Central East Local Health Integration Network
CEO Report to the Board
September 22, 2010

The following is a compilation of some of the major activities/events undertaken during the month of May in support of the Central East LHIN's Strategic Directions; a) Transformational Leadership, b) Quality and Safety, c) Service and System Integration, and d) Fiscal Responsibility. The Central East LHIN is beginning to work towards achieving the Strategic Aims of the 2010-2013 IHSP; 1. Save a Million Hours of Time Patients Spend in the Emergency Departments by 2013 and, 2. Reduce the Impact of Vascular Disease by 10% by 2013 (2010-2013 IHSP).

Transformational Leadership: The LHIN Organization will demonstrate accountability and systems-thinking in all decision-making and leadership actions, reward innovation which is aligned with the IHSP and model fair, transparent, and honest interaction with one another and with Health Service Providers.

Service and System Integration/Quality and Safety: The LHIN Organization will create an integrated system of care that is easily accessed, sustainable and achieves good outcomes. Healthcare will be people-centred in safe environments of quality care.

Stocktake Report: A new Stocktake report, now including all MLPA indicators was compiled and submitted to the Ministry on August 27. This is in preparation for the joint LHIN peer meeting on September 15 involving all LHINs.

Underperformance:

- 90th Percentile ER Length of Stay (LOS) for Admitted Patients
- 90th Percentile ER LOS for Non-Admitted Complex Patients
- % ALC Days
- % Repeat unplanned emergency visits within 30 days for Mental Health Conditions
- % Repeat unplanned emergency visits within 30 days for Substance Abuse Conditions
- Cataract—90th Percentile Wait Time
- Hip—90th Percentile Wait Time
- MRI Scan—90th Percentile Wait Time

Good or Best Performance:

- 90th Percentile ER LOS for Non-Admitted Minor Uncomplicated Patients
- Proportion of admitted high acuity patients treated within 8 hours
- Proportion of non-admitted high acuity (CTAS I-III) patients treated within 8 hours
- Proportion of non-admitted low acuity (CTAS IV-V) patients treated within 4 hours
- Time to Physician Initial Assessment*
- Readmission within 30 days for Selected CMG's
- Cancer—90th Percentile Wait Time*
- Cardiac—90th Percentile Wait Time
- Knee—90th Percentile Wait Time
- CT Scan—90th Percentile Wait Time

Management will provide a complete Stocktake Report to the Board at the October meeting.

Save A Million Hours of Time Spent in the ER Department.

ED/ALC Hospital Senior Leadership Meetings: During the months of August and September, the CE LHIN Senior Team meet individually with the senior leadership of each CE LHIN Hospital. Hospitals representatives at the meetings were CEOs, Chief Financial Officers, Vice Presidents of nursing and clinical programs, and ED Directors. Each meeting lasted two to three hours, and provided an opportunity to

- Review knowledge and process of the upcoming HSAA
- Share the MPLA performance areas and specific targets
- Review current ED/ALC initiatives by hospital and for the entire LHIN
- Explore new or expanded opportunities to meet our Strategic Aims and meet our MLPA obligations.

The outcomes of these meetings were extremely positive for all parties. Hospitals identified new opportunities to help reduce ALC, and identified mechanisms to help the LHIN achieve its MLPA obligations. There was strong confirmation and support of our AAH and ED strategies, specifically on the implementation of GAIN and Home First. The meetings also provided a forum to identify a LHIN-wide integration opportunity on data sharing and decision support. Based on the success of these meetings, all parties agreed to conduct them on a regular basis.

ED Pay for Results (P4R) 2010: Funding letters were received for Pay for Results (P4R) fixed funding (FY2010) and P4R Variable funding (Q1). Letters are being drafted for respective hospitals and ED/ALC Strategy meetings are being held with each hospital throughout the months of August and September.

The August P4R report is due to the Ministry on September 28. Three hospitals have submitted change request forms to re-allocate P4R funds. These requests are currently under review by CE LHIN staff. A Home First outcomes dashboard has been developed for Lakeridge Health Corporation. A Home First process dashboard is also in the development stage. Weekly meetings of the implementation team will be held throughout the month of October.

Aging at Home Strategy – Year 3: In July the recent Toronto Central LHIN Peer Support Process required extensive staff resources until the final report submission on July 30. Following an August 4 teleconference with the Ministry further effort was expended in developing, within very short turn-around times, revised Detailed Service Plans for Year 3 funded services. Funding approval was received, on a one time basis, for the Geriatric Assessment and Intervention Network (GAIN), Home First and four smaller projects/services. A full update is to be provided at the September 22, 2010 CE LHIN Board Meeting

The AAH Enhanced Bed Capacity Detailed Service Plans have taken longer to complete due to the complexities inherent in the bed reconfiguration processes both at Peterborough Regional Health Centre and Northumberland Hills Hospital, along with the need to coordinate some bed approvals with the Long-Term Care Compliance Branch of the Ministry. Details outlined are outlined below:

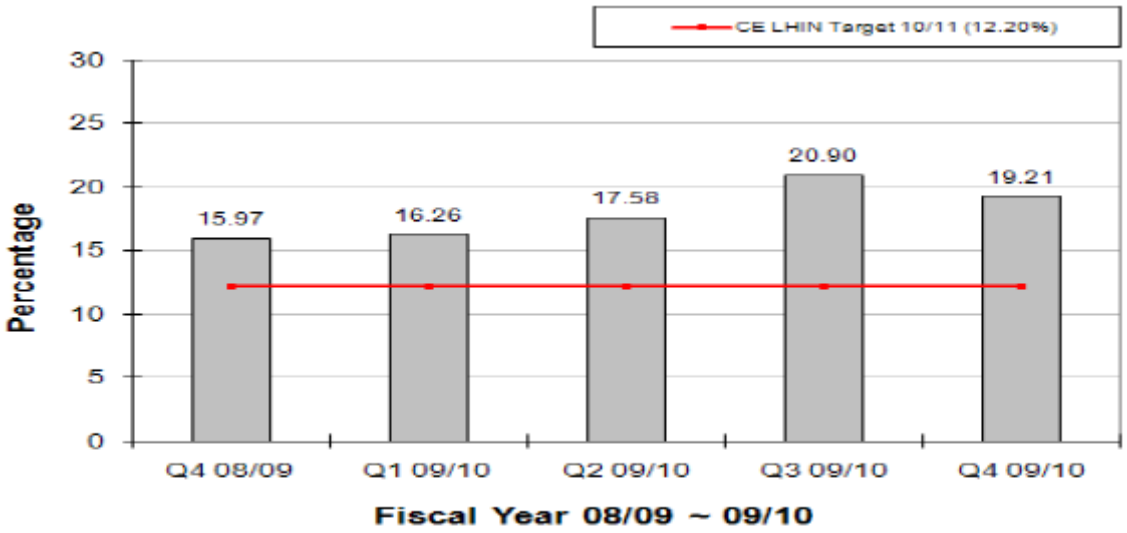
- Northumberland Hills Hospital: Eight restorative care beds. Submitted at the end of August, and approved on Sept 7. 2010
- Strathaven Lifecare Centre in Bowmanville: Fifteen convalescent care beds. Recent communications with the Ministry and with the Compliance Branch, have indicated that funding approvals for these respective projects is forthcoming.
- Peterborough Regional Health Centre: Twelve Inpatient Rehab beds and seven interim Long-Term Care Beds. Submitted to the Ministry on Sept 10

