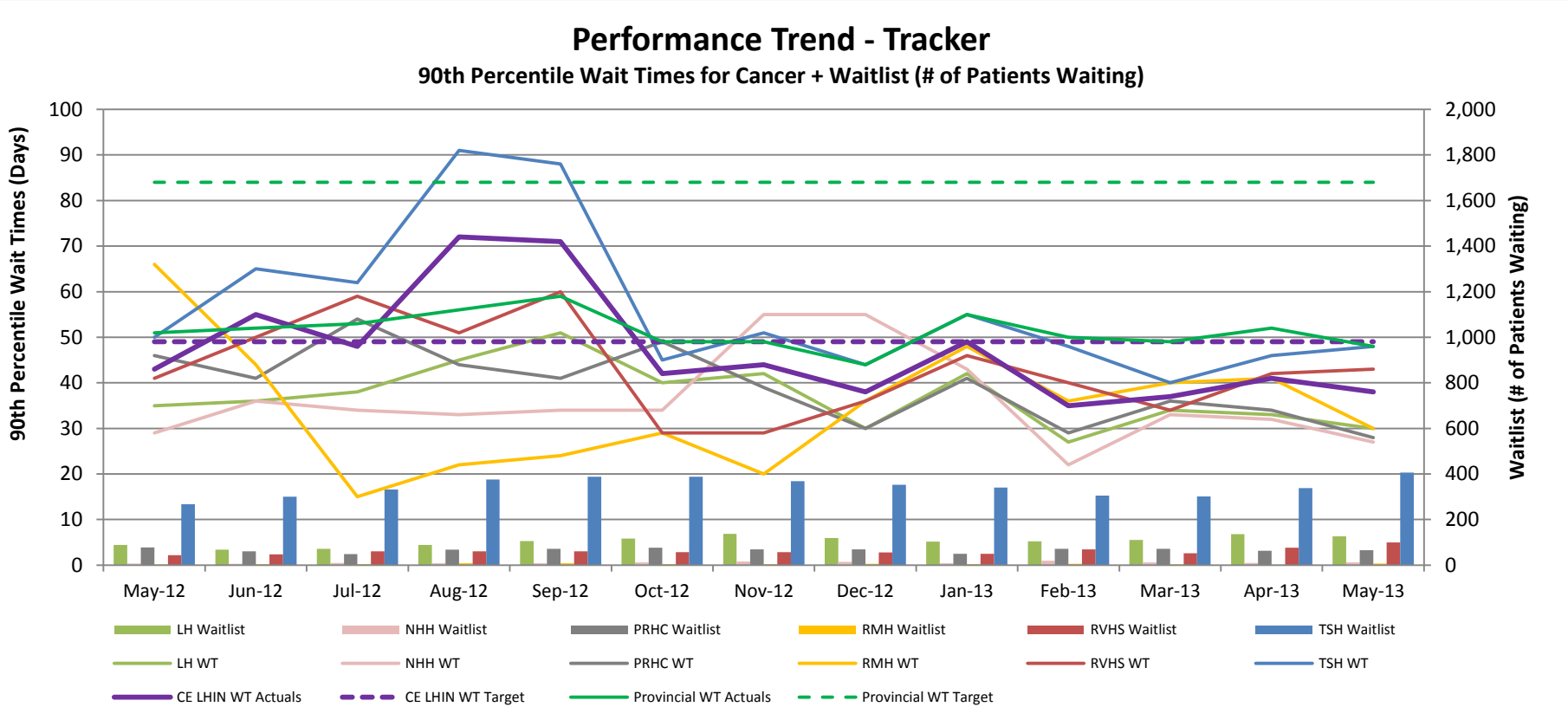
MLPA PERFORMANCE INDICATOR DASHBOARD

Performance effective as of:
May 2013

	Performance Indicator (PI)	Indicator Type	Provincial Target	LHIN Starting Point or Baseline 12/13	LHIN FY2012/13 Target	Actual LHIN Performance	Current Status	Trend [1]	LHIN Ranking [3]	Data Source [2]	Reporting Period
1	**90th Percentile Wait Times for Cancer Surgery**	Access	84 days	47	49	38	●	↓	3	WTIS	May 2013
2	**90th Percentile Wait Times for Cataract Surgery**	Access	182 days	114	135	123	●	↑	4	WTIS	May 2013
3	**90th Percentile Wait Times for Hip Replacement**	Access	182 days	163	179	146	●	↓	4	WTIS	May 2013
4	**90th Percentile Wait Times for Knee Replacement**	Access	182 days	166	179	163	●	↑	3	WTIS	May 2013
5	**90th Percentile Wait Times for Diagnostic MRI Scan**	Access	28 days	83	83	42	●	↑	7	WTIS	May 2013
6	**90th Percentile Wait Times for Diagnostic CT Scan**	Access	28 days	23	28	20	●	↑	2	WTIS	May 2013
7	**Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution [4]**	Integration	9.46%	17.35%	14.8%	15.0%	●	↑	9	DAD	2012/13 Q3
8	**90th Percentile ER Length of Stay for Admitted Patients**	Access	8 hours	44.53	36	27	●	↓	10	ERNI	May 2013
9	**90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients**	Access	7 hours	6.83	7.0	6.0	●	↓	2	ERNI	May 2013
10	**90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients**	Access	4 hours	4.33	4.0	3.9	●	↓	7	ERNI	May 2013
11	**Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions [5]**	Access	TBD	18.66%	17.0%	19.3%	●	↑	11	NACRS	2012/13 Q2
12	**Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions [5]**	Access	TBD	21.87%	19.6%	22.2%	●	↓	6	NACRS	2012/13 Q2
13	**90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management) [6, 4]**	Access	TBD	56	40	28	●	↓	7	HCD	2012/13 Q3
14	**Readmission within 30 Days for Selected CMGs [5]**	Efficiency (Quality)	TBD	15.74%	14.9%	16.56%	●	↑	5	DAD	2012/13 Q2

NOTES:

1	Trend analysis comparison to prior reporting period and/or established baseline (where applicable) of current reporting period
2	Data Sources: **WTIS** = Wait Time Information System. Wait times are from the Adult Surgery and DI Hospital Comparison Report from DoN (Directory of Networks). MRI and CT waitlists are submitted by hospitals via Central East LHIN's Wait Time Strategy Working Group's monthly survey. **ALC** = Alternate Level of Care; CIHI Inpatient Discharge Abstract Database (DAD), HAB, Intellihealth **ERNI** = National Ambulatory Care Administrative Database (NACRS, CIHI) via Ontario's ER NACRS Initiative (ERNI-Level 1) **NACRS** = National Ambulatory Care Reporting System (NACRS) **HCD** = Home Care Database (HCD), OACCAC, Health Data Branch SAS EG Server
3	LHIN Ranking (1 = shortest, 14 = longest) indicates how the LHIN's current value compares against all other LHINs in the province.
4	2012/13 Q3 data Trend analysis comparison to prior reporting period
5	2012/13 Q2 data - Most recent available data
6	No established Target; monitoring indicator only



