Central East LHIN Strategic Aim
Vascular Health Aim Update

Update to the Central East LHIN Board of Directors
May 25th, 2016

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Ontario
Local Health Integration Network

Agenda

- Overview of the Vascular Health Strategic Aim
- Strategic Aim Metrics Update
  - Progress Report on the Vascular Health Strategic Aim
  - Review of Supporting Indicators
- Update and Highlights of Vascular Health Initiatives
- Moving Forward - Next Steps

Overview

Vascular Health Strategic Aim

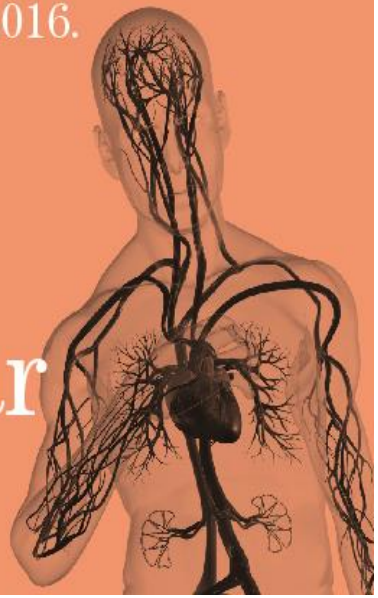
Overview : 2013-2016 Central East LHIN Integrated Health Service Plan

Community
FIRST

Help Central East LHIN residents spend more time in their homes and their communities.

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

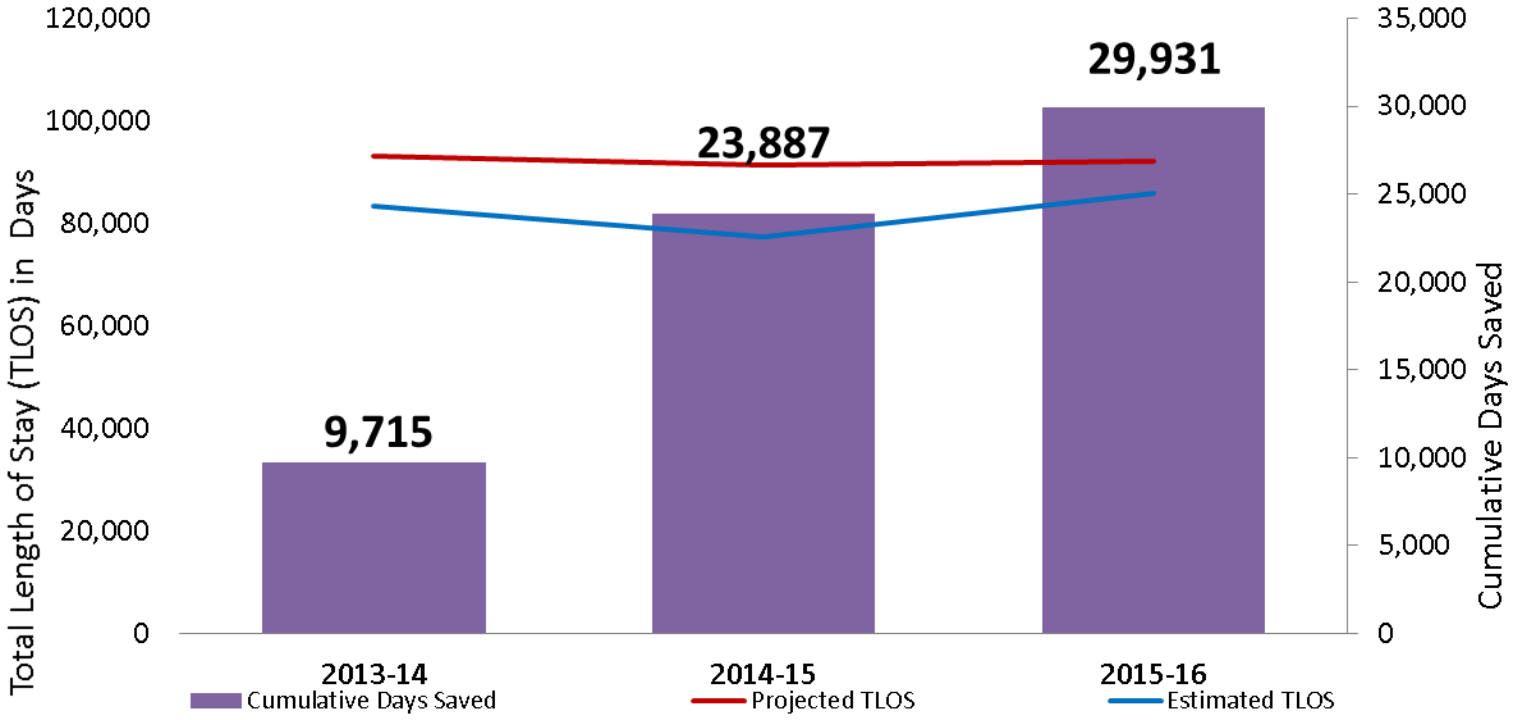
Vascular Health



Aim Metrics Update

Vascular Health Strategic Aim

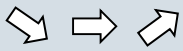
Vascular Strategic Aim Update



Cumulative Days Saved: the purple bars represent the difference between the Projected Total Length of Stay (red line) and the Actual/Estimated Total Length of Stay (blue line).

Projected Total Length of Stay (TLOS): the red line represents a projection of Total Length of Stay based on 3 years of historical data.

Supporting Indicators – Definitions

Terms	Definition
Baseline	Where there is sufficient data, the baseline is the average of the two most recent fiscal years.
Central East LHIN Target	The formal Central East LHIN target for that indicator (typically developed for use in existing scorecards, such as the MLPA). This formal target is indicated by **bold formatting**. Where there is no formal target, the baseline less 10% is used as an informal Central East LHIN Target.
Current Performance	The Central East LHIN performance for the indicator using the most current data available.
Current Status	The current performance is compared with the CE LHIN target and the result is summarized by a colored dot following the parameters below: • A red dot indicates that the current performance deviates from the desired target by more than 10%. • A yellow dot indicates that the current performance is within 10% of the target • A green dot indicates that the current performance meets the target or is performing better than the desired target
Direction	The direction of the data uses all the data from the baseline and any additional data, up to and including the most current data available.
	A gray arrow indicates that there are at least 7 data points available to calculate the direction of the data.
	A white arrow indicates that there are fewer than 7 data points available. The direction of data should be interpreted with caution.

Vascular Aim - Supporting Indicators

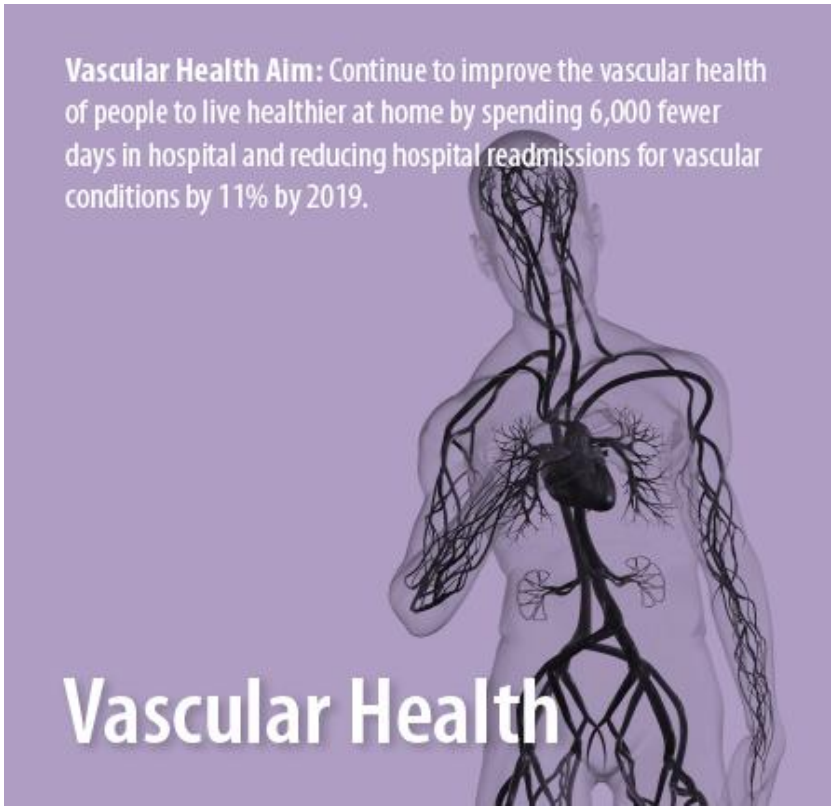
Indicator	Baseline	CE LHIN Target *(MOHTLC or ON Target)*	Time Period for Current Performance	Current Performance	Current Status	Direction
30-Day Readmission for select CMG (Cardiovascular) (Goal: decrease)[1]	14.2%	*13.0%*	15/16 Q1	16.5%		
30-Day Readmission for select CMG (CHF) (Goal: decrease)[1]	23.1%	*22.6%*	15/16 Q1	21.4%		
30-Day Readmission for select CMG (COPD) (Goal: decrease)[1]	18.5%	*20.0%*	15/16 Q1	20.1%		
30-Day Readmission for select CMG (Diabetes) (Goal: decrease)[1]	13.3%	*15.1%*	15/16 Q1	9.1%		
Percentage ALC days (stroke) (Goal: decrease)	23.7%	21.4%	15/16 Q2	33.4%		
Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation (Goal: increase)	36.2%	*45.4%*	FY 14/15	42.7%		
Proportion of stroke/TIA patients treated on a stroke unit any time during their inpatient stay (Goal: increase)	31.9%	*72.3%*	FY 14/15	42.7%		

Note:
1 Italicized font indicates a MOHLTC calculated target or an Ontario target.