Efforts to expedite the development of four geriatric urgent/emergent clinics Geriatric Assessment and Intervention Network (GAIN) have been initiated. A new project governance structure has been implemented including an overarching Steering Committee, an Implementation Team and working groups at each of the four hospital sites where a clinic is to be located (PRHC, TSH, LHC and RVHS). The Steering Committee has met several times which included

Vice Presidents from each hospital and the CCAC. Recruitment has been initiated for a project manager, administrative support and a Program Director. The first clinic to open will be at Lakeridge Heath Corporation in October.

Implementation planning for Home First continued throughout July and August despite not having assurances for funding. Again, there is a Steering Committee and an Implementation Team. A soft launch of the initiative occurred on August 23 with full launch on September 7. A two week 1A Priority period generated over two dozen placements of existing patients at Lakeridge Health Corporation designated as Alternative Level of Care and waiting placement into Long Term Care. Education of hospital and CCAC staff was intensive and communication strategies have been implemented. Discussions with physicians have also been undertaken. A team has been assembled to examine the root causes of all future ALC designations. Early results are encouraging: As of September 2, LHC reported its lowest daily ALC census for patients waiting for Long-Term Care since April 2010. During that period there were as many as 189 clients waiting for LTC, whereas on September the number of clients were 139.

While still far from the CE LHIN MLPA Target of 12.2% ALC, rates did decrease by 1.69% in the Fourth Quarter of 2010-11. This rate of decrease was the greatest of any other LHIN in the same period. During the same period, the provincial % ALC increased by 1.23%.



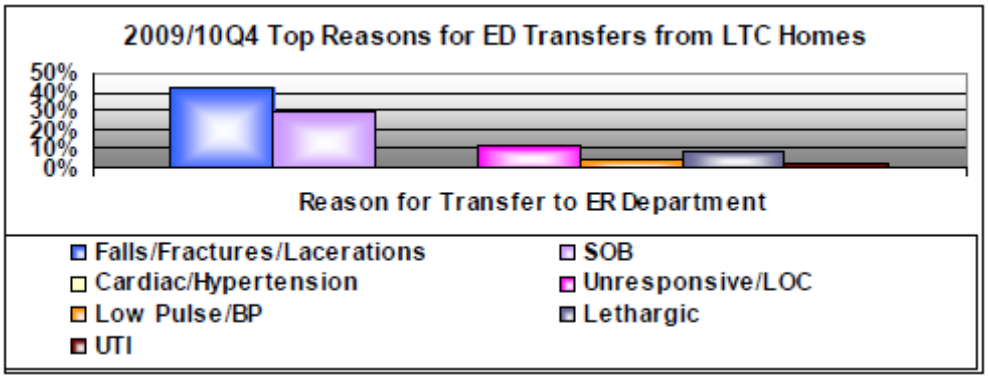
(Data Source: CIHI-DAD)

Nurse Practitioner Supporting Teams Averting Transfers (NPSTAT) from Long-Term Care: CE LHIN is gathering data from both the Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) teams and from all Long Term Care Homes (LTCH) in the LHIN. Currently, there is one Ministry funded team of 3 NP's at the CE CCAC and two additional teams (4 additional NP's), as well as a newly created position of NP Clinical Director to provide program and clinical oversight to the CE LHIN program. Of the 70 LTCH in the CE LHIN, 22 LTCH have signed a Memorandum of Understanding with respect to the NPSTAT Initiative.

As of 2010/11 Q1, there were a reported 316 NPSTAT encounters. Of the total, 68% were acute (residents seen who are classified as "Preventative Care", and "Definite + Probable" ED Diversions) and 32% non-acute (non-acute resident care provision & supportive activities). An ED diversion rate = 93% as of the first fiscal quarter. For July 2010, the NPSTAT ED Diversion Rate % = 95.7% with a Total Number of Diverted Transfers by CE LHIN = 133. . The Total ED hours saved for the same month = 467 hours in CE LHIN which is conservative as calculations are based on average length of stay (LOS) of all patients, not just the frail and elderly. Based on the number of NPSTAT encounters, uptake to

the program is growing and this should only result in greater care for LTCH residents and reducing avoidable transfers to the hospital ED.

The NPSTAT data collection includes primary reasons for transfers in subsequent Stocktake reports. As part of our renewed commitment to Quality Improvement and Evaluation, an in-depth data collection and monitoring tool and process has been set up (including the measurement of NP encounters by CTAS level) starting in Q2. Work continues to build an evaluation framework based on Triple Aim (at this point, efforts are on the implementation phase). Next steps will include improved engagement for participating homes and soliciting further involvement from others.



The Nurse Practitioner Supporting Teams Averting Transfers (NPSTAT) Steering Committee has initiated detailed monthly reporting at a meeting held in August. An expression of interest document has been drafted, approved and posted to seek additional members for the Steering Committee.

Community Care Access Centre CCAC: Several meetings have transpired with the CECCAC as we work with them to develop a dataset that will assist both the CE LHIN and the CECCAC in our monitoring processes. The dataset will provide monthly reports on LTC applications, demand and placement, Home care services by type, Service Maximum / Exceptional Support Clients – those clients receiving additional home care supports as part of ALC strategy, Palliative Care Services and ED Diversion. These reports are now becoming available to the CE LHIN and while further refinement will occur, the reports will be utilized to assist in understanding the activities of the CECCAC and interfacing with the hospital, community and LTCH sectors.

Community Care Access Centres (CCAC) Service Maximums Funding: In support of our ED/ALC initiatives such as Home First, the MOHLTC has provided the CE LHIN with $11,103,100 in cumulative base funding for 2010/11 to support the increase in service maximums for home care personal support and homemaking services in Community Care Access Centres. This allocation is to support targeted persons with high levels of need to remain at home, or return safely home from hospital while they recover or wait for Long-Term Care placement. Incremental services are being targeted and tracked through the new reporting structure noted above.