Performance Commentary

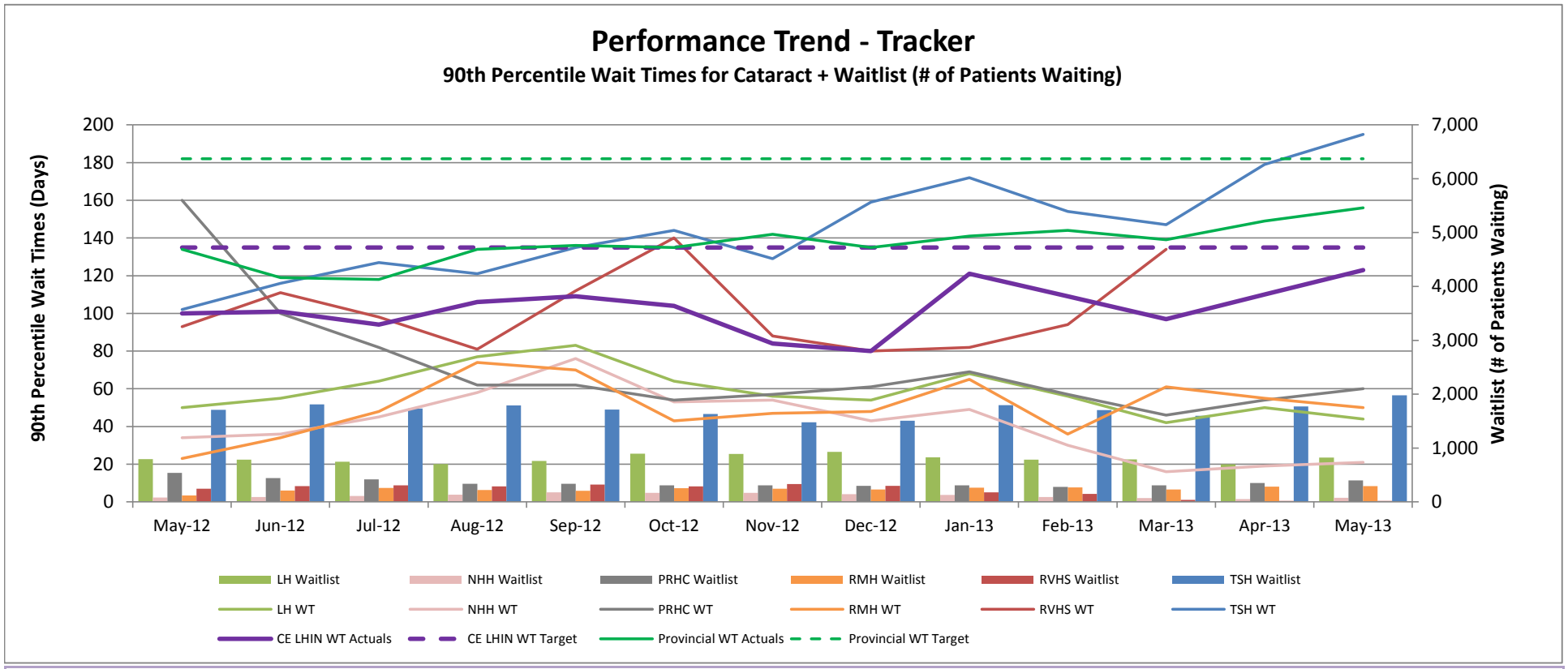
The CE LHIN 90th percentile wait time (WT) for cancer surgery decreased slightly from 41 days in April to 38 days in May. This is well below the 2012/13 negotiated target of 49 days. Compared to last month, the wait times primarily increased for RVHS and TSH, although they were still below the CE LHIN target. (Note that the wait time for TSH, previously impacted by surgeon vacation time in the summer, substantially decreased in October due to ongoing waitlist management and increased operating room [OR] time.)

Funding/Allocations: Incremental cancer surgery volumes have not yet been received from the Ministry for 2013/14.

Action/Strategy:

1) The CE LHIN implemented a Wait Time Strategy Working Group (WTSWG) at the beginning of 2009/10 with participation from all hospitals delivering wait times services in order to discuss, identify and resolve pressures/risks, as well as to share best practices.
2) The hospitals and CE LHIN implemented ongoing data quality improvement initiatives.
3) Wait time performance indicators have been incorporated into the Hospital Service Accountability Agreements (H-SAAs) with hospital-specific negotiated targets.
4) The CE LHIN fully implemented the Surgical Utilization Booking Management Integration Tool (SUBMIT) in June 2012 to assist with the management of wait times.

* When wait time is not reported (i.e. less than 10 completed cases), wait time is approximated as the average of the last 3 months.



Performance Commentary

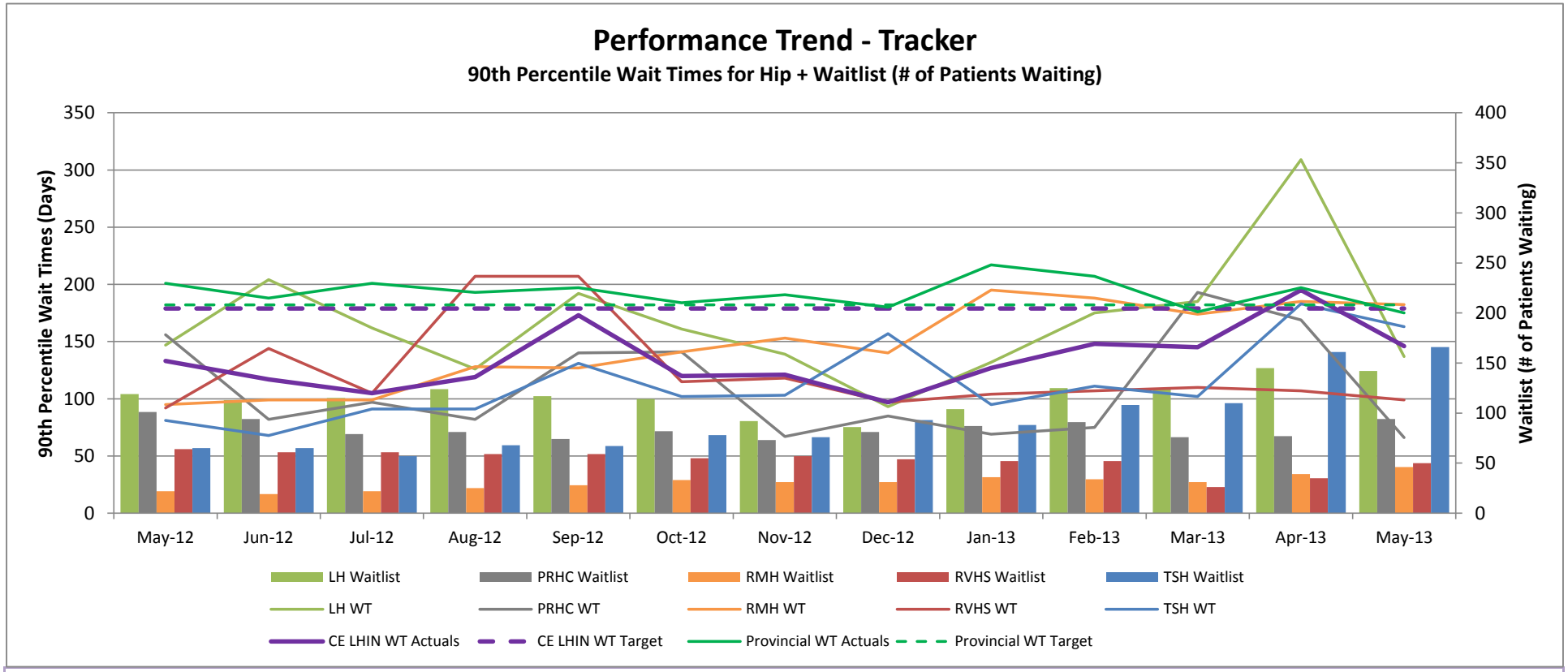
The CE LHIN 90th percentile wait time for cataract surgery increased from 110 days in April to 123 days in May. This is still below the 2012/13 negotiated target of 135 days. Compared to last month, the wait times primarily increased for PRHC and TSH, although PRHC was well below their H-SAA target. TSH received fewer volumes last fiscal year than in previous years, resulting in deferred surgeries, which led to increased wait times this month. Note that RVHS is no longer performing cataract surgery starting in 2013/14 and the LHIN has transferred their volumes to TSH.

Funding/Allocations: In June 2013, the Ministry informed the LHIN of the preliminary 2013/14 Quality-Based Procedure (QBP) volumes (cataracts, hips and knees), which are the same as the 2012/13 LHIN-approved volumes. However, the Ministry did not transfer cataract volumes from RVHS to TSH as advised, and the LHIN is working with the Ministry to rectify this error. In late June 2013, the Ministry informed the LHIN of the 2013/14 final draft Wait Time Strategy (WTS) incremental allocations for bilateral cataracts, which are the same as the 2012/13 volumes.

Action/Strategy:

1) The CE LHIN implemented the WTSWG at the beginning of 2009/10 with participation from all hospitals delivering wait times services in order to discuss, identify and resolve pressures/risks, as well as to share best practices.
2) The hospitals and CE LHIN implemented ongoing data quality improvement initiatives.
3) Wait time performance indicators have been incorporated into the H-SAAs with hospital-specific negotiated targets.
4) Volumes have been allocated among hospitals to optimize wait time performance.
5) The CE LHIN fully implemented SUBMIT in June 2012 to assist with the management of wait times.
6) The CE LHIN, in collaboration with the clinical and financial leadership of hospitals and CCAC, completed a regional planning process in 2012/13 and determined that the optimal model of service delivery for cataracts was volume optimization.
7) A meeting with TSH is being arranged to determine the mitigation strategies for their increasing wait times.

* When wait time is not reported (i.e. less than 10 completed cases), wait time is approximated as the average of the last 3 months.