Summary

- The positive achievements of the Vascular Aim are a reflection of the continued improvement in the acute Length of Stay (LOS) for cardiovascular Case Mix Groupings (CMGs)
- The targets for the re-admission rates were achieved for Diabetes, CHF and COPD. This is the first time that all three indicators have performed better than the target
- There is Improvement in the proportion of acute stroke patients discharged from acute care and admitted to in-patient rehabilitation
- There continues to be an opportunity for programs supporting vascular clients across the continuum of care to continue to work on transitions between the hospital, primary care and other community providers to minimize re-admissions

2016-19 Central East LHIN Integrated Health Service Plan



Vascular Health Strategic Aim Current Supporting Structures

Vascular Health Strategic Aim

Local Health Integration Network (LHIN)

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Vascular Health Strategic Aim Coalition

Regional Programs

Cardiovascular Rehabilitation and Secondary Prevention

Vascular Surgical Services

Ontario Renal Network

Ontario Stroke Network

Centralized Diabetes Intake

Self Management

Telehomecare

Scarborough

- Cardiovascular Rehabilitation and Secondary Prevention (CRSP)-1 site
- Vascular Surgical Program – The Scarborough Hospital (TSH)
- Part of the South East Toronto and North East GTA Stroke Networks
- Dialysis Program-TSH
- Scarborough Diabetes Network:
    - Diabetes Education Programs (DEPs)- 4 adult DEPs
    - 1 Pediatric DEP
- Centre for Complex Diabetes Care (CCDC)
- Self Management

Durham

- CRSP (7 sites, 1 to be established)
- District Stroke Centre- Lakeridge Health (LH)
- Dialysis Program-LH
- Durham Diabetes Network
    - DEPs- 4 Adult DEPs
    - Charles H. Best Centre (Type 1 Diabetes, pediatric to adult clients)
- Centralized Diabetes Intake
- CCDC
- Self Management

North East

CRSP (5 sites, 1 to be established)

- Vascular Surgical Program – Peterborough Regional Health Centre (PRHC)
- District Stroke Centre-PRHC
- Dialysis Program- PRHC
- North East Diabetes Network
    - DEPs – 5 Adult DEPs
    - 1 Pediatric DEP
- CCDC
- Self Management
- Telehomecare- 2 sites

Initiatives and Achievements

Vascular Health Strategic Aim

Regional Cardiovascular Rehabilitation and Secondary Prevention (CRSP)

Vascular Health Strategic Aim

CRSP Program Accomplishments

1. Increased volume of patients participating in cardiovascular rehabilitation (3,500 patients across the LHIN)

2. Enhancement of CRSP to include chronic disease management (diabetes, renal, stroke, cardiovascular disease, and congestive heart failure [CHF])

3. Hired nurse practitioners and heart failure nurse specialists to triage and assess patients in the community to follow-up on their care

4. Completed a community based outreach strategy (primary care visit, mall events, education events)

5. Enhanced linkages, through integration within care pathways and communication to:
   - Primary care;
   - Other programs in the Central East LHIN (i.e. CHF, Diabetes, Renal, Stroke, Vascular); and
   - Providing Exercise and Fall Prevention classes at 7 CRSP sites.

CRSP Program Performance

Fiscal Year 2015/16 Metrics	Target	Actual	Comment/Reflection
Number of Clients	3,000	3,300	Funding received starting in Q4 2014-15 from Central East LHIN to bridge a gap in needs
Number of Visits	45,000	49,500	
Referral Quality	90%	100%	Driven by harmonized central intake processes
Client Compliance with the Program	70%	74%	This metric is driven by: • Additional sites closer to home • Standardized care across sites • Case management model
Data Collection	100%	100%	Electronic data collection and database
Cost per Patient	$1,180	$850	Improved efficiencies through regional staffing model, centralized referral and booking processes
Client Travel Time to Program Locations	<30min	95%	Patients are able to access sites closer to home
Wait Times for Program	<2 wks.	93%	Additional funding, increasing class size efficiency, and opening new sites

Opportunities and Challenges

Opportunities:

1. Maximize participation in Health Links (Coordinated Care Planning);
2. Implementation of additional CRSP sites in Bobcaygeon and Seaton;
3. Increase access of CRSP services in outreach areas (Halliburton) by exploring use of Ontario Telemedicine Network (OTN) and other technologies;
4. Automatic referral to CRSP from all Central East LHIN hospitals for chronic disease management patients (renal, stroke, diabetes); and
5. Research project underway with Institute for Clinical Evaluative Sciences (ICES) to evaluate efficacy of CRSP services.

Challenges:

1. To ensure access to services are equitable across the LHIN

Vascular Surgical Services

Vascular Health Strategic Aim

Vascular Surgical Services Program Accomplishments

- The Central East LHIN Vascular Surgical Services Steering Committee:
  - Operates under the formal agreement of *Vascular Surgery Regional Services Memorandum of Understanding* between the member organizations (signed by member organizations on June 25th, 2014);
  - Acts as champion and advocate for advancing the regional model and participates in planning and advocacy for the expansion/continuation of vascular services;
  - Ensures that high quality, consistent, and equitable vascular surgical services are delivered in the Central East LHIN;
  - The Steering Committee held its inaugural meeting on March 7th, 2016; and
  - Meets twice per year with its next meeting to be held in the Fall 2016.

Ontario Renal Network (ORN)

Vascular Health Strategic Aim

ORN Program Accomplishments

- **Newly restructured Regional Committee – Integrated Renal Program Council**, now has a patient representative as an additional member
- **Lakeridge Health (LH):** Successful planning, implementation and opening of a new four station “Transition Unit” at the Whitby site
- **The Scarborough Hospital (TSH):** TSH will now continue as a formal Community of Practice site for peritoneal dialysis access post the initial pilot project
- **Peterborough Regional Health Centre (PRHC):** Successful implementation of the Patient and Family Advisory Committee

Opportunities and Challenges

Hospital	Challenges	Opportunities
The Scarborough Hospital (TSH)	Capacity issues at TSH: significant growth of patients requiring chronic dialysis, surpassing physical capacity at TSH	Short-term capacity proposals being reviewed by ORN for small scale expansion approvals. Regional planning to start to assess potential medium-term solutions for TSH
Lakeridge Health (LH)	Slightly reduced independent dialysis rates	Opening of new "Transition Unit" (April, 2016) at Whitby site to improve home dialysis rates
Peterborough Regional Health Centre (PRHC)	Patients driving to PRHC for dialysis, transportation costs and care not "close to home" Access to clean water for current and potential Home Hemodialysis patients	PRHC leaders working with ORN, and local communities to review issues and to continue to grow the home dialysis programs, including peritoneal dialysis

Stroke

Vascular Health Strategic Aim

Stroke Report Card and Progress Report

LHIN Stroke Report Card:

- Produced by the Ontario Stroke Evaluation Program which provides comprehensive evaluation of the Ontario Stroke System;
- Intentional selection of indicators across the care continuum with system level impact; and;
- Interpretation to support identification of gaps and opportunities for collaboration with system stakeholders to drive improvement.

LHIN Progress Report:

- Reviews LHIN performance relative to its past performance;
- Compares 2014/15 performance to the average of the previous 3 years; and
- Rates performance as progressing well, progressing or not progressing.

Summary of the Stroke Report Card and Progress Report for 2014/15

- Poor performance
- Acceptable performance
- Exemplary performance
- Data not available or benchmark not available

HP = High Performer Provincially

	Indicator	Report Card	Progress Report (change from 2011/12-2013/14 in comparison to 2014/15)
1	Proportion who arrived at ED by ambulance		Progressing- improved performance
2	Inpatient admission rate for Stroke/TIA	HP	Performance unchanged
3	30-day mortality rate		Performance unchanged (benchmark not available)
4	Proportion with a-fib prescribed anticoagulant		Data not available
5	Proportion with carotid imaging before discharge		Progressing
6	Median door-to-needle		Not progressing – decreased performance
7	Proportion receiving thrombolytic therapy (tPA)		Not progressing – decreased performance
8	Proportion treated on Stroke unit during stay		Progressing very well
9	Proportion with dysphagia screening		Data not available
10	Proportion acute ALC days to total LOS		Trending in a positive direction
11	Proportion admitted to Inpatient Rehab	HP	Progressing very well- improved performance
12	Proportion with referral to outpatient rehab		Data not available
13	Time to inpatient rehab admission (days)	HP	Progressing very well-improved performance
14	Mean minutes of rehab therapy per day		Data not available
15	Proportion achieving RPG LOS targets		Progressing very well
16	Median FIM efficiency		Progressing very well
17	Mean number of CCAC visits		Progressing very well
18	Proportion of inpatient rehab with severe stroke		Progressing very well
19	Proportion discharged from acute to LTC/CCC		Trending in a positive direction
20	Readmission rate at 30 days		Progressing (benchmark not available)

Stroke Program Accomplishments

LHIN CEO Forum on Stroke held on March 30th, 2016 to promote cross- LHIN collaboration in stroke system planning towards the goal of a common model of community based care

- Hosted by the Central East LHIN
- Attended by CEOs and teams from Central East, Central and Toronto Central LHINs, Ontario and Regional Stroke Networks

Outcome: CEOs shared common values and expressed commitment to:

- Understanding the benefits and issues of a common model of community care;
- Exploring the potential for transferability of community model to broader patient population; and
- Alignment with LHIN priorities such as primary care reform and community care reform.