Reducing the Impact of Vascular Disease by 10% (2010-2013 IHSP):

Vascular Strategic Aim:
A draft Vascular Health Strategy was developed for discussion on Sept 3 with Vascular Health Strategic Aim Coalition. Helen Brenner, VP Northumberland Hills Hospital and Dr. Andrew Steele, Nephrologist, Lakeridge Healthcare Corporation have been appointed as the first Co-Chairs of the Vascular Health Strategic Aim Coalition. Two sub-committees have been formed to review the draft strategy and make recommendations with regard to proposed activities and initiatives to move toward achievement of the Aim. With the support of the Primary Care Working Group and the Health Professionals Advisory Committee the Coalition took initial steps toward design of an in-hospital Smoking Cessation initiative based on the model developed by the Ottawa Heart Institute.

Did you know… The Alignment of our Vascular and ED/ALC Aims – A major component of the CE LHIN ALC strategy is the investment in expanding capacity to hospital based restorative care services that aim to enhance patient rehabilitation. This expansion will ensure they can return safely to home and possibly prevent further institutionalization. The CE LHIN has invested in these types of resources at Northumberland Hills Hospital and PRHC, and considering other opportunities at RVHS. In the RVHS example, the target client population for its proposed restorative care program is 29% of all medicine and cardiology patients. These patients have CMGs related to vascular conditions. Fifty percent of this patient group's Length of Stay is comprised as ALC. So by improving patient rehabilitation and reducing ALC, we are also reducing the burden of vascular disease on patients and the health system.

Diabetes – Call for Proposals for Centres for Complex Diabetes Care (CCDC): The MOHLTC is establishing CCDCs to address the needs of individuals with diabetes who have complex health requirements. These centres will work directly with an individual's primary care provider and will be a single point of access to specialized inter-professional teams. The ministry has identified the CE LHIN during this first call for proposals based on analysis of prevalence, complexity of the individuals to be served and service availability. Health service providers in the CE LHIN area were encouraged to submit proposals through the Stand Up to Diabetes website at: www.ontario.ca/diabetes

The CE LHIN supported the Regional Coordinating Centre in planning and facilitating of a multi- proponent meeting. The targeted outcome was a consensus to develop an over-arching cover letter/submission to which all members would contribute. There was agreement that a CE LHIN level strategy/proposal would have been ideal, however, timing and complexity of assembling such a proposal was not available (Provincial Call 4 weeks). Many of applicants and proposals were previously well known and supported by the CE LHIN staff. There is no further information on timing of announcements of successful applications.

The **CE LHIN Living Well with Diabetes Resource Guide** was recently translated into Tamil and Cantonese. The document is now available in French, English, Tamil and Cantonese and has also been marketed to address the Chronic Kidney Disease audience.

As part of the Ontario Diabetes Strategy (ODS) a Self Management provincial working group has been formed. Margery Konan from the CECCAC is the CE LHIN representative on this group which is advising the Ministry on the provincial strategy for Self Management.

Chronic Kidney Disease/Renal: Jay Wilson from The Scarborough Hospital has been appointed as the Regional Administrative Lead for the Ontario Renal Network (ORN). Jay will continue to support the CE LHIN Renal Network and its partners. The final versions of the CE LHIN Renal Chronic Disease Prevention and Management Promising Practices report and Practitioners Field Guide have been developed. Both are currently posted on the ORN and the CE LHIN web-sites. A Home Hemodialysis program has been approved by the ORN for the Peterborough Regional Dialysis program – this is one of the objectives identified by the CE LHIN Renal Network. CE LHIN staff participated in an orientation regarding the new provincial framework. A formal consultation and launch will be conducted by the Ministry in the coming months.

Diabetes Indicator Project: The evaluation report for this project is in review by the project group and further development of documentation and reports are being supported by eHealth. Discussion of the indicator project is planned with LHIN and Ministry of Health Diabetes Strategy staff and material has been provided by eHealth in preparation for a demonstration meeting in September.

Cardiac Integration: Contact with all Cardiac Stakeholders within the CE LHIN is underway. The Cardiac Integration Steering Committee met on August 18, 2010 and is in the process of finalizing their Terms of Reference. The Rouge Valley Health System (RVHS) Code STEMI (Segment Elevation Myocardial Infarction) expanded to the Durham Region. RVHS and Lakeridge Health Corporation (LHC) Cardiac Rehab services are looking at integration opportunities.

The CE LHIN Cardiac Integration consultant will be sitting on the RVHS/LHC Rehab Integration Committee Meetings, to oversee and support cardiac integration initiatives.

The CE LHIN is currently awaiting approval from the Ministry on PRHC Percutaneous Coronary Intervention (PCI) services.

Focus on Population Health

Investment Reaction Model (IRM): The Terms of Reference for this joint Ministry and CE LHIN initiative have been finalized. The CE LHIN was selected as the provincial test site for development of the provincial model. The outcome of the IRM project is to provide a model and methodology for assessing the probable impact of policy changes and funding investments on the ability of patients to 'flow' through the system of care within a LHIN. This project is being lead by the Centre for Healthcare Engineering Research from the University of Toronto. A call for applications for three expert panels in Acute, Community and Institutional (LTC, CCC) has gone to all Health Service Providers in the CE LHIN with a response requested by Sept 14. First meetings are targeted for October with completion of the work in January 2011.

Aboriginal Engagement: The CE LHIN staff has been working towards an event to celebrate the creation and signing of the Terms of Reference of our two aboriginal circles (First Nation and Métis, Non-Status and Inuit). A small planning group meeting was held on September 7 and a date has been chosen for September 30 at 1:30pm at Alderville First Nation Community Centre. The planning group has prepared a very exciting event, "A Celebration of Partnership", to appropriately mark this significant milestone. Foster, James and I will participate in the ceremonial signing of the terms of reference that will include drums and dancers. The invitation to this historical event has been sent to all of our government stakeholders, our hospital CEOs and chairs and many individuals associated with our First Nation and Métis partners.

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Focus on Accessible Health Care

Primary Care: Expansion of Nurse Practitioner-led clinics and Family Health Teams: At the request of the Ministry the CE LHIN, in conjunction with volunteer members of the Primary Care Working Group, this summer our team reviewed NP clinic and FHT applications and provided criteria-based recommendations to the MOHLTC. At the end of August the Minister announced fourteen (14) new Nurse Practitioner-led clinics and 30 new Family Health Teams are being created throughout the province. In the CE LHIN area we have been allocated two new Nurse Practitioner-led clinics in Peterborough and Scarborough, and three new Family Health Teams in Port Perry, Cobourg and Scarborough. These welcome additions will play an important role in supporting patients so that they do not have to go to emergency departments and in reducing the impact of vascular health. The CE LHIN issued a news release on August 25, 2010 which is posted on our website to alert our stakeholders to these recent announcements. For more information see Appendix A.