Performance Commentary

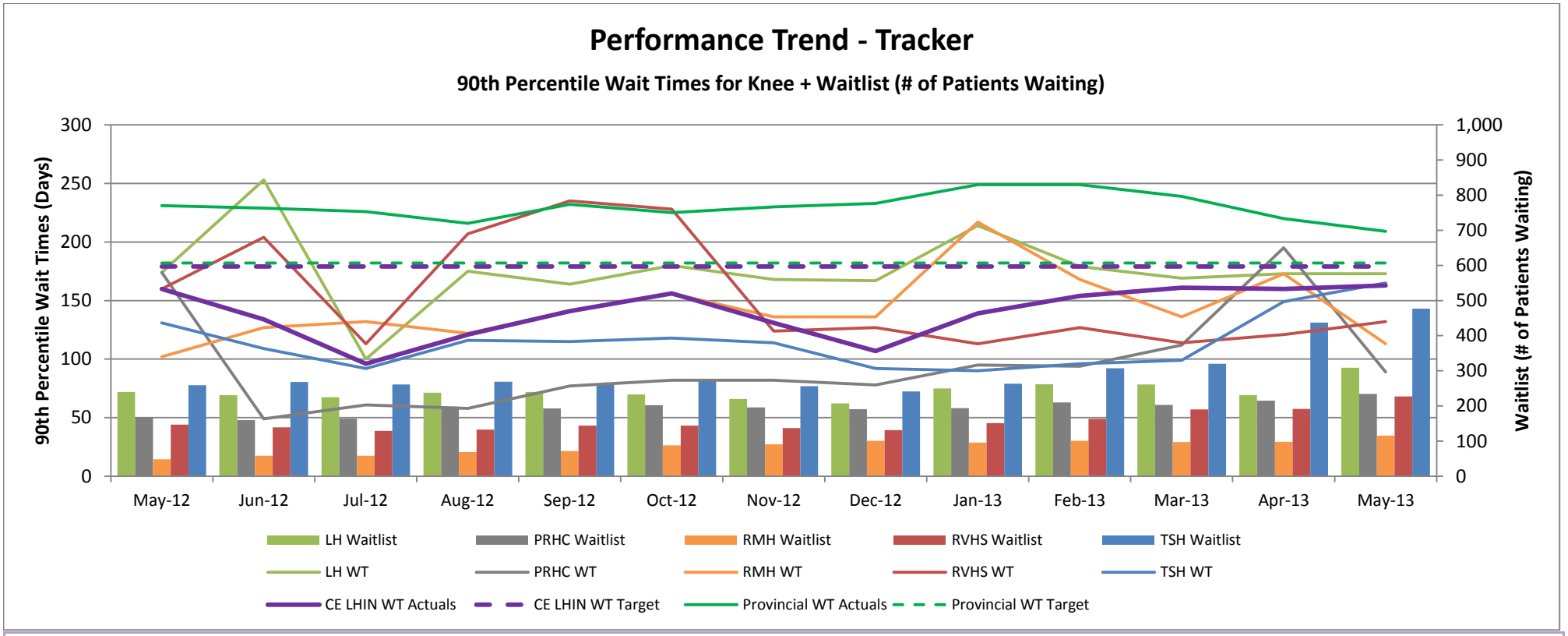
The CE LHIN 90th percentile wait time for hip replacement surgery decreased substantially from 195 days in April to 146 days in May. This is well below the 2012/13 negotiated target of 179 days. Compared to last month, the wait times decreased for all hospitals. (Note that the increased wait time for LH in April was due to surgeon unavailability and several long-wait cases. LH continues to work actively with surgeons' offices to reduce wait times and review data reporting processes.)

Funding/Allocations: In June 2013, the Ministry informed the LHIN of the preliminary 2013/14 QBP volumes (cataracts, hips and knees), which are the same as the 2012/13 LHIN-approved volumes.

Action/Strategy:

1) The CE LHIN implemented the WTSWG at the beginning of 2009/10 with participation from all hospitals delivering wait times services in order to discuss, identify and resolve pressures/risks, as well as to share best practices.
2) The hospitals and CE LHIN implemented ongoing data quality improvement initiatives.
3) Wait time performance indicators have been incorporated into the H-SAAs with hospital-specific negotiated targets.
4) Volumes are allocated among hospitals to optimize wait time performance.
5) The CE LHIN fully implemented SUBMIT in June 2012 to assist with the management of wait times.
6) The CE LHIN, in collaboration with the clinical and financial leadership of hospitals and CCAC, is undergoing a regional orthopaedic planning process to determine the optimal model of service delivery for all orthopaedic Quality-Based Procedures (QBPs).

* When wait time is not reported (i.e. less than 10 completed cases), wait time is approximated as the average of the last 3 months.



Performance Commentary

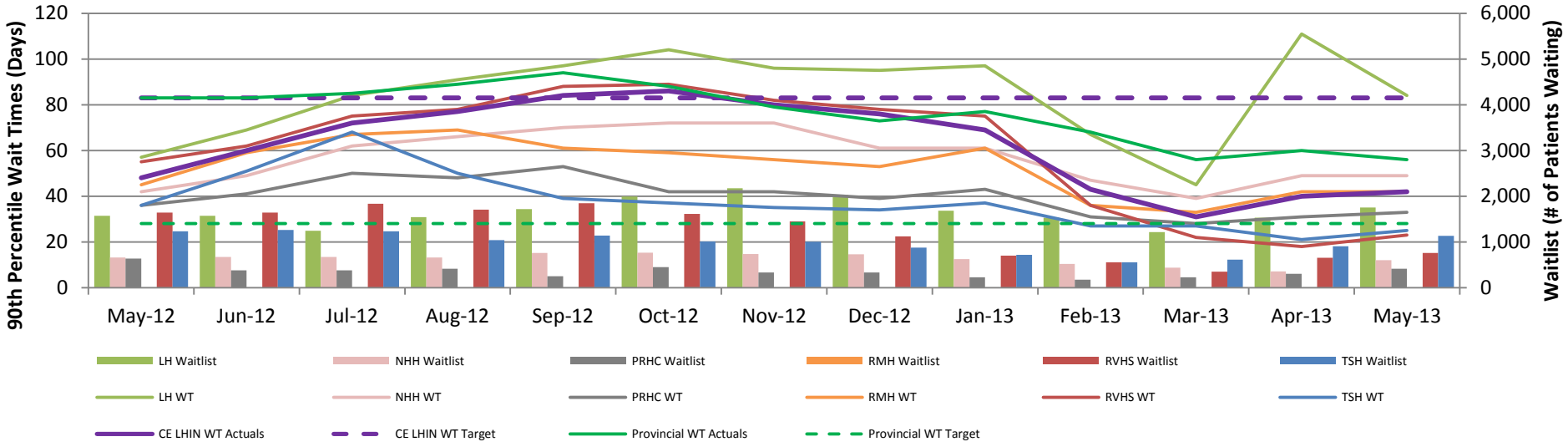
The CE LHIN 90th percentile wait time for knee replacement surgery increased slightly from 160 days in April to 163 days in May. This is still below the 2012/13 negotiated target of 179 days. Compared to last month, the wait times primarily increased for RVHS and TSH, although RVHS was below their H-SAA target. TSH used up their funded volumes last fiscal year and had to defer surgeries to 2013/14, which led to increased wait times this month.

Funding/Allocations: In June 2013, the Ministry informed the LHIN of the preliminary 2013/14 QBP volumes (cataracts, hips and knees), which are the same as the 2012/13 LHIN-approved volumes.

Action/Strategy:

1) The CE LHIN implemented the WTSWG at the beginning of 2009/10 with participation from all hospitals delivering wait times services in order to discuss, identify and resolve pressures/risks, as well as to share best practices.
2) The hospitals and CE LHIN implemented ongoing data quality improvement initiatives.
3) Wait time performance indicators have been incorporated into the H-SAAs with hospital-specific negotiated targets.
4) Volumes are allocated among hospitals to optimize wait time performance.
5) The CE LHIN fully implemented SUBMIT in June 2012 to assist with the management of wait times.
6) The CE LHIN, in collaboration with the clinical and financial leadership of hospitals and CCAC, is undergoing a regional orthopaedic planning process to determine the optimal model of service delivery for all orthopaedic QBPs.
7) To address the increasing demand for knee replacements over hip replacements, hospitals will be able to move volumes from hips to knees during the 2013/14 reallocation process, subject to LHIN & Ministry approval.

* When wait time is not reported (i.e. less than 10 completed cases), wait time is approximated as the average of the last 3 months.



