Central East Local Health Integration Network
CEO Report to the Board
July 25, 2012

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The following is a compilation of some of the major activities/events undertaken during the month of July 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.

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 Integrated Health Service Plan (IHSP) 2010 - 2013 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 accessible, sustainable and achieves good outcomes. Healthcare will be people-centred in safe environments of quality care.*

The Central East LHIN is working towards achievement of 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 Integrated Health Service Plan (IHSP) 2010 - 2013 and model fair, transparent, and honest interaction with one another and with Health Service Providers.

Transitions in Care:
The Central East LHIN Transitions in Care Steering Committee is a new and evolving structure within the LHIN aimed at improving the overall quality of care through better transition management of patients'/clients'/residents' information by their care teams. The Steering Committee is accountable to the Central East LHIN for the strategic guidance and quality improvement for emerging Transition Management priorities, and for providing oversight to selected Transition Management quality improvement initiatives.

The Central East LHIN Transitions in Care Steering Committee, chaired by the CEO of Rouge Valley Health System (RVHS) and the Senior Director, Client Services of the Central East CCAC, has oversight over the full spectrum of quality improvement and/or business process initiatives designed to directly improve the transitions in the patient/client/resident journey through the healthcare system. Its purpose and work are aligned with provincial level initiatives and Central East LHIN priorities. It provides leadership to system and sector-specific committees and projects within the LHIN related to priorities and/or projects intended to improve care transitions. The Home First Oversight Committee and the Resource Matching and Referral Oversight Committee report to the Transitions in Care Steering Committee.

The Transitions in Care Steering Committee met for the third time on June 20, 2012. The key messages from each Committee include:

Transitions in Care Steering Committee

- Spring Stocktake report has been circulated. The performance indicators in the report will assist in the ongoing work of the committee. The MLPA performance indicator dashboard was circulated and reviewed.
- Discussions are ongoing to determine the options around designing the QI Lean Community of Practice committee and whether the scope for this should be broadened to be the Quality Improvement Committee.
- A Mental Health quality improvement initiative around Assertive Community Treatment Teams, led by Ontario Shores, will look at standardizing the referral process and develop test practices in intake assessment.

Resource Matching and Referral (RM&R) Oversight Committee

- The focus will be to implement the RM&R. A plan will also be developed to implement the changes in the Health System Funding Report related to hip and knee rehabilitation. The 10% streamed to inpatient rehab and the 90% streamed to the community will be taken into consideration.

Home First Sustainability Oversight Committee

- New metrics comparing similar size hospitals against each other are now available.
- Efforts to improve repatriation from hospital to long term care and retirement homes are being undertaken by this Committee. Recommendations are being developed and once complete, will be presented to the committee.

Central East LHIN Doctor Talks:
Central East LHIN's Primary Care Physician Leads Dr. Robert Drury and Dr. Christopher Jyu are working with the LHIN staff and in partnership with the Ontario Medical Association to plan the first ever *Doctor Talks*, a series of physician led OTN-supported webinars being held in July, August, September and October. Physicians attending these events will be able to claim up to five (5) Mainpro-M1 credits depending on the number of sessions they participate in. This Continuing Medical Education (CME) accredited "Doc *Talks"* series will provide primary care physicians in Central East with an opportunity to share their expertise and inform the development of the Central East LHIN's next Integrated Health Service Plan (IHSP). Key issues, challenges and opportunities from the perspective of primary care practitioners for five priority primary care topics will be covered:

- Monday, July 30, 2012, 8 - 9 a.m. - "Mental Health and Addictions", moderated by Dr. Christopher Jyu, with panelists Dr. John Maher and Dr. Steve Fishman;
- Monday, August 13, 2012, 8 - 9 a.m. - "Creating a System of Care for Frail Seniors", moderated by Dr. Rob Drury, with panelists Dr. Jenny Ingram and Dr. Wei-Hsi Pang;
- Monday, August 27, 2012, 8 - 9 a.m. - "Diabetes and Vascular Health", moderated by Dr. Christopher Jyu, with panelists Dr. Tom Bell and Dr. John Sigalis;
- Monday, September 10, 2012, 8 - 9 a.m. - "Palliative and End of Life Care", moderated by Dr. Christopher Jyu with panelists Dr. Howard Burke and Dr. Rahim Abdulhussein; and
- Monday, October 15, 2012, 8 - 9 a.m. - "LHINs and Primary Care", moderated by Dr. Robert Drury and Dr. Christopher Jyu, with panelists Dr. Paul Caulford and Dr. Don Harterre.

Central East LHIN Planning Partners including the Central East Mental Health and Addictions Network, the Regional Specialized Geriatric Services Entity - Governance Authority and related programs, the Vascular Health Strategic Aim Coalition, the Central East Hospice Palliative Care Network, the Primary Care Working Group, the Central East Renal Network, the Diabetes Regional Steering Committee, the LHIN's Medical Leadership Group/CNE/VP Clinical , Critical Care Lead, Emergency Department Lead and other medical specialists are also invited to observe and listen to the dialogue amongst Primary Care providers.

Each session will be moderated by one of the Primary Care Physician Leads, and discussion lead by a panel of two physicians representing primary and specialist care in rural and urban communities. Patient experience across their *healthcare career* will be used to initiate conversations on challenges for patients and their primary care providers. Central East LHIN planning partners will also be invited to observe these discussions as input received will help guide the development of IHSP work plans and strategy.