Opportunities and Challenges

Opportunities:

1. Central East LHIN Stroke planning
    - Supported by the Vascular Health Strategic Aim Coalition (VHSAC) and the Vascular LHIN Lead, develop a plan focused on stroke system redesign that integrates community Quality Based Procedures (QBP)
    - Continue local and system level efforts to increase access to endovascular therapy
2. Cross-LHIN system planning
    - An outcome of the CEO Forum, is to continue work with the Central and Toronto Central LHINs on a Community Model of Stroke Care that can be a "pilot' for other patient cohorts in alignment with the Central East LHIN priorities (e.g. Patients First Action Plan)

Challenges:

1. Variable access to stroke best practice care across the Central East LHIN
    - Stroke unit care (acute and rehab)
    - Community based services
2. Need for system level coordination and smoother transitions of care to support cross-LHIN movement of patients

Centralized Diabetes Intake (CDI)

Vascular Health Strategic Aim

CDI: Performance, Opportunities and Challenges

Q1 number of referrals	Q2 number of referrals	Q3 number of referrals	Q4 number of referrals	Total number of referrals 2015/16	Annual Target
404	340	404	456	1608	1180

Opportunities:

1. Diabetes Education Programs(DEPs) and Centres for Complex Diabetes Care (CCDC) spread the use of CDI at their sites and with referral sources
2. Increase awareness of programs through linkages to CDI internet page
3. Onboarding CDI process to be incorporated into the Rouge Valley Health System DEPs to facilitate community referrals
4. Common Electronic Regional Referral and Intake (CERRI) is developed and implemented for use by Primary Care Physicians

Challenges:

1. Awareness of CDI by Primary Care Providers
2. Establish new referral patterns by Primary Care Providers

Diabetes Education Programs (DEPs) Centre for Complex Diabetes Care (CCDC)

Vascular Health Strategic Aim

DEPs and CCDCs Accomplishments

- Durham Cluster continues to ensure ongoing access for patients is improved to avoid wait times.
- CDI is managing referrals in the Durham Cluster to ensure services are provided to patients during human resource shortages that may affect access to services across sites
- The North East Cluster continues to enhance Primary Care linkages, and focus on leveraging resources to support foot care and screening
- The Scarborough Cluster is improving their process for triaging and assessing patients, as well as developing a work plan to increase coordination of care
- The Scarborough Hospital CCDC staff implemented a recognition program for patients upon discharge to motivate them to continue in improving their health. This program has been well received by staff and patients.

Diabetes Services and Indigenous Communities

Peterborough:

- Curve Lake: half day monthly team visits for client counseling;
- Registered Nurse/Registered Dietician collaborated with Hiawatha, Curve Lake and Southern Ontario Aboriginal Diabetes Initiative (SOADI) on foot care assessment and diabetes education; and
- These events have focused on information sharing and storytelling.

Lakeridge Health:

- Satellite clinic operation half day every two weeks on the island of Scugog, in partnership with the Mississauga's of Scugog Island First Nations Aboriginal group; and
- The clinic takes place in the Health and Wellness Centre and with their primary care provider.

Diabetes Education Program Performance

Diabetes Education Programs	Clients served (Q1-Q4)	2015/16 Annual Target	Percent Above/Below Target
Brock CHC	436	635	-31%
Lakeridge Health	2,144	2,172	-1%
Durham CHC	1,254	1,619	-23%
Campbellford Memorial Hospital	581	535	9%
Haliburton Highlands Health Services	1,048	511	95%
Port Hope CHC	1,278	1,905	-33%
Peterborough Regional Health Centre	2,118	2,159	-2%
Pediatric DEP-Peterborough Regional Health Centre	139	167	-17%
Ross Memorial Hospital	1,684	1,143	47%
Rouge Valley Health System Ajax/Pickering	2,334	1,488	57%
Rouge Valley Health System Centenary	1,408	780	81%
Pediatric DEP-Rouge Valley Health System Centenary	283	225	26%
Scarborough Centre for Healthy Communities	3,853	3,334	15%
TAIBU CHC	658	635	4%
The Scarborough Hospital	2,881	1,677	72%
TOTAL (Q1-Q4)	22,099	18,985	16%

CCDC Program Performance

CCDC Site	Actual # of New Patient Visits (Q1-Q4)	2015/16 Target # of New Patient Visits	Percent Above/Below Target
The Scarborough Hospital	157	182	-13%
Lakeridge Health	98	93	5%
Peterborough Regional Health Centre	140	164	-14%
TOTAL (Q1-Q4)	395	439	-10%

Opportunities and Challenges

Opportunities:

- Follow up with DEPs who are not meeting targets to implement improvement strategy based on year-end results;
- Increase collaboration and planning for foot care services and eye care screening across the LHIN;
- Improve patient transitions of care;
- Integrating Health Link CCP into practice;
- Continued improvement in A1C and patient Diabetes Distress Scale levels;
- Continue to focus on self-management in order for patients to live healthier at home and reduce ER visits and readmissions;
- CCDC to continue to transfer accountability for patients to DEPs and primary care providers after self-management goals are met (typically after 6-9 months);
- To receive more referrals from DEPs to CCDC in order to maintain or increase current number of new patient visits; and
- Explore opportunities to extend diabetes services to other indigenous communities i.e. Alderville.

Challenges:

- Identification of appropriate patients with diabetes to participate in Health Links and integrating CCP into practice

Teleophthalmology

Vascular Health Strategic Aim

Teleophthalmology

Program Description: Utilizing Ontario Telemedicine network (OTN) to increase the access to annual screening for diabetic retinopathy for the purpose of preventing complications and vision loss.

Carefirst Community Services Association received funding for a 2-year pilot project. Screening program began in July 2015.

Target: 200 individuals screened (to be re-evaluated based on performance of provincial programs)

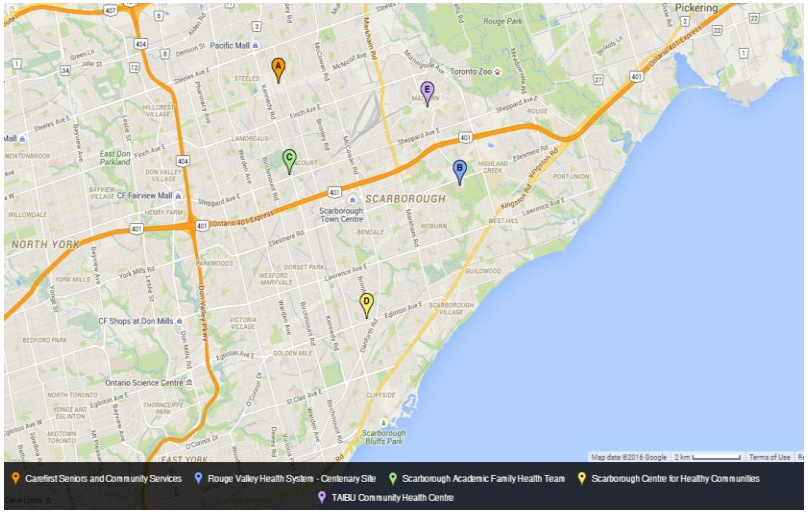
Progress to Date	Total Individuals Served (December-2015 April 2016)
Number of individuals outreached	200
Number of individual screened	50 (Target =200)
Referral to retinal specialist	0
Referral and follow up by general ophthalmologist	11

Teleophthalmology

Current screening locations with secure connections with the majority of Diabetes Education Programs across Scarborough.

Mobile screening locations include:

- Carefirst Seniors and Community Services Association;
- Rouge Valley Health System – Centenary Site*;
- Scarborough Academic Family Health Team;
- Scarborough Centre for Healthy Communities; and
- TAIBU Community Health Centre.



*In the process of securing RVHS – Ajax site to expand our services to patients who live in the Ajax community.

Opportunities and Challenges

Opportunities:

- Evaluate the success of the pilot project and support implementation of performance improvement plans;
- Explore opportunities to expand access beyond the Scarborough region with the existing team; and
- Develop a closer working relationship with other providers to expand access to care.

Challenges:

- DEPs are not able to refer to this program without primary care involvement; and
- Primary care awareness of the program and referrals.

Telehomecare

Vascular Health Strategic Aim

Telehomecare

- Central East Telehomecare (THC) program launched on February 16, 2016
- Current focus is to support patients with mild to moderate COPD or CHF through remote health monitoring and coaching by trained Telehomecare Clinicians
- Patients are provided with easy-to-use in-home monitoring equipment and will engage in 6 months of health coaching aimed at improving self-management for chronic conditions
- Initial target geography: patients living in Durham, Northumberland, Haliburton and City of Kawartha Lakes
- Staffed by 3 RN's: 2 at Central East CCAC, and 1 at Haliburton Highlands Health Services
- As part of LHIN's Vascular Aim Strategy, THC will help to improve the vascular health of people to live healthier at home and reduce hospital readmissions

Telehomecare: Performance (as of March 31st, 2016), Opportunities and Challenges

Number of Engagement sessions	Number of clients who consented to participate	Target number of clients for 2016/17
22	57	180

- THC Engagement Lead Manager promotes program regionally
- Target of 60 patients/clinician should be achieved by January 2017

Opportunities:

- Evaluate the success of the initiative and support implementation of improvement plans as necessary

Challenges:

- Primary care awareness of the program and referrals

Self-Management

Vascular Health Strategic Aim

Program Accomplishments

- **"Living a Healthy Life" Patient and Caregiver Workshops:**
  - *Chronic Conditions* program (February) and *Chronic Pain* Peer Leader Trainings (March);
  - Increased number of "graduate refresher sessions" to offer more ongoing self-management support; and
  - Program continues to focus on the furthest regions of the North East, such as Haliburton and Minden.
- **Health Care Provider Training:**
  - Coordinated *Choices and Changes: Motivating Healthy Behaviours* certification for 19 health care professionals across Ontario.
- **New Program Development:**
  - Trained one staff member to facilitate online version of chronic disease self-management program, called "Better Choices, Better Health®"; and
  - Trained two staff and two volunteers in "Powerful Tools for Caregivers" Program