Performance Commentary

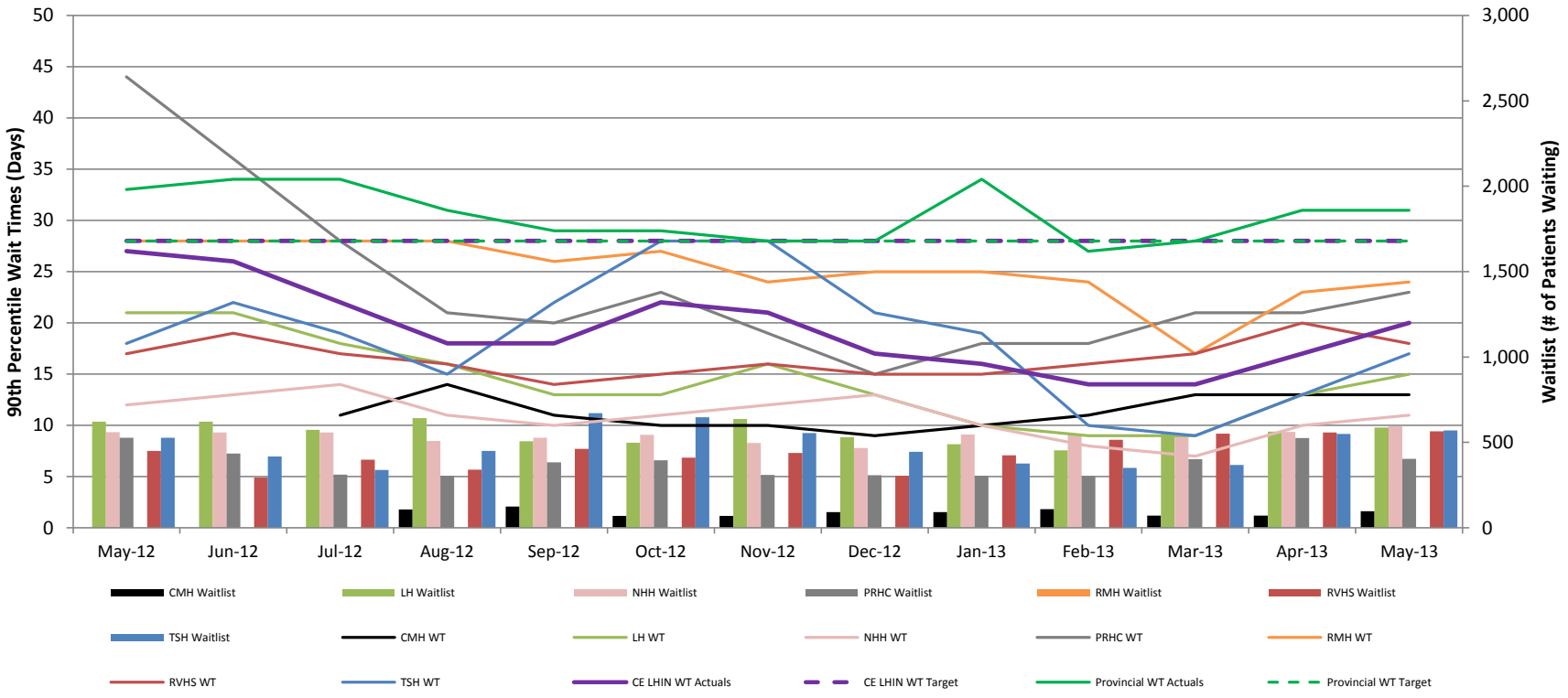
The CE LHIN 90th percentile wait time for MRI scan increased slightly from 40 days in April to 42 days in May. This is well below the 2012/13 negotiated target of 83 days. Additional volumes is an important factor in reducing wait times. Due to the additional LHIN-funded hours provided in January 2013, wait times have significantly decreased for all hospitals in Q4. Compared to last month, the wait times primarily increased for PRHC, RVHS and TSH, although they were all well below their H-SAA targets.

Funding/Allocations: In late June 2013, the Ministry informed the LHIN of the 2013/14 final draft Wait Time Strategy (WTS) incremental allocations, which increased substantially from 2012/13's initial incremental allocations.

Action/Strategy:

1) The CE LHIN implemented the WTSWG at the beginning of 2009/10 with participation from all hospitals delivering wait times services in order to discuss, identify and resolve pressures/risks, as well as to share best practices.
2) The Diagnostic Imaging (DI) Working Group looks at systemic issues, such as the education of primary care physicians, radiologists, referral patterns and protocolling best practices, which affect wait times.
3) The hospitals and CE LHIN implemented ongoing data quality improvement initiatives.
4) Wait time performance indicators have been incorporated into the H-SAAs with hospital-specific negotiated targets.
5) Volumes are allocated among hospitals to optimize wait time performance.
6) Ministry initiative - MRI PIP3, with province-wide participation, launched in 2013.
7) The CE LHIN will continue to closely monitor hospital performance and is exploring the expansion of SUBMIT to DI to assist with the management of wait times. With the current lack of LHIN investment opportunities, the LHIN submitted a business case in December 2012 to the Ministry to fund a DI module, called Diagnostic Imaging Requisition and Entry Collaboration Tool (DIRECT).

* Data is used as submitted by the hospitals into the Wait Time Information System (WTIS).
* Waitlist information is currently not available for RMH.



Performance Commentary

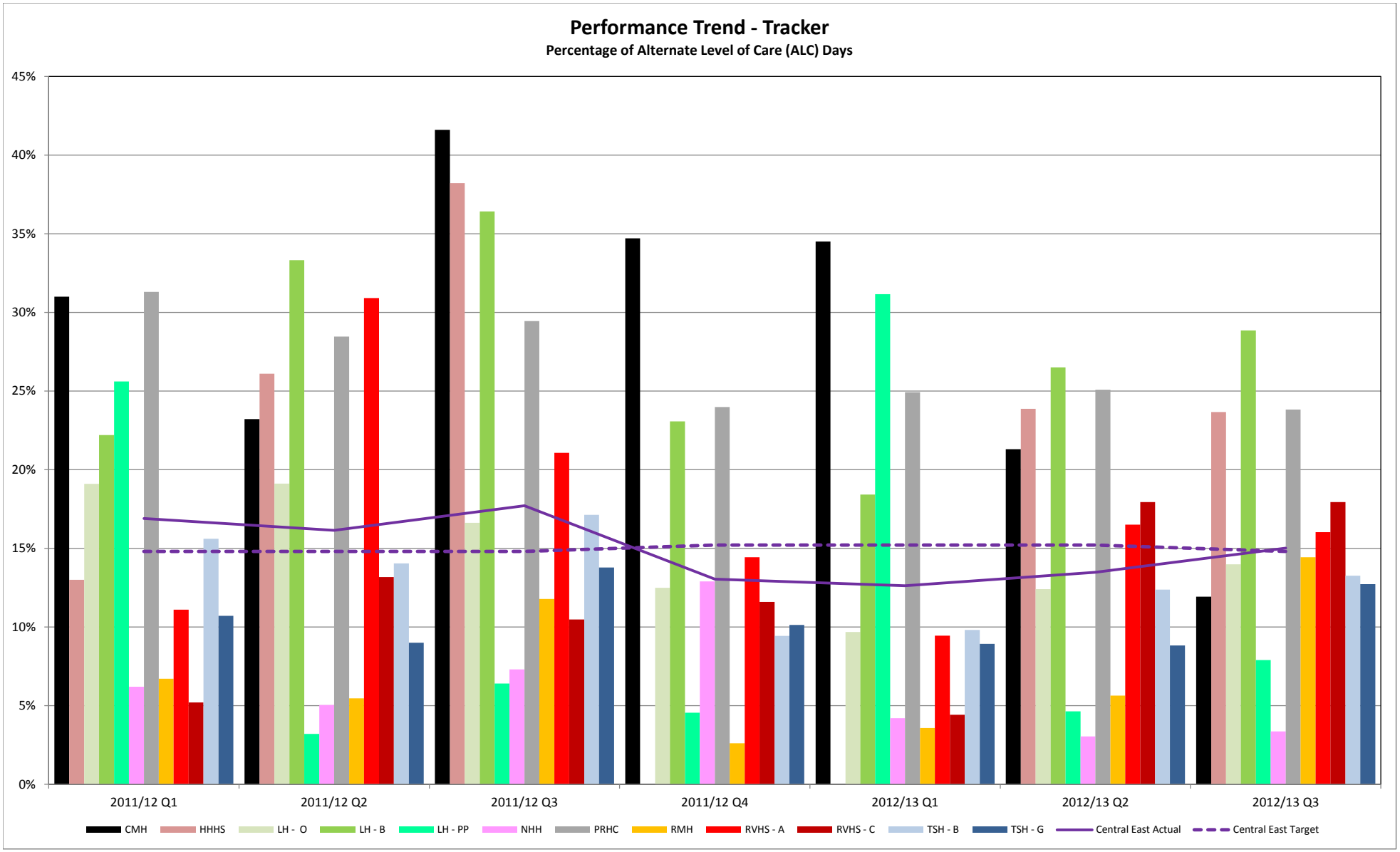
The CE LHIN 90th percentile wait time for CT scan increased slightly from 17 days in April to 20 days in May. This is well below the 2012/13 negotiated target of 28 days, and all hospitals were below the CE LHIN target.