Primary Care – Timely Discharge Information Systems (TDIS): The project objective is to establish a system to provide discharge information from hospitals to family physicians in a timely manner. TDIS Phase 1 will move forward with those sites that have signed the current Master Hosting Agreement which are Lakeridge Health Corporation (LHC – is the system host), Toronto Scarborough Hospital, Peterborough Regional Health Centre, Rouge Valley Hospital. The Consultant Project Manager and LHC Project Lead will continue to meet with clinics and vendors to bring more physicians on line. The eHealth team is working to document the process and identify new physicians. The project team met with Campbellford and Northumberland CEOs to activate their connections.

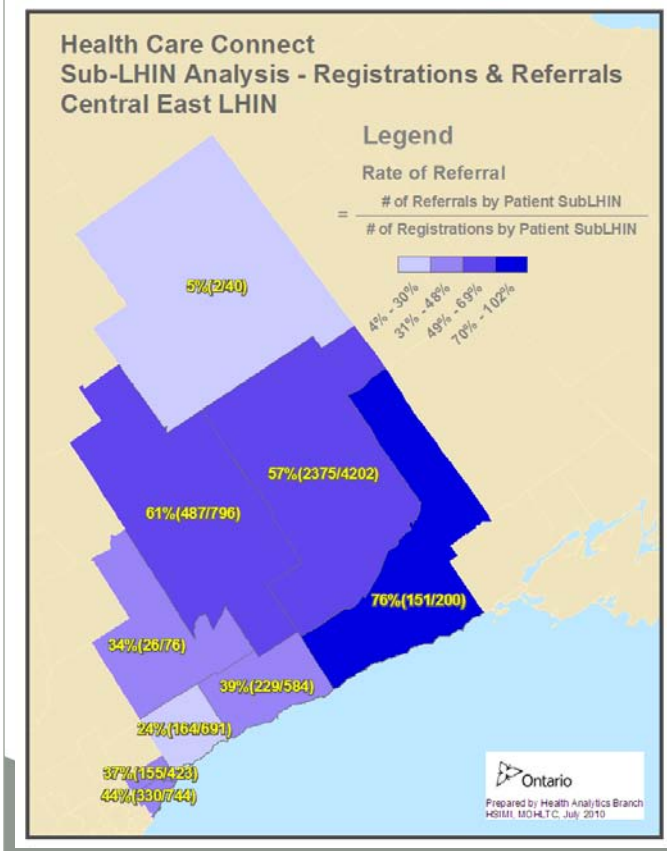
The TDIS Phase 2 goal is to expand TDIS to additional hospitals and determine further use of the application (additional documentation, etc). Funding has been approved through Connecting GTA (cGTA). Current activities include confirmation on the transfer payment agency and a Request for Service to acquire a project manager.

eReferral - Primary Care to Specialty: The eReferral project will provide an automated referral system from primary care physicians to a specialist and/or to specialty services. The project is a collaboration between the CE LHIN and the South East LHIN. Vendor selection and negotiations have been completed, selecting Navantis Inc. as the vendor to develop the Referral application. Initial data gathering workshops have been undertaken in order to complete the system requirements documentation for October. There are two pathways for the pilot: the SE LHIN has chosen 'surgical referrals for total joint replacement', and CE LHIN has chosen Mental Health Referrals. The proposed pathway was presented to the CE LHIN Primary Care Working Group (PCWG) in August. The PCWG group requested research to be done on four additional pathways. Research results have determined that Mental Health is the optimum choice as a pathway at this point in time.

Primary Care: Care Connects Program: Staff provided input/feedback to the provincial Health Care Connects program regarding program uptake across our LHIN; the MOHLTC will be consulting directly with PCWG members in October. In sight on how to strengthen the HCC program is being sought by MOHLTC. Current strategies employed in CE LHIN which have proven to increase both registration on the HCC list and subsequent acceptance of new clients on primary care physician rosters/models include – consistent messaging from primary care offices when inquiries are received from people seeking care; bulk registration on HCC of all individuals who are on local/clinic waiting lists and access to general health assessments for those on the waiting list.

HCC Registrations and Referrals as of July 31, 2010:

LHIN	Total patients registered	Patients registered online	Complex / Vulnerable patients registered	Complex / Vulnerable patients referred	Non- Complex / Vulnerable patients registered	Non- Complex / Vulnerable patients referred	Total patients referred	% of registered patients referred
Central East	8559	1,024	643	485	7586	3239	4010	47%
Ontario	75994	14,081	5138	4131	68308	29564	35884	47%



Notably, the **CE LHIN Unattached Patient Assessment** pilot project was successful in improving the uptake of new clients through its provision of a general health assessment, development of improved rapport between the team and potential accepting practices in addition, to the health benefits realized by unattached patients whose health conditions were identified, a management plan developed and who were referred to community and specialty services. Work is being concluded on the final report for the Unattached Patient Assessment and Referral Project (UPA), this is anticipated for completion at the end of September.

Patient Flow Performance Improvement Pilot Project: The government has embarked on an aggressive strategy which links the ALC challenge with ED wait times. Given the interdependencies of hospitals and other healthcare organizations, it is crucial that there be an organized and coordinated approach to manage patient flow, not just within an individual hospital but also across a LHIN. This project will address both hospital to hospital interfaces as well as the role of CCAC and primary care. The Patient Flow Performance Improvement Pilot Project directly relates to furthering two of the priorities identified by the Ontario Ministry of Health and Long Term Care - 1) Reducing wait times in Emergency Departments; 2) Reducing the time patients spend in alternate level of care beds in hospitals. The project is a LHIN based collaborative procurement model involving four LHINs - North East, Central West, Hamilton Niagara Haldimand Brant, and, Champlain LHIN. The Champlain LHIN will execute and manage the contract with the selected vendor who will perform work within all four LHIN areas.

Capital Planning: A web-enabled Datamart Capital submission tool has been designed and is currently being tested internally. The Provincial Capital Working Group has proposed modifications to the Pre-Capital H-SIP, these changes are being reviewed against our proposed Datamart tool and adaptations are currently underway. Monthly meetings are continuing between the CE LHIN and the Ministry Health Capital Investment Branch.