Access to French Language Services

Through the Joint Action Plan signed with the Entité 4, the Central East LHIN will achieve the Vascular Health Strategic Aim with the Francophone community, by enhancing access to primary care. This strategy includes:

- Developing a chronic disease self-management service model for Francophones living in Scarborough and Durham, to help improve system navigation and case management support for chronic disease prevention

Supporting activities:

- Recruiting Bilingual Health Promoter and Nurse Practitioner at TAIBU CHC to enhance system navigation and access to care; and
- Coordination of self-management workshops in French across Scarborough and Durham.
  - 17 Francophone individuals have completed the self-management workshop training held at TAIBU CHC (6 week program offered at least 2 times per year)

Self Management Program Performance

Indicator	LHIN Target	LHIN Year End (Q1-Q4)	MOHLTC Ontario Diabetes Strategy(ODS) Target	MOHLTC - ODS Year End (Q1-Q4)	Total Target (LHIN+MOHLTC-ODS)	Total Year End Target (LHIN+MOHLTC-ODS)
# of people who have attended a Stanford Self- Management Training workshop	660	706	300	300	960	1006
# of total workshops delivered	55	58	25	25	80	83

Opportunities and Challenges

Training Programs	Challenges	Opportunities
Living a Healthy Life Program	Holding workshops in hospitals can create barriers as participants have to pay for parking	• Opportunities to offer more trainings and workshops with Indigenous populations • Continued opportunities to create referrals to the workshops and identify additional geographic locations and populations for workshops • Greater integration with other vascular programs
Health Care Provider Training	No provision of backfill funding for HCPs coverage so they can attend self management training can create barriers to participation	• Exploring opportunities to train Physicians through workshops such as Choices and Changes and Brief Action Planning (BAP) • Work with the Association of Family Health Teams (AFHTO) to develop the ability to track use of BAP interventions using Electronic Medical Record (EMRs)

Next Steps

Vascular Health Strategic Aim

Next Steps

- Work with the Vascular Health Strategic Aim Coalition (VHSAC) and key supporting stakeholders to create integrated systems of care at the sub-LHIN level
- Ensure current governance structures support implementation of the Vascular Aim for 2016-2019 and achievement of Ministry-LHIN Accountability Agreement (MLAA) and Stroke Report Care indicators
- Priority initiatives for 2016/17 which will be supported by the VHSAC and other stakeholders are:
    1. Develop an action-oriented Central East LHIN Vascular Strategy with an implementation plan across Health Link Communities;
    2. Create greater access to culturally appropriate services within diabetes and vascular programs for Francophone, Indigenous populations, and new immigrants;
    3. Diabetes Education Programs and Centres for Complex Diabetes Care to continue enhanced linkages with other programs; and
    4. Cross-LHIN collaboration for stroke planning.

Questions?

Vascular Health Strategic Aim

Appendix 1

Additional Program Information

Background: Regional Cardiovascular Rehabilitation and Secondary Prevention (CRSP)

Program Description:

- CRSP program provides a regional integrated service utilizing referral criteria, centralized referral, acceptance and booking for patients with vascular disease (including those with diabetes, chronic renal disease, stroke, cardiac disease, congestive heart failure and peripheral vascular disease) who are at high risk for cardiovascular complications;
- CRSP is an evidence based strategy that has shown reduced morbidity and mortality related to cardiovascular disease; and
- CRSP is a multi- factorial, integrated secondary prevention program for all vascular patients, including coronary artery disease, congestive heart failure, peripheral vascular disease, non-disabling stroke and high risk persons with diabetes.

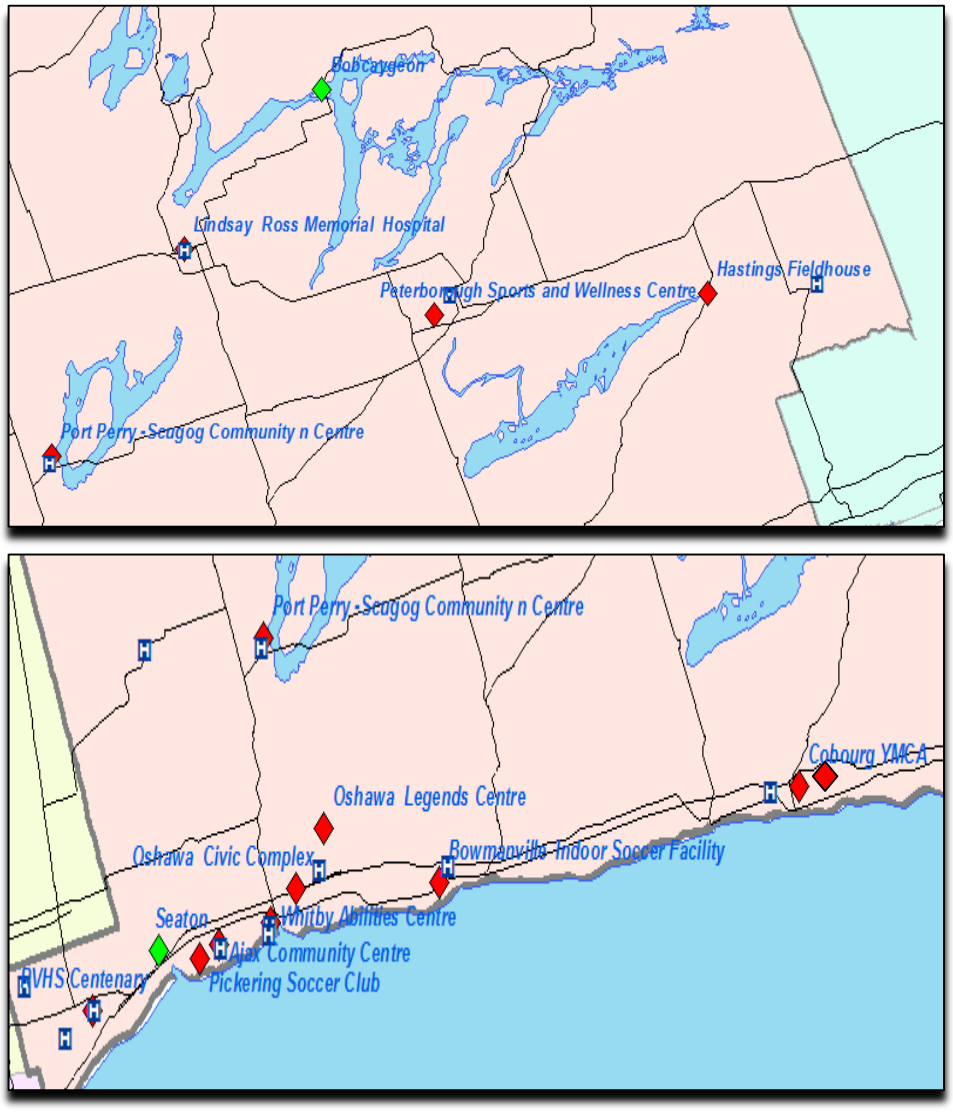
CRSP Regional Service Delivery Sites

13 CRSP Regional Community Sites:

- RVHS Centenary
- Pickering Soccer Club
- Ajax Community Centre
- Whitby Abilities Centre
- Oshawa Civic Complex
- Oshawa Legends Centre
- Port Perry -Scugog Community Centre
- Bowmanville Indoor Soccer Facility
- Lindsay Ross Memorial Hospital
- Peterborough Sports and Wellness Centre
- Campbellford Hastings Fieldhouse
- Cobourg YMCA
- Cobourg Community Centre

Future sites :

- Seaton
- Bobcaygeon



Background: Centralized Diabetes Intake (CDI)

Program Description: Centralized Diabetes Intake (CDI) provides accessibility to both health care providers and those living with or at risk of developing diabetes through a single phone call or faxed referral.

- Central East CCAC is the host agency for CDI, and the Care Coordinators assess for client eligibility and provide access to:
  - 18 Diabetes Education Programs (DEPs) and 3 Centres for Complex Diabetes Care (CCDC); and
  - Other Services: CRSP; Community Care Access Centre services; Community Support Services; Health Care Connect and the Central East Self-Management Program.

Background: Centre for Complex Diabetes Care (CCDC)

"This program I believe is vital to people. I believe that without it I would have been a lot worse off and maybe never have improved as much as I did. Also all aspects of the program are vital. The Social Worker helped tremendously in keeping everything together, Thank-you"

Program Description :

- CCDC is a program in the continuum of care for those patients living with **complex diabetes** for patients that need more contact, more resources and more follow-up across health care and social services systems;
- Focus on Self-Management and reduction of Emergency Department (ED) visits and hospitalizations;
- A shared model of care that includes an inter-professional team consisting of nurse practitioners, registered dietitians, social workers, registered nurses and pharmacists;
- Transition/discharge planning primary care providers and DEPs;
- The Central East CCDC care delivery sites at:
  - Lakeridge Health, Whitby
  - Peterborough Regional Health Centre
  - The Scarborough Hospital
- CCDC accountability is in the process of being transferred to the LHIN.

Background: Diabetes Education Programs (DEPs)

Program Description:

- Provide basic to intermediate level diabetes education and management services through a model that is needs-based and community-based;
- Develop a standard approach to care and management of diabetes, including screening, based on the current Canadian Diabetes Association's Clinical Practice Guidelines;
- Establish effective community-based approaches to prevent and manage diabetes-related complications; and
- DEPs are staffed by a multidisciplinary team of trained health professionals that includes, Registered Nurses and Registered Dieticians.