Funding/Allocations: In late June 2013, the Ministry informed the LHIN of the 2013/14 final draft WTS incremental allocations, which decreased slightly from 2012/13's initial incremental allocations.

Action/Strategy:

1) The CE LHIN implemented the WTSWG at the beginning of 2009/10 with participation from all hospitals delivering wait times services in order to discuss, identify and resolve pressures/risks, as well as to share best practices.
2) The DI Working Group looks at systemic issues, such as the education of primary care physicians, radiologists, referral patterns and protocolling best practices, which affect wait times.
3) The hospitals and CE LHIN implemented ongoing data quality improvement initiatives.
4) Wait time performance indicators have been incorporated into the H-SAAs with hospital-specific negotiated targets.
5) Volumes are allocated among hospitals to optimize wait time performance.
6) The CE LHIN will continue to closely monitor hospital performance and is exploring the expansion of SUBMIT to DI to assist with the management of wait times. With the current lack of LHIN investment opportunities, the LHIN submitted a business case in December 2012 to the Ministry to fund a DI module, called DIRECT.

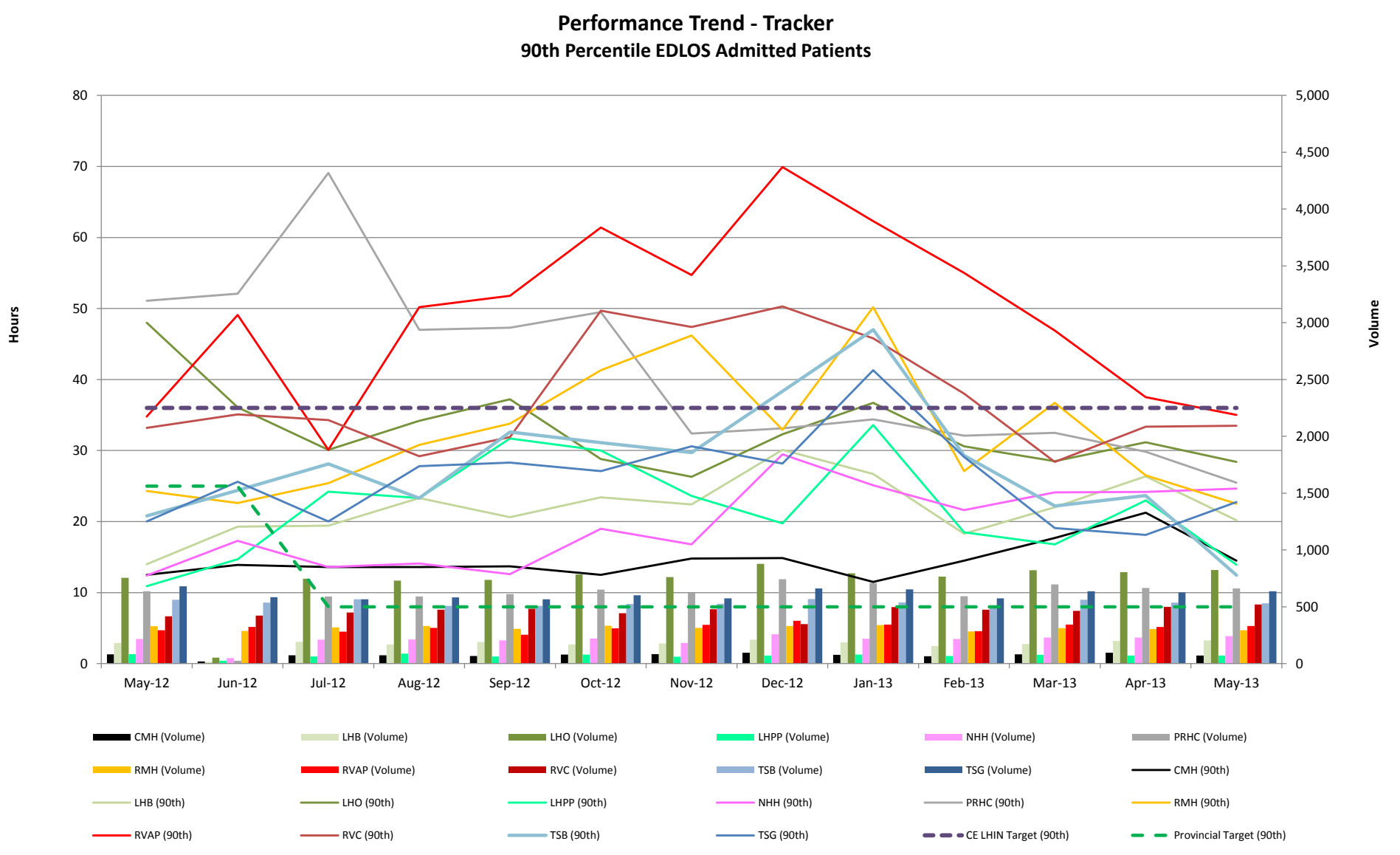
* Data is used as submitted by the hospitals into WTIS.
* CMH went live with WTIS reporting on July 16, 2012.
* Waitlist information is currently not available for RMH.



Performance Commentary

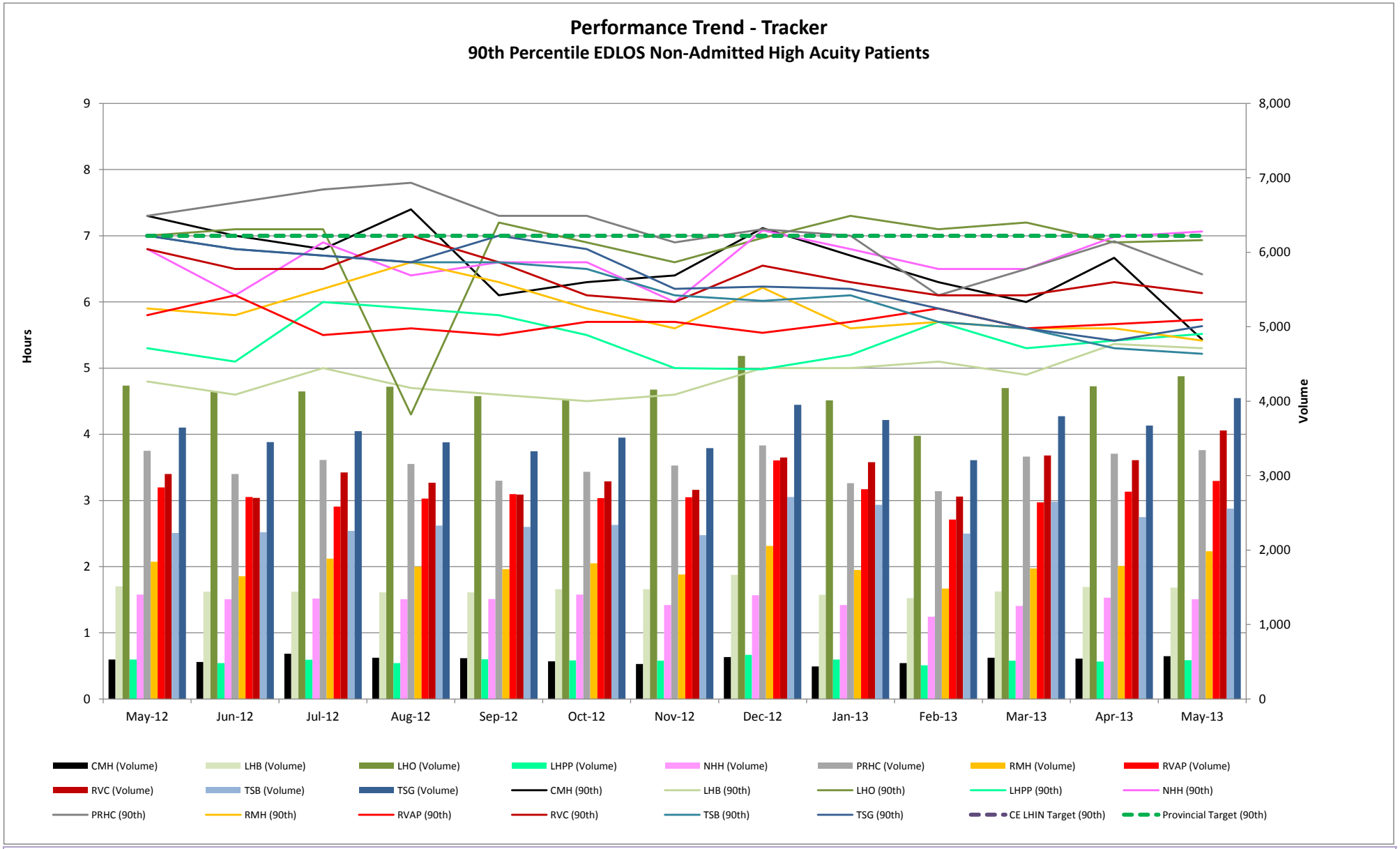
The performance for Q3 2012/13 has increased from 13.47% to 15.00% or 1.53 days. This is an increase of 11% though the performance for this indicator is still 13% below the Central East LHIN baseline and 0.20% below the Central East LHIN target of 15.20%.