Beacon House Consultation Process: The Ministry asked the CE LHIN to undertake a consultation process that will determine recommendations for the future use of the "Beacon House" property located in Oshawa. This facility, which is a detached house, has the capacity to house seven to ten people. It is located in South Oshawa. The house had initially been purchased by Durham Mental Health Services under the "Homelessness Initiative Funding", and sold to Ontario Shores for a nominal fee. Durham Mental Health Services (DMHS) agreed to sell the property to Ontario Shores in order that their "Personality Disorders Program" could be transferred to the community. Since that time, the program has undergone an external review, and the Oshawa property is no longer required to house the program. The Personality Disorders Program is now consolidated in one site located in the Central LHIN. Since the property is governed by a "Capital Use Agreement" between the Ministry and Ontario Shores, the Ministry must agree to any change in its use. Therefore, we have brought the ED Avoidance Coalition members together to determine the best use for this property. We are defining "Best Use", as that use that will have the most positive effect on reducing time spent in the Lakeridge Health Oshawa Emergency Department. The group has met once thus far, and is due to meet again on September 10. It is anticipated that the process will have been completed by the end of October, 2010.

Disordered Eating Project Wrap-Up: The Final Report of the Disordered Eating Project has been submitted to the CE LHIN. The Report has provided us with some valuable information in terms of reaching a better understanding of Disordered Eating issues. This Project was completed under budget and within the prescribed time frame. It was intended as a "Demonstration Project" to establish a LHIN-wide Advisory Committee on Disordered Eating Issues, and explore the potential of providing coordination services to families who were supporting a loved one. The Project also provided education to Emergency Room Staff, Caregivers and Service Recipients. The Project was successful in establishing a LHIN-wide Advisory Committee on Disordered Eating Issues. The Service Coordination Role was not as useful as had been anticipated, given the small numbers of people who accessed it. The education initiative was very successful and will be supported by Peterborough Regional Health Centre on a smaller scale in the future. The full report will be made available to the Board.

Forensics Proposal Review: CE LHIN staff met with the Forensics Team Lead at the Ministry of Health and Long Term Care to review a proposal that has been submitted to the MOHLTC at their request by Ontario Shores. The proposal outlines a plan to increase the Forensic Bed Capacity at Ontario Shores by an additional 20 beds. The Ministry made the request of Ontario Shores for a variety of reasons:

- An increased demand for Forensics Beds in the Greater Toronto Area caused by an increased demand from the Criminal Justice System
- An intention to provide treatment to people who have been in contact with the Criminal Justice System in a more timely manner
- The Ministry is seeking to build on the positive relationship that exists between the Canadian Association of Mental Health (CAMH), Ontario Shores and the MOHLTC.

CE LHIN staff discussed the proposal thoroughly and made the point that unless a strategy was established to more effectively support those with a Mental Health & Addictions (MH&A) issue who have had contact with the Criminal Justice System, the beds would soon be used to capacity. Looking at other supports in the community is certainly part of the strategy at the Ministry level. It was interesting to note that often people with MH&A issues find themselves in the Criminal Justice System for reasons that are not necessarily related to public or personal safety. Often issues of poverty, inadequate housing and lack of other supports can lead some people to have contact with the Criminal Justice System. These can include offences such as trespassing (in order to find shelter to sleep in) or shoplifting. CE LHIN staff expressed their support for the proposal that Ontario Shores has submitted, and will work with them on the implementation.

Enablers

Ontario LHINs Privacy Project – A Practical Approach to Privacy: The CE LHIN eHealth team is continuing to participate with the North Simcoe Muskoka (NSM) LHIN who are leading the project in conjunction with Erie St. Clair LHIN and Central West LHIN. A survey from Erie St. Clair is now completed, and work is underway to collate the information. The deliverables from this project will benefit all LHINs by creating a standard approach to privacy.

Data Centre Consolidation (DCC): The goal of the DCC project is to provide a central secure and state-of-the-art site for participating hospitals' technology infrastructure systems. The project has been underway for three years and has accomplished a number of phases that include assessment and feasibility study, inventory gathering and the recent data analysis phase. Currently the project is in the negotiation stage of finalizing the contract with the vendor Dell who will conduct a detailed assessment of the hospital environment. By conducting this assessment, Dell will gain an accurate understanding of the current number of servers, storage and networks in place, and will determine requirements for the hospitals from this state-of-the-art site. There are three LHINs and eighteen hospitals participating in the project – please see Appendix J.

Recently the partnership business case was submitted to OntarioBuys, a provincial funding agency, as the final deliverable in the funding process. A letter of intent is being developed for participating hospitals. The project will involve a shared services membership agreement that will meet all partners' requirements.

Eclipse Portfolio Project Management (PPM): Eclipse PPM has been upgraded to the most current version and configuration changes have been made to support hospitals using the software. Presently the Scarborough Hospital is using the product for all of its project management activities. The eHealth team has worked with PRHC in the use of the Eclipse application to support the Hospital Improvement Plan (HIP). Demonstration of the project has been requested by Lakeridge Health Corporation to use the application for organization projects. The eHealth team is developing standards for the configuration of Eclipse to ensure changes are agreed by all participating hospitals and the CECCAC.

eCAG – eHealth Clinical Informatics Group (formally the Clinical Infomatics Advisory Group): The eCAG group comprising of hospital clinical infomatics, and professional practice staff is supported by the eHealth team. The focus of this group is on driving the use of electronic documentation across the system. The first activity will be a review of the Meditech 6.0 Consolidation Standards work done by Perot (the project managers) on documentation standards and opportunities for improved clinical documentation. This is a good opportunity to leverage knowledge across LHINs and work together towards a common outcome which includes improving standardization and increased use of electronic documentation.

Software Deployment Collaboration: This collaboration has received a small amount of funding to support planning of software deployment systems. The System Centre Configuration Manager (SCCM) product allows an automated deployment of upgrades, new applications, and inventory and asset management checks. Lakeridge Health Corporation was determined to be the test environment, lessons learned and tools / information will be shared with the other

hospitals. Compucon was selected in 2009 as the reseller of Microsoft products for the CE LHIN hospitals. A request has been made to the reseller to determine if there is new-year funding (through Microsoft) to expand the planning to full deployment within the region.

Joint Procurement (Desktop Technology): The Information Management/Information Technology Advisory Committee is an eHealth committee comprised of Information Technology Directors of hospitals and Community Care Access Centres. As requested by the committee the CE LHIN hospitals have agreed to participate in the RFP for Technology (desktops, monitors, laptops, etc) that was initiated through Lakeridge Health Corporation and submitted for tender in August.

Fiscal Responsibility: Resource investments in the CE LHIN will be fiscally responsible and prudent.