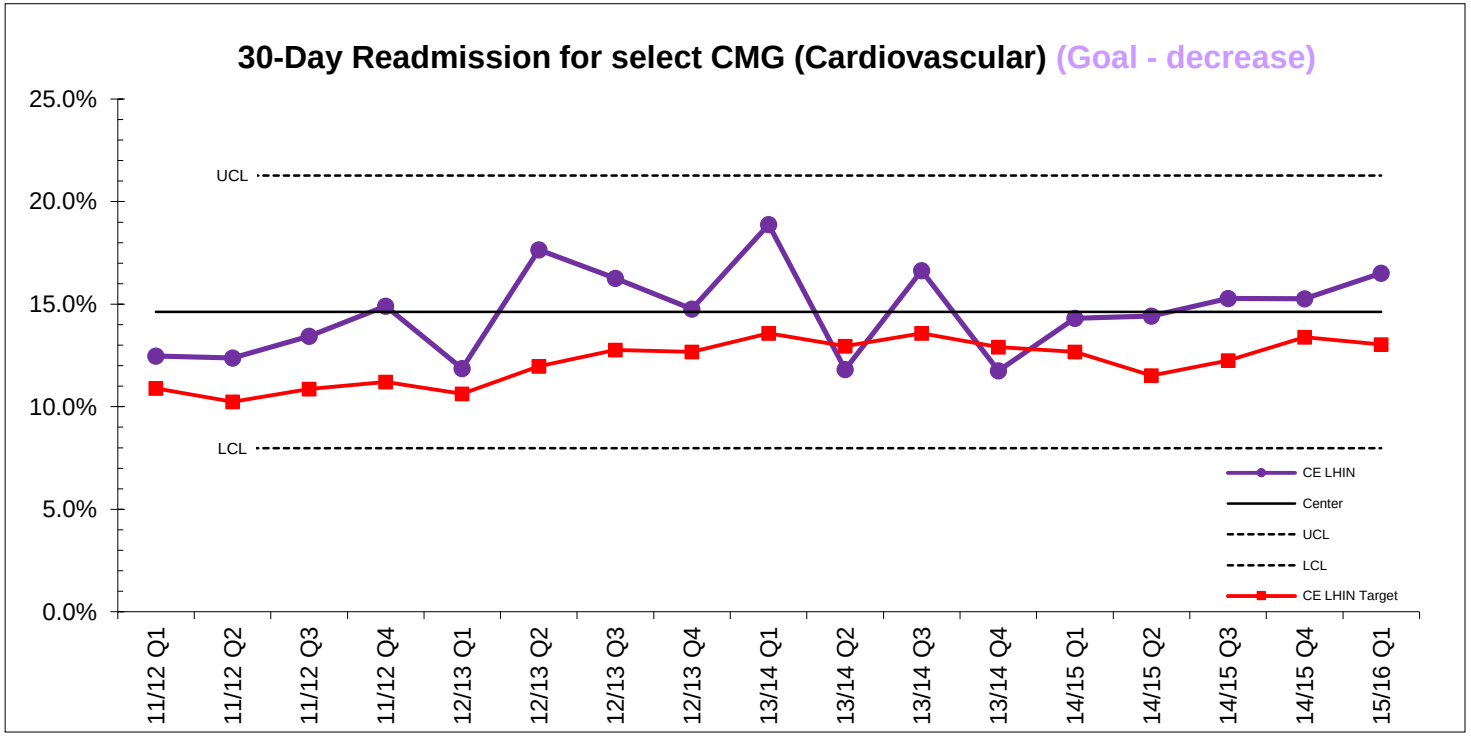
Telehomecare Patient Story

- One of our patient's primary caregivers is her ex-daughter-in-law. The caregiver was feeling burnt out, and trying to cope with the needs of the patient while working full time and raising her own child. She was initially reluctant about Telehomecare, thinking that it would be a burden on her already stretched time, adding yet another responsibility. Three weeks into the program, this caregiver cannot believe the positive results: she is learning about her mother-in-law's condition and now understands her symptoms, medications and what they are for; and she knows how to speak to the doctor in an informed manner. She is more confident in how to manage symptom exacerbations, making her better able to decide when to visit the doctor. Telehomecare has decreased her own stress she is less overwhelmed by the patient's needs: "I am a better caregiver".

- In addition, the caregiver's son has Asperger's Syndrome and is a technical whiz. He has become a diligent participant in the recording of health data, helping his grandmother use the tablet enter her readings. The routine has given him a meaningful role too.