To improve hospital bed utilization, the Central East LHIN has focused on moving patients through the hospital to the most appropriate setting which includes the community. The LHIN is concentrating on activities including additional bed capacity both in and outside the hospital setting, the sustainability of Home First across all hospitals in the LHIN and constantly reviewing access to post-acute related programs/services included long-term care, complex continuing care, inpatient rehabilitation and Assisted living. Notwithstaning ongoing challenges with overall rates of ALC days, the LHIN is strengthening its efforts on improving patient flow and reducing conservable hospital bed days. The Central East LHIN is continuing to work with the hospital partners to address flow issues within programs that result in ALC designations.



Performance Commentary

- In May of FY 2013-14, Central East LHIN performance at the 90th percentile in length of stay in the Emergency Department for Admitted patients has improved from 29.9 hours in March to 26.6 hours in May. Current performance at 90th percentile is below the 2012/13 target of 36.0 hours.
- All sites are perfoming with the FY2012 MLPA target of 36 hours in this indicator.
- In May 2013, TSB was the top performer in this indicator at 12.4 hours.

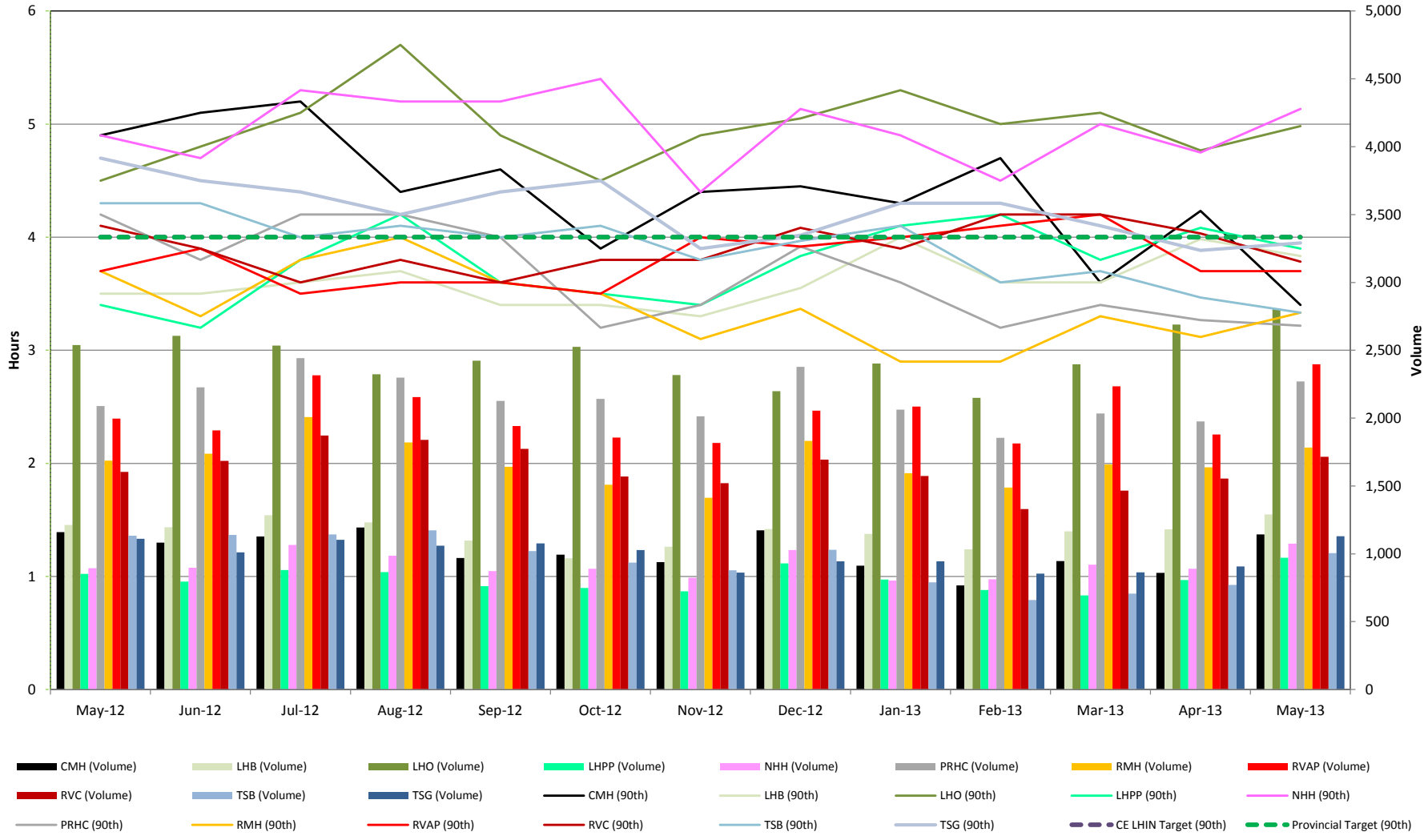


Performance Commentary

- In May of FY 2013-14, Central East LHIN performance at the 90th percentile in length of stay in the Emergency Department for non-Admitted high acuity patients is 6.0 hours, lower than the Central East LHIN MLPA target of 7.0 hours.
- In May 2013, NHH was slightly above the MLPA target at 7.1 hours.
- In May 2013, TSB were the top performers at 5.2 hours for this indicator.