Allocations:
Funding letters were sent and/or payments were processed for:
a) 2010/11 Hospital Funding Formula Base increase ($17.7M).
b) CCAC Service maximums funding ($4M).
c) 2010/11 AAH Year 3 funding ($4.8M).
d) 2010/11 Small Hospital Funding ($166,800)
e) 2009/10 AAH Year 2 reallocation to CCAC ($95K)
f) CCAC Nurse-Led Outreach Team funding ($250K)
g) ED Pay for Results Q1 Premium funding ($450,200) and
h) Pay4Results funding ($7.4M).

Other: a) The Hospital High Growth funding allocations ($1.2M) was sent to MOH in August (to be reviewed by the CE LHIN Board in September. **b)** Psychiartric sessional fee additional funding request was forwarded to MOH in August for approval ($501,200).

CE LHIN Hospitals: All CE LHIN hospitals developed plans for a balanced run rate by March 31, 2011 based on a base funding increase of 0%. Each plan has timing issues (e.g. not all savings will be annualized in 2010/11 and one-time re-structuring costs (e.g. severance)). The 2010/11 hospital base funding allocation (1.47% for CE LHIN) will be used to off-set both timing issues and some of the re-structuring costs; however, it is insufficient to off-set the entire amount. At this time, no further saving strategies are available and hospitals will incur related one-time deficits in 2010/11. Specific details for each hospital will be provided in the quarterly Risk Summary Report. CE LHIN is working with each hospital to implement saving strategies as quickly as possible in the current fiscal year. Progress of the implementation of the saving strategies will be monitored throughout the year.

Ontario Shores Centre (OSC): Recruitment and retention of psychiatrists at OSC is at risk. These physicians are salaried, paid from the global budget. The OMA/MOHLTC signed a Physician Salary Agreement (PSA) to provide a 12.25% increase to Fee for Service (FFS) for psychiatry. The widening gap between OSC and the private sector could gradually erode services at OSC. This is a provincial issue that needs to be addressed by MOHLTC across all LHINs that have the specialty psychiatric hospitals.

Central East Community Care Access Centre (CECCAC): The CE CCAC finished the 2009/10 fiscal year in $4.2M deficit position (This was on top of the prior year $10M deficit). With a new more stringent deficit reduction plan in place by the CE CCAC, a better than balanced run rate will be reached by the end of 2010/11 with a recovery of the total 2008-2011 deficit of $14.2M in 2010/11.

Since Q1, the CCAC has implemented more aggressive constraint measures, reduced expenditures, initiated efficiency measures, but also implemented wait lists for select services. A report from the nD Insight (consultant) is expected to identify further organizational efficiencies and improvements. The CECCAC financial results for July indicate a further

$1.2M savings to budget with a year to date surplus of $3.1M. They continue to implement the 'wound protocol' at the remaining branches and are moving forward with standardizing all branch service levels. These initiatives, if successfully managed, should result in increased monthly savings and help achieve the $14.2M surplus for the 2010/11 fiscal year.

Due to fluctuations in financial performance against their financial recovery plan, the CECCAC is now required to report on their progress towards meeting their recovery targets: weekly to the Team Lead Finance; monthly to the CE LHIN CEO and quarterly to the CE LHIN Board. The Ministry has committed to allow the CE CCAC to retain surpluses in this implementation period to allow for the multi-year balancing after which it is expected that the CCAC will operate with a balanced run-rate. The CECCAC had a surplus for each of the last 7 months.

Community Care Centres (CHCs): For the new CHCs, CE LHIN has identified that the Ministry's current allocation of Operating Costs at 24% of total compensation costs (inclusive of benefits & relief) does not meet the current market costs for establishment of new CHCs in the CE LHIN (e.g. with Taibu, Port Hope, New satellite of Youth Centre, City of Kawartha Lakes and Brock once they occupy their permanent site).

The CE LHIN advised CHCs that in the absence of resolution of this discrepancy each CHC will be required to reduce their services to match the anticipated shortfall. The TAIBU CHC has received a partial funding adjustment to a portion of their shortfall and they are working on a revised financial plan to balance the remaining shortfall. CE LHIN and the MOHLTC continue to work together to explore opportunities to adjust the allocation to CHCs to lessen the impact of service cuts for the remaining CHCs

2010-12 MLPA Ministry/LHIN Performance Agreement *(formerly MLAA, Ministry/LHIN Accountability Agreement)*

The 2010-12 Ministry/LHIN Performance Agreement (MLPA) targets for fiscal 2010/11 were submitted to the Ministry on June 4th, followed with the target-setting meeting on June 18th, 2010. Shortly after the CE LHIN Board approval of the targets, the Ministry of Health and Long-Term Care has slightly revised one indicator, replacing the MLPA performance indicator, 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management) with the 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management). At this time, the baseline and proposed target have not yet been finalized (no timeline has been given yet).

Indicator	CE LHIN Baseline	Negotiated CE LHIN target		Additional Follow Up?
		Ministry Proposed Target 2010/11	CE LHIN & Ministry Negotiated Target 2010/12	
Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions	15.2%	13.0%	13.0%	
Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions	20.6%	17.5%	17.5%	
90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)	TBD	TBD	TBD	Has been revised since the CE LHIN July 2010 Board of Directors Meeting.
Readmission within 30 Days for Selected CMGs	15.5%	15.2%	15.3%	
90th percentile wait times for Cancer Surgery	49 days	Maintain or improve baseline	Maintain or improve baseline	
90th percentile wait times for Cardiac By-Pass Procedures	NA	Maintain or improve baseline	NA	
90th percentile wait times for Cataract Surgery	127 days	Maintain or improve baseline	140 days	LHIN will drive performance against this target lower if funding is available through reallocation across LHINs
90th percentile wait times for Hip Replacement Surgery	173 days	Maintain or improve baseline	179 days	
90th percentile wait times for Knee Replacement Surgery	171 days	Maintain or improve baseline	179 days	
90th percentile wait times for Diagnostic MRI Scan	107 days	65 days	76.5 days	LHIN will drive performance against this target lower if base funding for MRI operations is awarded to the CE LHIN hospital(s)
90th percentile wait times for Diagnostic CT Scan	41 days	28 days	36 days	
90th percentile ER length of stay for admitted patients	48 hrs	34.4 hrs	39 hrs	
90th percentile ER length of stay for non-admitted complex patients	8 hrs	7 hrs	7.6 hrs	
90th percentile ER length of stay for non-admitted minor/uncomplicated patients	5.1 hrs	4 hrs	4.8 hrs	
Percentage of ALC Days	15.26%	TBD	12.20%	
**Blue Font Indicators = New*	**Green Font Indicators = Met 2009/10 CE LHIN Target*			**Red Font Indicators = Did NOT meet 2009/10 CE LHIN Target*

Hospital Service Accountability Agreements (H-SAA): Although direction has not yet been provided by the province-wide H-SAA Working Group on the 2011-13 H-SAA, the CE LHIN process is well underway with the development of an internal project team, project charter and project plan. In the absence of Hospital Annual Planning Submission (HAPS) templates or the H-SAA agreement itself, the Hospital/CCAC Financial Leadership Group (HCFLG) is determining revenue and expense assumptions, and beginning discussion on hospital indicators.