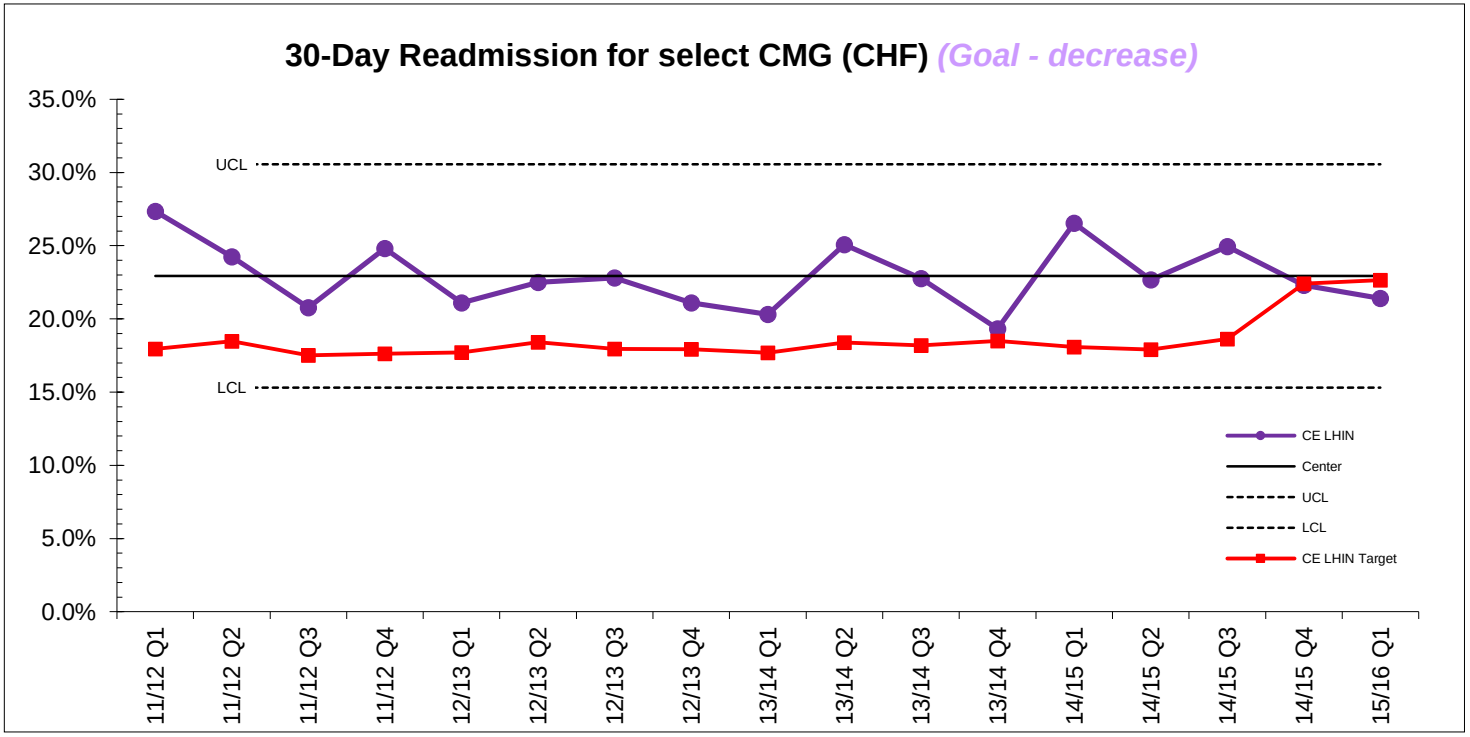
Appendix 2

Vascular Health Strategic Aim



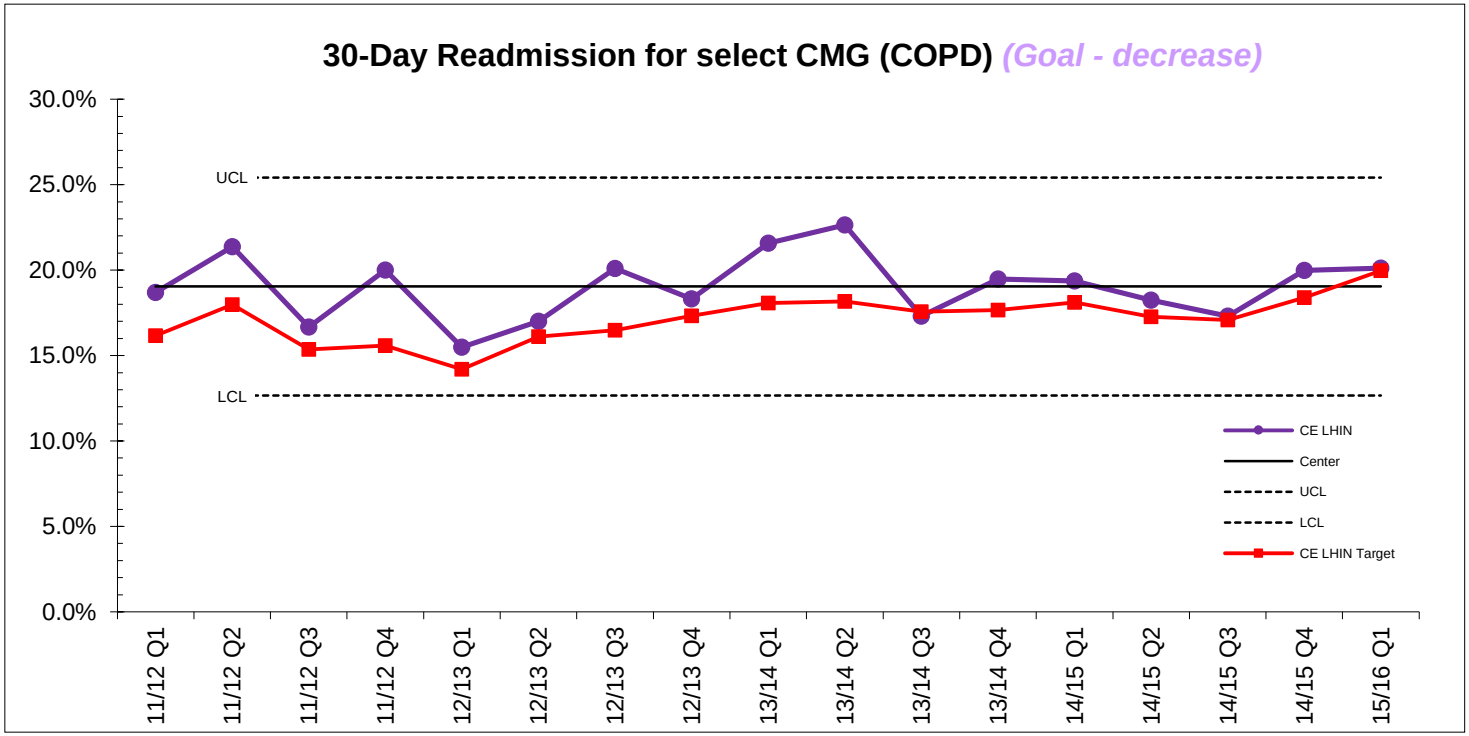
Analysis: Central East LHIN 30-day readmission for Cardiovascular CMG in Q1 2015/16 was slightly higher at 16.5% than the Expected Readmission Ratio of 13.0%. The focus of on going work within this sector will be on integration of services, linkages with Health Links and primary care to decrease re-admission rates.

Data Source: DAD, CIHI from MLPA Supplementary Data provided by MOHLTC



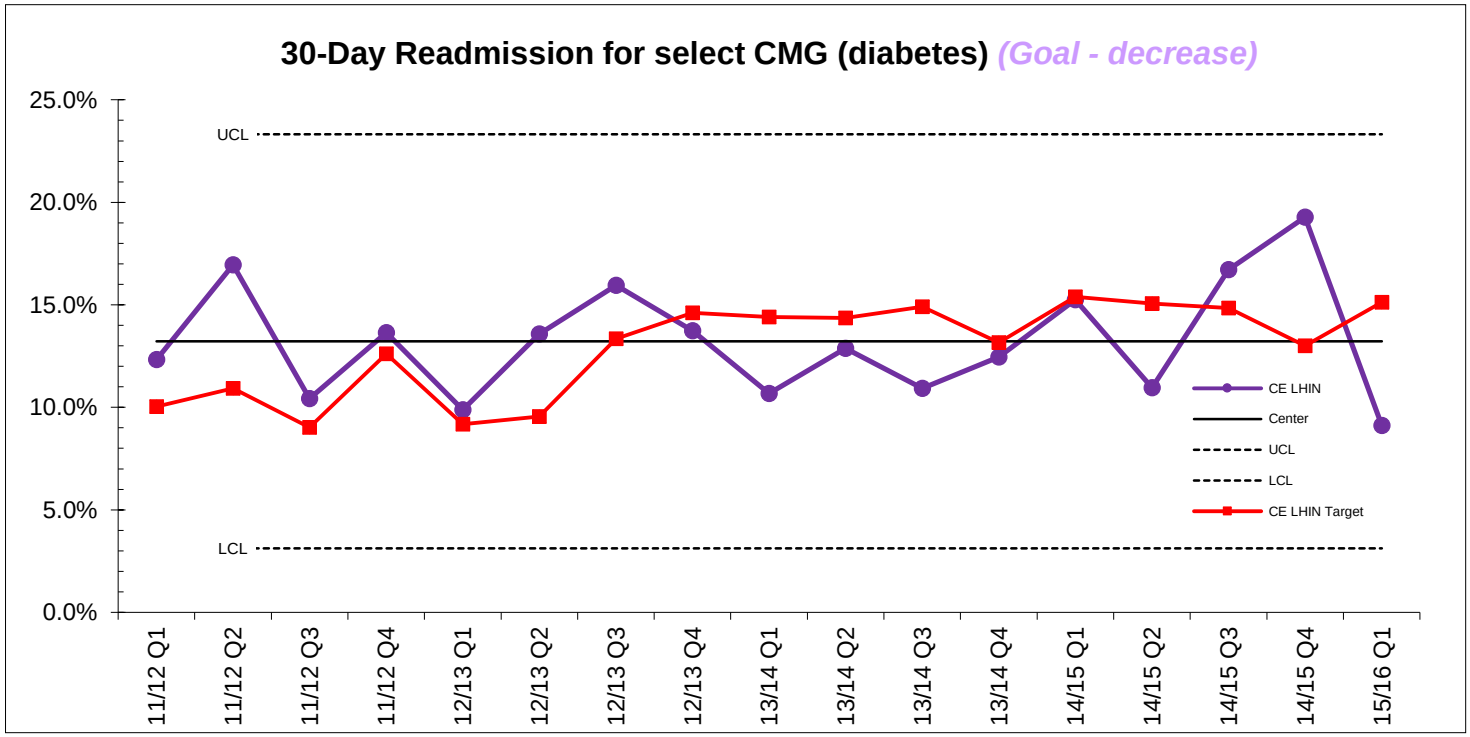
Analysis: Central East LHIN met and exceeded the Expected Readmission Ratio for CHF in Q1 2015/16. Currently, our rate is 21.4% for this select diagnosis. There has been increased awareness of other Heart Failure clinics in community and linkages with other Chronic Disease Management Groups.

Data Source: DAD, CIHI from MLPA Supplementary Data provided by MOHLTC



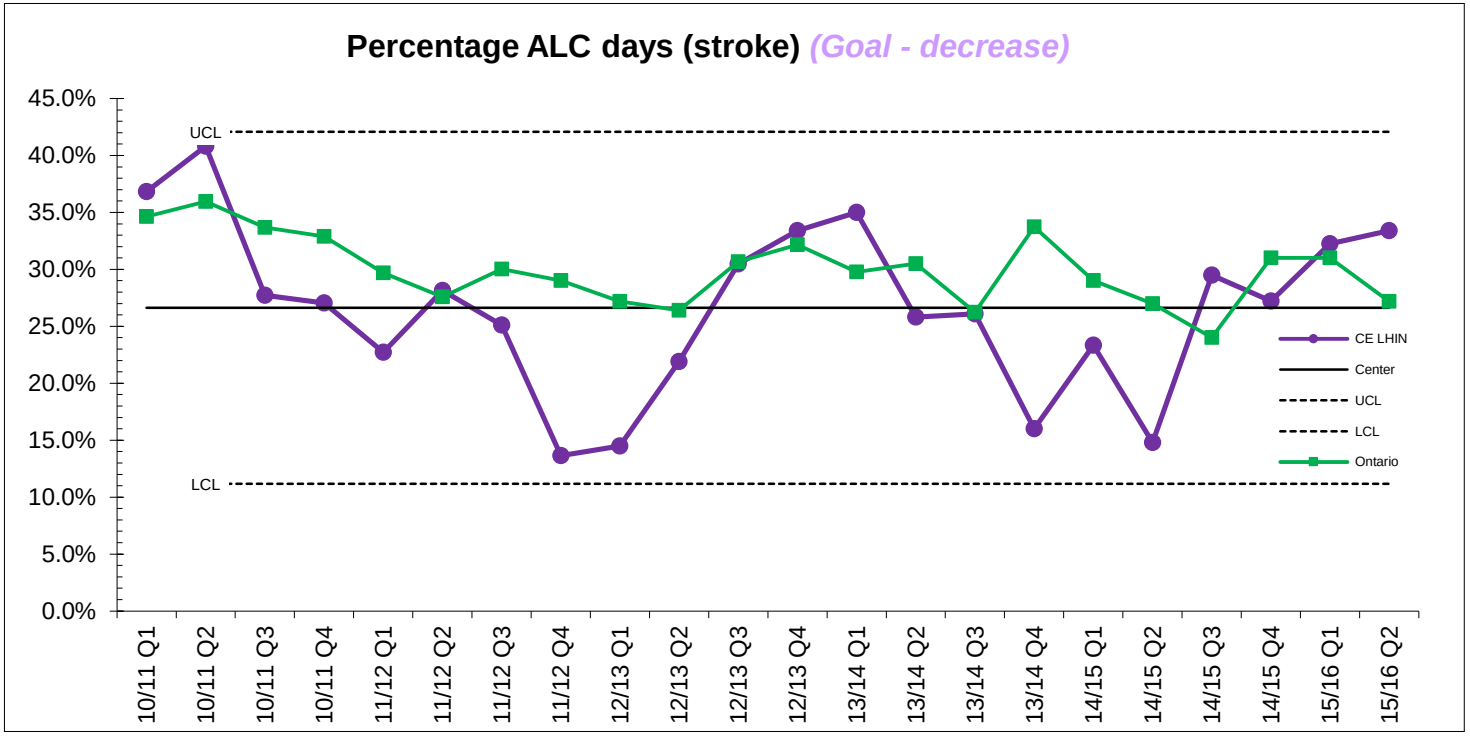
Analysis: The Central East LHIN 30-day readmission for COPD has remained constant in the last two quarters. In Q1 2015/16, Central East LHIN met the Expected Rate of Readmission for this select diagnosis. There are three COPD/Respiratory clinics within the Central East Region that manage the referrals from hospital to community.