Performance Trend - Tracker

90th Percentile EDLOS Non-Admitted Low Acuity Patients

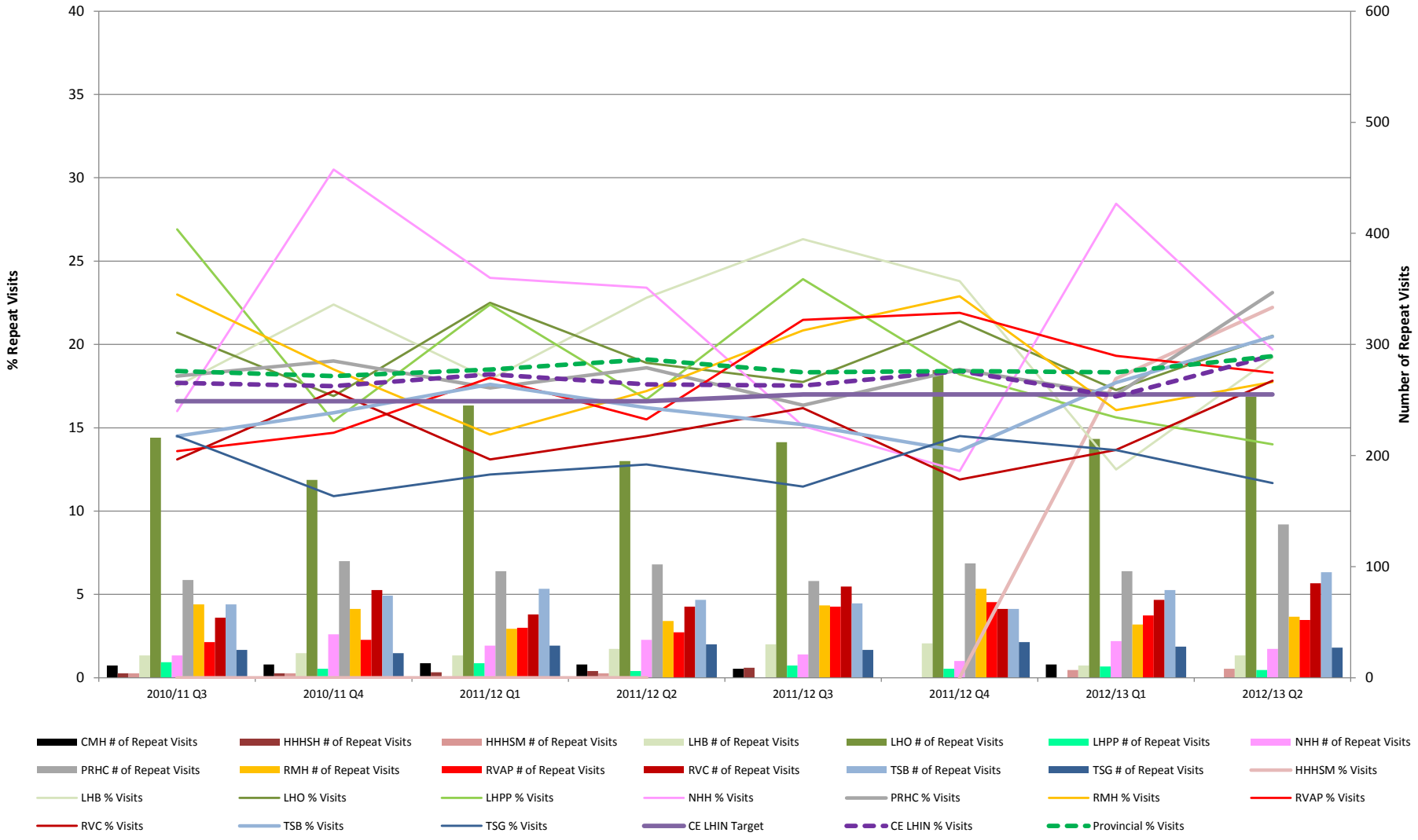


Performance Commentary

- In May of FY2013-14 Central East LHIN performance at the 90th percentile in length of stay in the Emergency Department for non-Admitted low acuity patients was 3.9 hours.
- In May 2013, the facilities: NHH and LHO were above the CE LHIN target of 4.0 hours.
- In May 2013, RMH was the top performers in this indicator at 3.2 hours.

Performance Trend - Tracker

Repeat Emergency Visits Within 30 Days for Mental Health Conditions + Number of Repeat Visits by Site



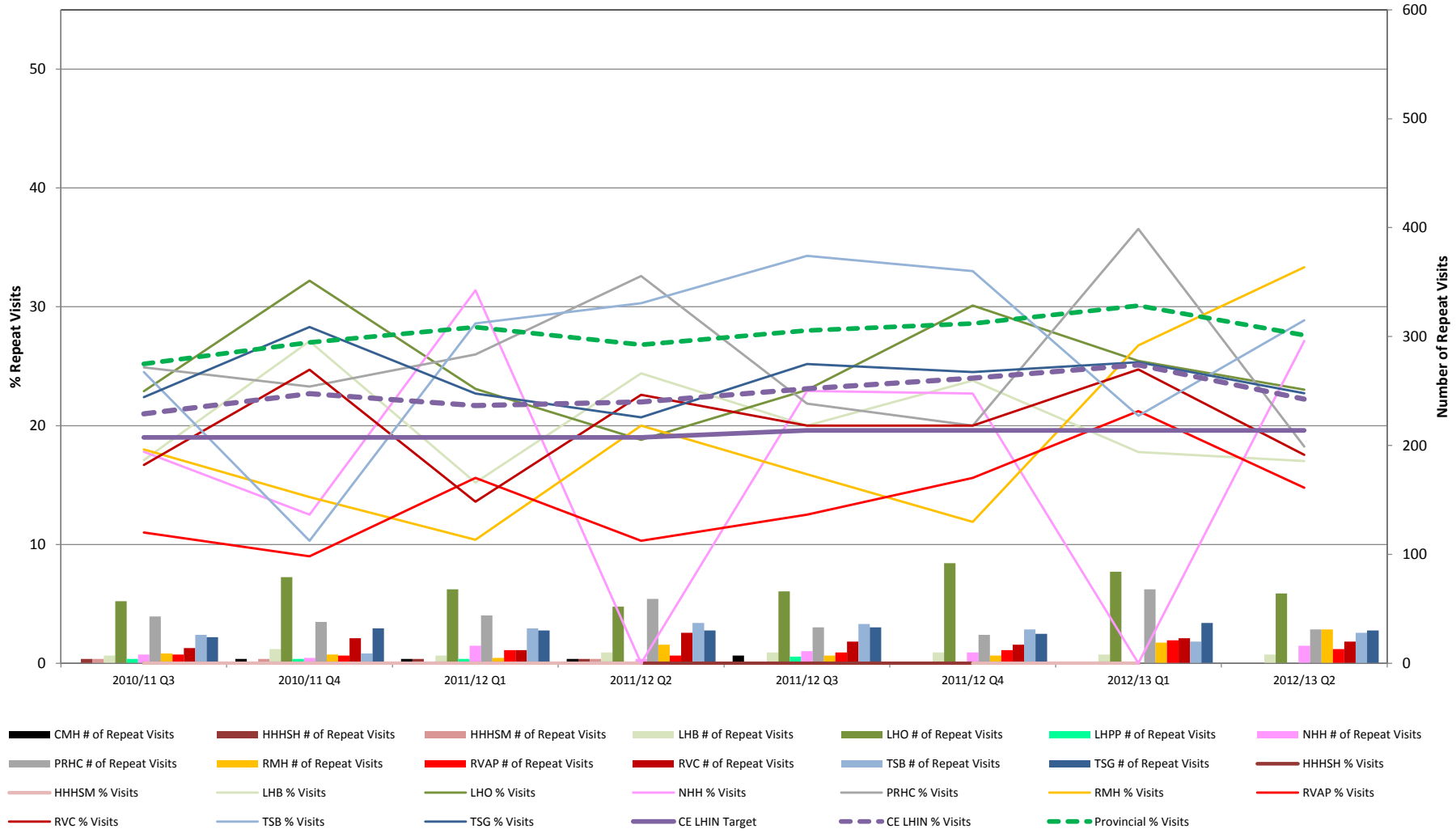
Performance Commentary

Central East is on an average level with other GTA LHINS. Although we had expected to see no increase due to the implementation of the H2H strategy, this did not occur.

It is anticipated that there will be a return to Central East LHIN target of 17.0% By FY 12/13, Q3. Hospital to Home will continue with a Quality Improvement approach that will work from the patient perspective to correct any issues in the system that contribute t the high unscheduled return visit rates. H2H will highlight any data issues that are beyond the control of the LHIN, for example, transfers between hospital sites constituting an 'repeat unplanned visit'. A Child and Adolescent hospital based program review is underway.