Integral to this process is the development of targets at the hospital level which will roll up to the system level and support the LHIN's MLPA targets. The determination of Hospital-specific MLPA targets will be an important component of the H-SAA negotiations meetings planned for the fall.

For the 2010/11 H-SAA, all hospitals in Ontario are required to submit a budget extension report on the Web-Enabled Reporting System (WERS) with actual Q1 information. For those hospitals that have made no changes to their volumes, only some forms in the budget extension report will have to be completed. For hospitals that will be making amendments to their schedules, the entire report must be completed. All CE LHIN hospitals have been able to maintain their original H-SAA targets and will not be required to redo their submissions, nor re-execute the agreement. The timeline for hospitals to submit their WERS report is September 10, 2010.

Multi-Sectoral Service Accountability Agreements (M-SAA) 2010-2013: The M-SAA process parallels the H-SAA process this year with all signed agreements due on March 31, 2011. This poses a particular challenge for resources for CE LHIN staff and at the Health Service Provider level. The project team, charter and project plan have also been developed for the M-SAA Project. Three engagement sessions (one in Durham, one in Peterborough and one in Scarborough) are planned for the early fall to introduce the community providers to the LHIN's accountabilities and the community's role in working with the LHIN to achieve system-wide goals. It is not anticipated that the Community Annual Planning Submission Templates (CAPs) nor the M-SAA itself, will be available in time to present at these sessions. Once the M-SAA and H-SAA templates and indicators are available, they will be subject to approval by the CE LHIN Board.

The 2009/10Q4 Community Analysis Tool (CAT) submissions and Annual Reconciliation Report (ARR) via the Web-Enabled Reporting System (WERS) have all been successfully submitted and have undergone an extensive data quality assessment. Data cleansing of all submissions has been completed but this is also an on-going process that will be applied for each (quarterly and annual) submission. At this time, continued follow-up and dialogue with various health service providers for significant variances between actual outcomes versus budget/target outcomes is underway. The information garnered from this review and subsequent dialogue with the Health Service Providers (HSP) will also supplement the Risk report. A new version of the CAT, Version 3, has been launched and there will be no further changes going-forward this fiscal year as this will be the last year it is used. This is a positive improvement as the Health Service Providers who utilize this tool will not be required to re-learn how to use it. Consequently, the 2009/10YE M-SAA Dashboard has been populated, verified and will be ready for presentation at the September 2010 Board of Director's Meeting.

CRM/Share Point Project:
The Pilot Project Objectives were:

- to test the CRM data load process;
- ensure that the data migration template will accurately load and map LHIN data to CRM Dynamics based on LHIN feedback;
- validate the base functionality of CRM to support LHIN Account and Contact information and Affiliations;
- identify and prioritize key system enhancements and understand the true benefit of CRM;
- identify best practices to share with the other LHINs for training purposes;
- Issues Management to ensure that there is a process that enables initial inquiry to resolution

The Go-Live date for the CRM project was April 1st, 2010. As of May 2010, all pilot users were fully able to use the system. The main feature of CRM is communications that require a response and an Issues Management process. The Issues management team has used CRM to enable a smooth process flow from the initial inquiry to resolution. The documentation of this process is tracked and managed using the CRM system.

The next steps will involve Phase 2 which will focus on allocation tracking, activity management, change to internal business processes/protocols, and installation on all staff computers, training, process mapping and co-lead impact assessment.

CE LHIN Wait Time Strategy Working Group (WTSWG): Early this summer, the Ministry had sent out an invitation to all Ontario hospitals, to submit, through the LHINs, MRI business proposals to the Wait Time Strategy (WTS) Office in order to receive funding for new and/or existing MRI hours to improve current MRI wait times.

Any hospital that was interested could submit a proposal(s) for operational base funding:

1. A new MRI machine;
2. Operational funding for an existing machine not already funded by the Ministry;

Of the four CE LHIN hospitals that submitted their MRI business proposals (within the given timeline), all were subsequently reviewed and approved in the June 2010 CE LHIN Board of Directors Meeting. All completed MRI business proposals were then forwarded to the Ministry/WTS with a letter of recommendation from CE LHIN.

1. Lakeridge Health Corporation (LHC);
2. Rouge Valley Health System (RVHS);
3. Peterborough Regional Health Centre (PRHC);
4. The Scarborough Hospital (TSH);

As indicated in earlier reports and presentation to the Board, all LHIN-approved MRI proposals were to be forwarded to the Ministry without any LHIN ranking. They would then be reviewed and ranked by the MRI/CT Expert Panel based on set criteria.

The original request focused on MRI hours in general; however, the Ministry has recently requested further assessment by each LHIN with ranking of submitted proposals. It is important to note that they have now limited the review to machine funding requests and are no longer considering incremental unfunded operating hours for new funding. In this context only the proposals of RVHS and TSH would be eligible for consideration. The Ministry provided the ranking criteria/methodology tools used by the expert panel to assist the LHIN. Staff will be providing the Ministry WTS with the outcome of that evaluation on Sept 9.

With respect to the 2009/10 Year End reconciliation of Wait Time Strategy Funded volumes, all data has been validated working in collaboration with each of our hospitals providing Wait Time Services and has been submitted by the requested timeline, August 6, 2010.

Ministry Announcements:

Transition of Regional Infection Control Networks (RICNs): The Ministry of Health and Long Term Care (MOHLTC) have announced the transfer of the financial administration of the RICNs to the Ontario Agency for Health Protection and Promotion (OAHPP) due to the complementary mandates of both organizations to build capacity, reduce duplication of effort and provide more comprehensive programs to the field. The MOHLTC thanked the LHINs for their involvement with the financial administration of the RICNs in the past.

Increase in Psychiatric Sessional Funding: The Ministry of Health and Long Term Care (MOHLTC) recently announced that the CE LHIN has been approved to receive $501,200 to strengthen access to community mental health and addictions services. The funding is aimed at addressing unattached patients and emergency department congestion and is in accordance with the 2008 Physician Services Agreement.

Additional MOHLTC funding for Hospitals: In recognition of the planning process undertaken by hospitals and the LHINs which identified strategies for ensuring front line services are maintained and in line with the government's approach to local planning through LHINs, MOHLTC has announced a $17, 663,900 addition in base funding. There is an additional amount of $1,201,100 for hospital high growth allocated to Ross Memorial, Halliburton Highlands Health Services Corporation, Lakeridge Health Corporation and Rouge Valley Health System. The CE LHIN has also been allocated $166,800 in base funding for small and multi-site hospitals to offset the costs related to diseconomies of scale, isolation and remoteness.