Data Source: DAD, CIHI from MLPA Supplementary Data provided by MOHLTC



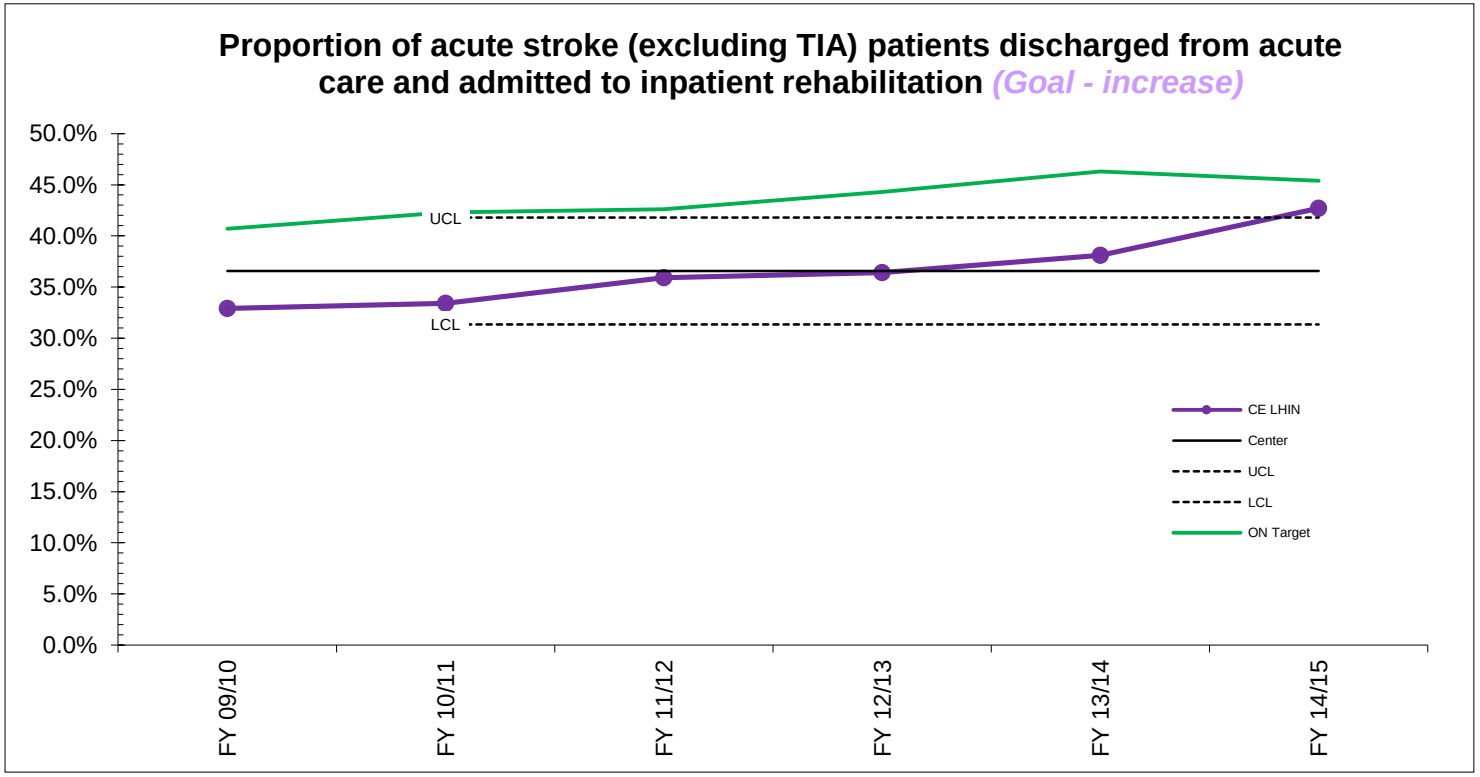
Analysis: The Central East LHIN Readmission rate for Diabetes has experienced a significant decrease in Q1 2015/16. Central East LHIN performance in Q1 2015/16 was 9.1% exceeding the target of 15.1% for Expected Rate of Readmission for Diabetes. Centres for Complex Diabetes Care opened at three separate sites across the LHIN to provide intensive support for patients with complex presentations and diabetes. Access to Centralized Diabetes Intake also provides support directly to the patient.

Data Source: DAD, CIHI from MLPA Supplementary Data provided by MOHLTC



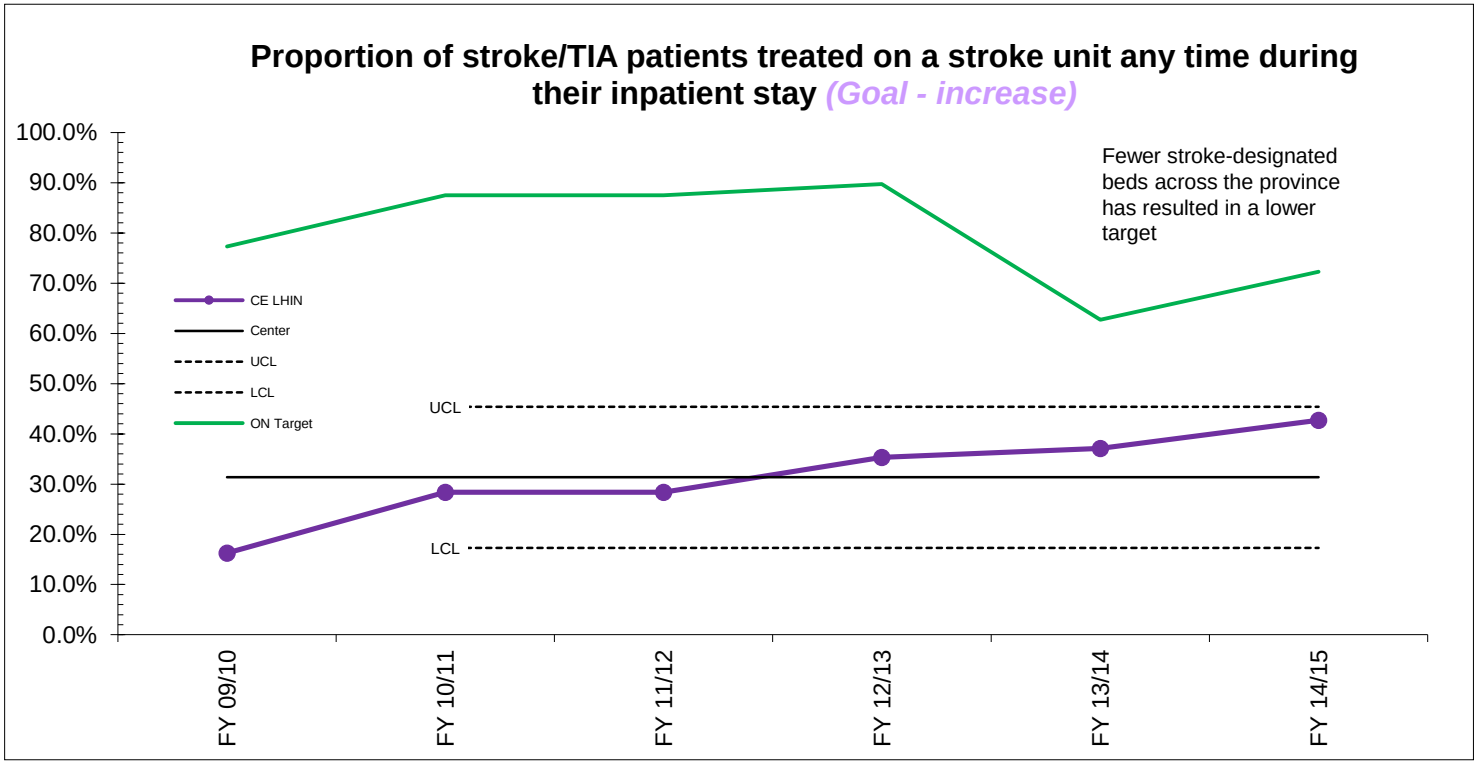
Analysis: Central East LHIN has seen an increase in Percentage ALC Days during the last two quarters for stroke patients. In Q2 2015/16, two corporations (three sites) contributed substantially to this increase. Results of the Central East LHIN ALC Strategy report will be reviewed.

Data Source: DAD, CIHI from IntelliHealth, MOHLTC



Analysis: Since FY 2009/10 there has been a gradual increase in proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation, from 32.9% to 42.7% in FY 2014/15. This may be partially due to improved coordination of data metrics to measure performance management of facilities referring to inpatient rehabilitation, and more admissions of clients to this level of care.

Data Source: Stroke Progress Report 2014/15 from the Canadian Stroke Network and Ontario Stroke Network



Analysis: Between FY 2012/13 and FY 2014/15 there has been a 7.4% increase in proportion of stroke or TIA patients treated on a stroke unit any time during their inpatient stay, from 35.3% to 42.7%. The creation of a unified stroke system was identified as a priority by the Vascular Aim Coalition. Increased coordination and communication among hospitals with a supporting MOU has resulted in enhanced utilization of stroke units, as demonstrated by this indicator.

Data Source: Stroke Progress Report 2014/15 from the Canadian Stroke Network and Ontario Stroke Network

Stroke Report Card Indicators

20 indicators comprise the report card:

- Divided into care continuum categories: Public awareness, prevention, acute management, rehabilitation, reintegration;
- Types of indicators: 12 facility-based, 8 population-based,75% process indicators, 3 HSAA indicators; and
- Population based indicators reflect the importance of system wide access, efficiency, effectiveness, and integration.

Provincial benchmarks:

- Calculated by achievable benchmark calculation (ABC) methodology;
- Enable comparison within and across LHINs; and
- Colour coded to indicate performance against benchmark.