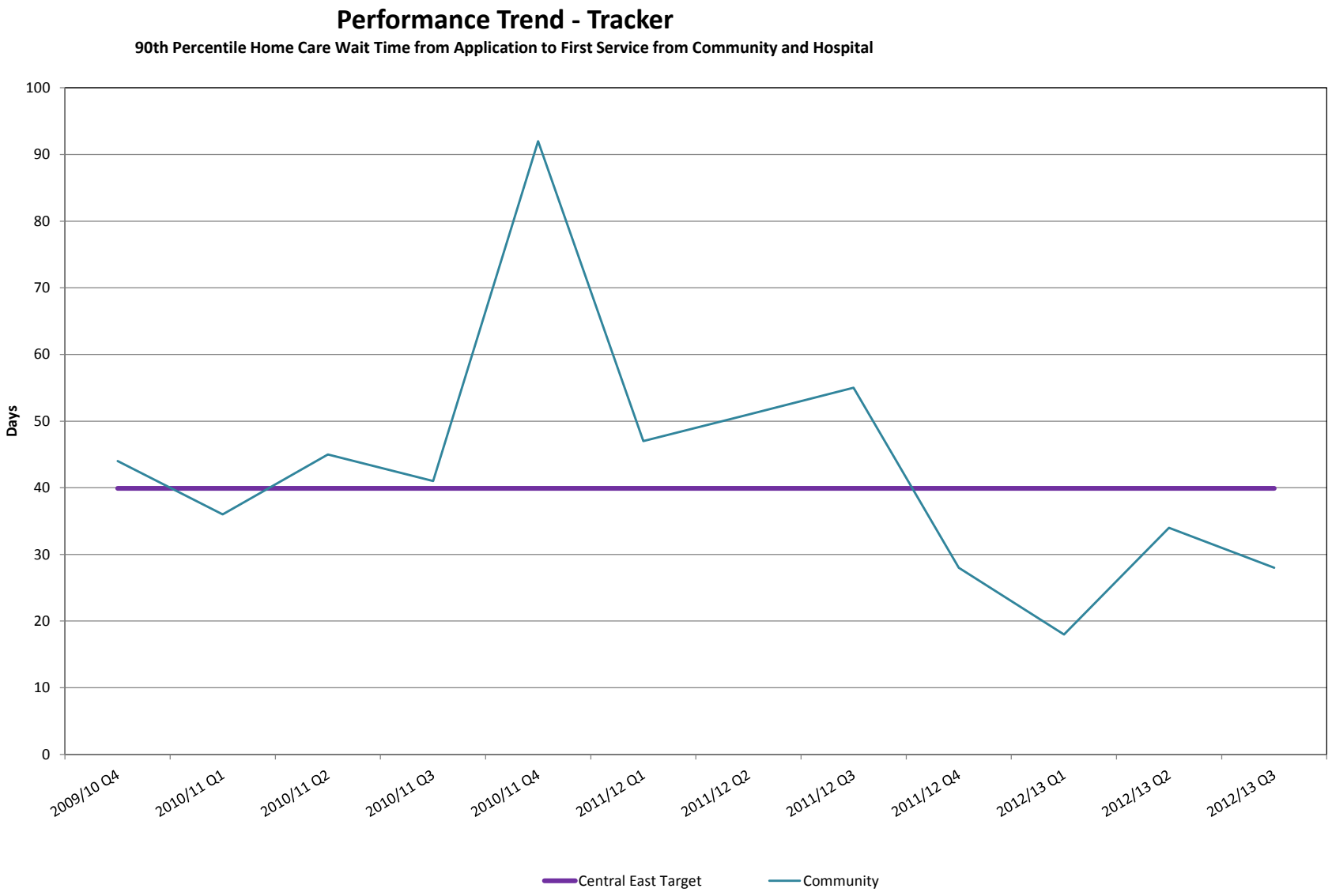
Performance Trend - Tracker

Repeat Emergency Visits Within 30 Days for Substance Abuse Conditions + Number of Repeat Visits by Site



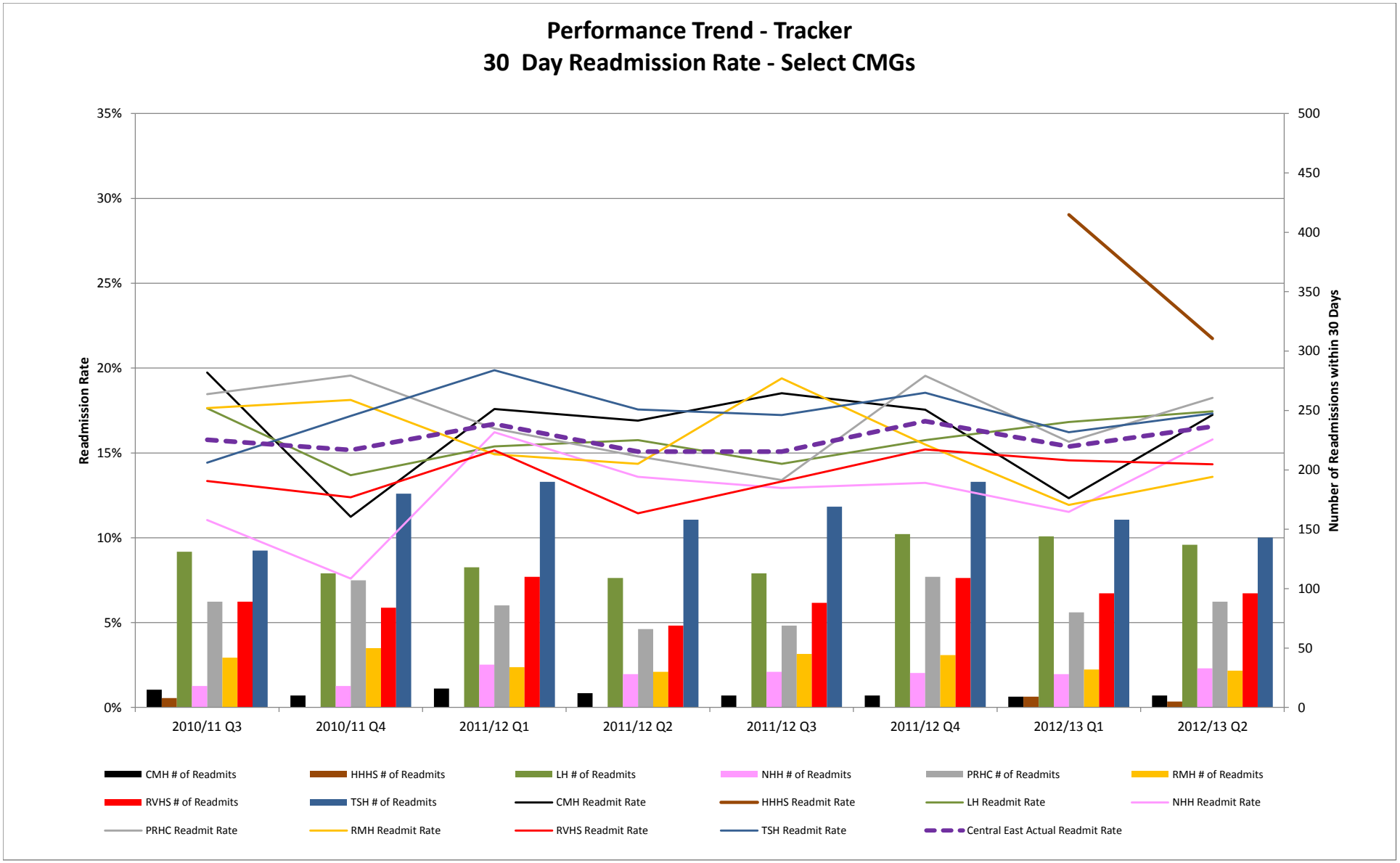
Performance Commentary

As of April 1, 2012, H2H, Hospital to Home Team was implemented in both the Northeast and Durham Clusters. Central East is on average with other GTA LHINS. The H2H Strategy is focused on Concurrent Disorders, and has an addictions component in the Durham Cluster. It was expected that this Team would reduce the unscheduled return visits for Addictions. The Opiate Strategy will come online in FY 13/14, Q4. H2H outcomes have continued to be positive as the project has matured. A reduction to the Central East LHIN target of 19% is anticipated. The Opiate Strategy will be implemented throughout the LHIN by Q4 2012/13 with particular attention paid to vulnerable populations such as aboriginals and in those areas of the LHIN where the numbers of methadone registration is high.



Performance Commentary

The Q3 2012-13 90th percentile wait time for CCAC In Home Services is 28 days. The CECCAC continues to support the LHIN and health system focus on the reduction of hospital utlization and to that end, continued to experience high hospital referrals over the second quarter of this year. Many clients referred from the hospital, both inpatient and emergency departments, have high needs and therefore have a shorter wait time between referral and first service. While the CECCAC appears to be performing below the target, the CECCAC will continue to look for opportunities to reduce our waitlist. However it is important to note that the wait times may continue to fluctuate as our community waitlist continues to grow related to our commitment to Home First and ED/ALC strategies, and as we have opportunities to provide service to clients on the wait list. Our CECCAC waitlisted community clients have been waiting for a significant period of time, and bringing them on service will cause an increase in the performance of this target. CCAC will work closely with the 6 Assisted Living for High Risk Seniors Programs to identify potential clients from our Personal Support Waitlist that could be transferred for service from these programs. Lastly, the CECCAC has identified the reduction in the personal support wait list as a 2013-16 strategic goal.



Performance Commentary

Central East LHIN expects to see improvements in the baseline in 2013 with a vascular health coalition dedicated to specific vascular priorities that utilize quality improvement indicators to measure initiatives across the Central East LHIN in addressing avoidable hospital readmission rates. Incorporating education programs into the vascular priorities of the Central East LHIN for both professionals and patients in smoking cessation, diabetes management and rehabilitation for both stroke and cardiac and heart failure, alongside self-management and self-management support, this has identified the need for better communication initiatives between primary and tertiary HSPs. The coalition facilitated by the LHIN is incentivizing voluntary integration proposals and vascular management partnerships both on a cluster-based level and LHIN-wide level. The Diabetes Regional Coordination Centre alongside the Central East LHIN also facilitated a Value Stream mapping event in April 2012, and the outcomes have been evaluated to include centralized intake as a core quality process improvement in diabetes health services. All HSPs have surpassed their COPD and CHF targets with the exception of two hospitals. This has been influenced by one hospital conducting a substantial "refresh" to external HCPs who also refer to the comparative hospital in the same Cluster that provides a Heart Failure Clinic.