Increase in base funding for Dialysis Management Clinics Inc. The MOHLTC has approved an increase in base funding of $97,786 for Dialysis Management Clinics Inc. which is an Ajax independent health facility.

Peterborough Networked Family Health Team to participate in the Physician Assistant New Graduate Initiative: The MOTLTC has approved the Peterborough Family Health Team to hire two full-time equivalent Physician Assistants to improve access to quality health care for the Peterborough community. Starting in September 2010, the one-time funding available for this initiative is up to $424,400. It is planned that over a two year period new graduates will be hired from the McMaster University Physician Assistant Education program.

Other:

LHIN Annual Reports: The 2008/9 and 2009/10 LHIN Annual Reports have been tabled in the legislature and, as such, are now considered public documents. These CE LHIN Annual Reports are available on our website: www.centraleastlhin.on.ca

Lakeridge Health Corporation, Whitby Site – Approval to Tender to Sub-Trades for the remaining Infrastructure Upgrades Work: Lakeridge Health Corporation's request to include the remaining infrastructure work (suspended driveway replacement and window replacement) as change orders to the executed contract for the Fire Code Retrofit project, has been accepted by the ministry. The grant available for completing this work is $1,277,247.

***Public Sector Compensation Restraint to Protect Public Services Act, 2010*:** The Act prohibits increases in compensation, including rates of pay, pay ranges, benefits, perquisites and other payments, for non-bargaining public sector employees which includes the health care sector, before the beginning of April 2012. For employees who bargain collectively the government will respect all current collective agreements. However, when agreements expire and new contracts are negotiated the government expects transfer payment partners (including LHINs, hospitals and other health care providers) and bargaining agents to seek agreements of at least two years' in duration that provide no net increase in compensation. A Q & A section is posted to the Ministry of Finance website at www.ontario.ca/compensation

Lakeridge Health Corporation and University Health Network share management of Laboratory Services: Lakeridge Health (LH) and University Health Network (UHN) announced the shared management of LH's Laboratory Services with those of UHN. UHN's laboratory currently manages all services for Princess Margaret Hospital, Toronto Western Hospital and Toronto General Hospital, and thirteen other hospitals. Laboratory services will continue to be provided in the LH laboratory while being managed by UHN administrative, clinical, and quality experts. Please see Appendix B

Electrical Disruption at Peterborough Regional Health Centre (PRHC): The CE LHIN was notified by PRHC that a short in an electrical connection disrupted the main power system affecting about half of the hospital operations on July 6, 2010. Given the heavy load on the electrical system during the heat wave and the fact that emergency power would have to be used while repairs were being made, the hospital cancelled forty one surgeries. Cases were subsequently rescheduled when the power system was restored on July 7, 2010.

Scarborough Centre for Health Communities: West Hill Community Services has been renamed Scarborough Centre for Health Communities as of September 1, 2010. In recognition of this important milestone the centre will be hosting a number of special events this fall. For more information see Appendix E.

Campbellford Memorial Hospital (CMH) News: Campbellford Memorial Hospital's (CMH) submission called "*Control of Clostridium Difficile Associated Diarrhea by Antibiotic Stewardship in a Small Community Hospital*" has been accepted for publication in the Ontario Hospital Association's (OHA) 2010 Patient Safety Leading Practices Guidebook entitled, Advancing Patient Safety through Ideas and Innovations. For more information see Appendix F.

Core Business Requirements – CE LHIN Operations

The Corporate Business Support unit is working on the contingency planning report as required by the Ministry of Health and Long-Term Care for the operations budget of the CE LHIN. The reporting exercise includes identifying risk in the following scenarios: zero base, increased and decreased funding. The operations budget is continually monitored by monthly variance reports for each unit of the organization.

The Harmonized Sales Tax (HST) was introduced on July 1, 2010 for certain goods and services and has implications on forms and procedures for our internal accounting. In order to record and claim the HST, administrative procedures and forms require reformulating to identify the tax for the service or goods procured.

The LSSO IT support team has scheduled the Office 2007 upgrade for the CE LHIN on the second week of September 2010. In preparation for this change, staff attended a "Lunch n Learn" session, that included a tutorial review, question & answer period and champion users were identified to assist other staff.

Welcome to the new French Language Services Coordinator Mr. Denys Begin, who started on July 5, 2010. Denys is working with the System Design & Implementation Unit to provide responsibilities in planning and collaborating with the Francophone communities of the CE LHIN region.

Dana Lian has joined the SFPM team as of Tuesday, September 7, 2010 on a short-term contract as the Program Assistant for the unit. Dana's experience includes volunteering at St. John's Rehab Hospital in their finance department and in the Ministry of Health and Long-Term Care.

Vicky Gao who has been our co-op student for the summer will be starting a short-term contract as a Financial Analyst. Vicky's experience includes financial planning & analysis at GE, IBM and Siemens in China.

Brittany Peterson will be moving over to the Finance team and will provide program assistance for them with a financial focus.

Respectfully submitted,

Deborah Hammons
Chief Executive Officer

Appendices

Appendix A
CE LHIN News Release on NP and FHT Announcement

NP and FHT expanded FINAL.pdf

Appendix B
Lakeridge Health and University Health Network Partnership on Laboratory Services - News Release and Backgrounder

Backgrounder.pdf

News Release.pdf

Appendix C
LHIN Shared Services – *The Blueprint* Newsletter

LHIN Shared Services Newsletter J

Appendix D
The LHIN Collaborative (LHINC) Communication Documents

- Communique - July 9, 2010
- Health System Indicator Initiative Communique
- LHINC-IN Newsletter

Health System Indicator Initiative Cc

LHINC Council Meeting Communique

ENGLISH LHINC IN v2010 August.pdf

Appendix E
Scarborough Centre for Healthy Communities News Item

CEO Appendix E - Sept 2010.doc

Appendix F
Campbellford Memorial Hospital's (CMH) announcement re submission to OHA Patient Safety Leading Practices Guidebook

OHA Patient Safety Guidebook message t

Appendix G

Ontario Telemedicine Network (OTN) Central East Report

CEO Report
Appendix - Central Ea

Appendix H
Health Professional Advisory Committee (H-PAC) Report

H-PAC Briefing Note
August 2010.doc

Appendix I
Building To Deliver" - Canadian Blood Services Newsletter

OHA NFRP
„Announcement - 201(

Appendix J
Date Centre Consolidation Partners

Sept. CEO Report -
Appendix J.docx