Provincial, LHIN, sub-LHIN and facility level data available:

- Canadian Institute for Health Information; and
- NACRS, DAD and CIHI special projects.

Stroke Report Card FY 2014/15

- Poor performance
- Acceptable performance
- Exemplary performance
- Data not available or benchmark not available

Indicator No.	Care Continuum Category	Indicator[4]	LHIN FY 2014/15 (2013/14)	Variance Within LHIN[5] (Min–Max)
1	Public awareness and patient education	Proportion of stroke/TIA patients who arrived at the ED by ambulance.	59.0% (57.7%)	56.3–63.6%
2	Prevention of stroke	Annual age- and sex-adjusted inpatient admission rate for stroke/TIA (per 1,000 population).	1.2 (1.2)	1.3–1.5
3[§]	Prevention of stroke	Risk-adjusted stroke/TIA mortality rate at 30 days (per 100 patients).	11.7 (11.9)	5.1–22.0
4	Prevention of stroke	Proportion of ischemic stroke/TIA patients with atrial fibrillation prescribed or recommended anticoagulant therapy on discharge from acute care (excluding those with contraindications).	–	–
5	Prevention of stroke	Proportion of ischemic stroke inpatients who received carotid imaging.	70.8% (72.5%)	7.7–88.1%
6	Acute stroke management	Median door-to-needle time among patients who received acute thrombolytic therapy (tPA) (minutes).	68.0 (58.0)	57.0–250.0
7[§]	Acute stroke management	Proportion of ischemic stroke patients who received acute thrombolytic therapy (tPA).	12.0% (12.6%)	8.8–16.4%
8[§]	Acute stroke management	Proportion of stroke/TIA patients treated on a stroke unit[8] at any time during their inpatient stay.	42.7% (37.1%)	31.6–50.4%
9	Acute stroke management	Proportion of stroke (excluding TIA) patients with a documented initial dysphagia screening performed during admission to acute care.	–	–
10[§]	Acute stroke management	Proportion of ALC days to total length of stay in acute care.	20.2% (31.4%)	0.0–56.4%
11[§]	Acute stroke management	Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation.	42.7% (38.1%)	36.9–47.2%
12	Stroke rehabilitation	Proportion of stroke (excluding TIA) patients discharged from acute care who received a referral for outpatient rehabilitation.	–	–
13[§]	Stroke rehabilitation	Median number of days between stroke (excluding TIA) onset and admission to stroke inpatient rehabilitation.	6.0 (6.0)	5.0 - 9.0
14	Stroke rehabilitation	Mean number of minutes per day of direct therapy that inpatient stroke rehabilitation patients received.	–	–
15[§]	Stroke rehabilitation	Proportion of inpatient stroke rehabilitation patients achieving RPG active length of stay target.	71.3% (61.8%)	41.9–79.3%
16	Stroke rehabilitation	Median FIM efficiency for moderate stroke in inpatient rehabilitation.	1.4 (1.2)	0.9–1.8
17	Stroke rehabilitation	Mean number of CCAC visits provided to stroke patients on discharge from inpatient acute care or inpatient rehabilitation in 2013/14-2014/15.	6.7 (5.5)	–
18	Stroke rehabilitation	Proportion of patients admitted to inpatient rehabilitation with severe strokes (RPG = 1100 or 1110).	52.9% (46.9%)	36.7–59.9%
19[§]	Reintegration	Proportion of stroke/TIA patients discharged from acute care to LTC/CCC (excluding patients originating from LTC/CCC).	6.9% (8.1%)	3.2–11.7%
20[§]	Reintegration	Age- and sex-adjusted readmission rate at 30 days for patients with stroke/TIA for all diagnoses (per 100 patients).	7.9 (7.8)	0.0–12.7

Stroke Progress Report Card for the Central East LHIN

Indicator No.	Care Continuum Category	Indicator[4]	LHIN FY 2014/15 (previous 3-year average)	Variance within LHIN[5] 2014/15 (2011/12)		Greatest Improvement[6]	
				Min	Max	Sub-LHIN/Facility	LHIN
1	Public awareness and patient education	Proportion of stroke/TIA patients who arrived at the ED by ambulance.	59.0% (58.4%)	56.3% (54.7%)	63.6% (60.8%)	Woodbridge (Vaughan) Sub-LHIN	3
2	Prevention of stroke	Annual age- and sex-adjusted inpatient admission rate for stroke/TIA (per 1,000 population).	1.2 (1.2)	1.3 (1.2)	1.5 (1.4)	Algoma Sub-LHIN	None
3[§]	Prevention of stroke	Risk-adjusted stroke/TIA mortality rate at 30 days (per 100 patients).	11.7 (11.5)	5.1 (6.4)	22.0 (26.9)	North Bay Regional Health Centre	6, 2
4	Prevention of stroke	Proportion of ischemic stroke/TIA patients with atrial fibrillation prescribed or recommended anticoagulant therapy on discharge from acute care (excluding those with contraindications).	–	–	–	–	–
5	Prevention of stroke	Proportion of ischemic stroke inpatients who received carotid imaging.	70.8% (68.8%)	7.7% (11.1%)	88.1% (86.0%)	Brockville General Hospital	2, 12
6	Acute stroke management	Median door-to-needle time among patients who received acute thrombolytic therapy (tPA) (minutes).	68.0 (61.4[†])	57.0 (59.1[†])	250.0 (66.0[†])	Royal Victoria Regional Health Centre	12
7[§]	Acute stroke management	Proportion of ischemic stroke patients who received acute thrombolytic therapy (tPA).	12.0% (12.9%[†])	8.8% (10.0%[†])	16.4% (15.0%[†])	Flamborough Sub-LHIN	2, 6
8[§]	Acute stroke management	Proportion of stroke/TIA patients treated on a stroke unit[7] at any time during their inpatient stay.	42.7% (35.3%)	31.6% (15.9%)	50.4% (46.0%)	Belleville Sub-LHIN	10, 3
9	Acute stroke management	Proportion of stroke (excluding TIA) patients with a documented initial dysphagia screening performed during admission to acute care.	–	–	–	–	–
10[§]	Acute stroke management	Proportion of ALC days to total length of stay in acute care.	20.2% (26.8%)	0.0% (0.0%)	56.4% (42.6%)	Rouge Valley Health System, Ajax	None
11[§]	Acute stroke management	Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation.	42.7% (37.2%)	36.9% (25.6%)	47.2% (45.4%)	Central York Region Sub-LHIN	8, 5
12	Stroke rehabilitation	Proportion of stroke (excluding TIA) patients discharged from acute care who received a referral for outpatient rehabilitation.	–	–	–	–	–
13[§]	Stroke rehabilitation	Median number of days between stroke (excluding TIA) onset and admission to stroke inpatient rehabilitation.	6.0 (7.0)	5.0 (5.0)	9.0 (15.0)	Grand River Hospital Corp., Freeport, and Hamilton Health Sciences Corp., General Regional Rehab	8, 3
14	Stroke rehabilitation	Mean number of minutes per day of direct therapy that inpatient stroke rehabilitation patients received.	–	–	–	–	–
15[§]	Stroke rehabilitation	Proportion of inpatient stroke rehabilitation patients achieving RPG active length of stay target.	71.3% (59.9%)	41.9% (50.0%)	79.3% (95.2%)	Bruyère Continuing Care Inc.	3, 8
16	Stroke rehabilitation	Median FIM efficiency for moderate stroke in inpatient rehabilitation.	1.4 (1.1)	0.9 (0.9)	1.8 (1.6)	Grand River Hospital Corp., Freeport	3, 12
17	Stroke rehabilitation	Mean number of CCAC visits provided to stroke patients on discharge from inpatient acute care or inpatient rehabilitation in 2013/14-2014/15.	6.7 (5.6)	–	–	North East CCAC	13, 6
18	Stroke rehabilitation	Proportion of patients admitted to inpatient rehabilitation with severe strokes (RPG = 1100 or 1110).	52.9% (44.3%)	36.7% (15.6%)	59.9% (57.1%)	Providence Healthcare	8, 5
19[§]	Reintegration	Proportion of stroke/TIA patients discharged from acute care to LTC/CCC (excluding patients originating from LTC/CCC).	6.9% (7.3%)	3.2% (3.9%)	11.7% (9.9%)	Dufferin County Sub-LHIN	3, 6, 10
20[§]	Reintegration	Age- and sex-adjusted readmission rate at 30 days for patients with stroke/TIA for all diagnoses (per 100 patients).	7.9 (8.2)	0.0 (0.0)	12.7 (23.3)	Peterborough Regional Health Centre	None

[1] Statistically significant improvement.
[2] Performance improving but not statistically significant.
[3] No change or performance decline.
[4] Facility-based analysis (excluding Indicators 1, 2, 7, 8, 11, 12 and 19) for patients aged 18+108. Indicators are based on CIHI data unless otherwise specified. Low rates are desired for Indicators 2, 3, 6, 10, 13, 19 and 20.

Hospital Service Accountability Agreement Indicators, 2010/11
– Data not available n/a = Not applicable [§] = Contribute to QBP performance

- Progressing very well
- Progressing
- Not progressing
- Data not available or benchmark not available

Key Messages

The 2014/15 Stroke Report Card and Stroke Progress Report show ongoing progress in Central East LHIN for key performance indicators:

- In comparison to other LHINs, Central East LHIN had an "exemplary performance" in four indicators measuring above provincial benchmark in the following categories: prevention of stroke, acute stroke management, and stroke rehabilitation;
- "Poor performance" in indicators relating to acute stroke management and reintegration;
- Significant improvement in 7 of 16 indicators, and progress continues in 5 of 16 indicators in year over year comparison from 2011/12 to 2014/15; and
- No change or decline in performance for 4 of 16 indicators from 2011/12 to 2014/15.