Service and System Integration

The LHIN organization will create an integrated system of care that is easily accessible, sustainable and achieves good outcomes. Healthcare will be people-centred in safe environments of quality care.

Stocktake Report:
The Stocktake report is the unified report of all LHIN activities and performance to the Ministry of Health and Long Term Care (Ministry), and is completed collaboratively by representatives of all LHIN portfolios to communicate our strategies and plans clearly. The Stocktake Report includes all indicators related to the following initiatives and agreements:

- Ministry LHIN Performance Agreement (MLPA)
- Pay-for-Results (P4R)
- Nurse Practitioner Supporting Teams Averting Transfer (NPSTAT)
- *Excellent Care for All* Act (ECFAA)
- Community Care Access Centre (CCAC) Wait Times Emergency Department-Performance Improvement Plans (ED-PIP)
- Transitional Care
- Mental Health and Addictions

All LHINs are currently utilizing MLPA targets established for 2011/12. New MLPA targets (2012/13) will be established during a joint Central East LHIN/Ministry meeting being set for mid-late July. The next Stocktake cycle takes place in August.

Central East Regional Specialized Geriatric Services (CE RSGS):
The CE RSGS Governance Authority (GA) met on June 19, 2012. Presentations were received from the Behavioural Supports Ontario (BSO) initiative, Assisted Living Services for High Risk Seniors (ALS HRS) program as well as the Senior Friendly Hospitals project.

A recruitment process for additional members to complete the Governance Authority membership was conducted and the two new members were present at the June 19 meeting. Heather Power, Executive Director, Thornton View Long-Term Care Centre and Lydia Rybenko, Nurse Practitioner and Clinical Manager, Port Hope CHC were welcomed. One vacancy remains for a Primary Care Practitioner. Dr. Robert Drury, Primary Care Lead for the Central East LHIN, has agreed to fill this vacancy on an interim basis. In addition, Victoria Van Hemert was welcomed as the new Executive Director for the Central East RSGS. Victoria comes to Central East from the Central LHIN where she held a Senior Director position. Victoria officially starts in her new position as of July 9, 2012 and will be based out of the RSGS offices at Northumberland Hills Hospital.
A draft Memorandum of Understanding between the Central East LHIN and the Governance Authority was reviewed as was the RSGS budget. Efforts continue in the development of the RSGS contribution to the LHIN's 2013-16 Integrated Health Service Plan (IHSP).

Behavioural Supports Ontario (BSO) Program:
The Behavioural Supports Ontario (BSO) program in Central East continued to be busy in June. The schedule for the ten Roll-Out Workshops for Part 1 of the Long-Term Care BSO value stream process was completed

with a final presentation in Scarborough and follow-up teleconferences were held throughout the month. Follow-up teleconference coaching calls focus on supporting staff of the Long-term Care Homes in implementing BSO quality improvement methods such as the Plan, Do, Study, Act (PDSA) cycles. These sessions are led by Early Adopter Long-Term Care Home staff, supported by Central East LHIN improvement facilitators and attended by a sub-set of homes within close geographic proximity to each other.

Also in June, the BSO team was supplemented with the hiring of a second Improvement Facilitator (IF) to support the spread and implementation of the BSO process into long-term care and the community through the use of quality improvement methodology. The BSO team is now formally established at the Central East Community Care Access Centre (CECCAC) and consists of a project manager, administrative support, an improvement facilitator supervisor, and an improvement facilitator. This is in addition to the Central East LHIN BSO Lead and Executive Lead and other Central East LHIN supports.

Planning for the BSO project continued to be led by the Design Team (comprised of key stakeholders from across the system) and work also continued for the Education and Capacity Building Committee and the Measurement and Metrics Committee. Included in this work was the drafting of the BSO Training Schedule for 2012/13 and the next revisions of the Long-Term Care Homes Value Stream Map and the Behavioural Assessment Tool (BAT), which is in its tenth version and will be tested for an extended period prior to any further changes. Two members of the Design Team also prepared and delivered a presentation to the Governance Authority of the Regional Specialized Geriatric Service at their June meeting.

Also in June, the provincial Coordinating and Reporting Office of the BSO project was very active in distributing a 'good news' story from one of our BSO Early Adopter LTCHs (Streamway Villa) in Cobourg which was posted in the corporate newsletter for that home. We have been asked for follow up for even more detailed information so this story can be further shared with senior staff within the Ministry of Health and Long-Term Care.

Transitional Care Program:
In mid-May the Ministry of Health and Long-Term Care requested the LHIN provide information on programs that have been implemented which support an "assess and restore" model of care "to help inform the Ministry's planning and development of a more consistent approach to assess and restore programs across the province to support government objectives outlined in Ontario's Action Plan for Health Care."

The request was completed in June and included the following programs in Central East:

- Glenhill Strathaven Lifecare Centre – 15 convalescent care beds;
- Northumberland Hills Hospital – 8 restorative care beds;
- Rouge Valley Ajax Pickering – 20 transitional restorative care beds;
- Peterborough Regional Health Centre – 7 interim long-term care beds;
- Ross Memorial Hospital - Functional Enhancement/Restorative Care beds;
- Lakeridge Health Whitby – 10 restorative care beds;
- Campbellford Memorial Hospital – restorative care unit; and
- The Scarborough Hospital – enhanced functional/cognitive/social therapy.

Senior Friendly Hospitals:
At the June meeting of the Governance Authority of the Regional Specialized Geriatric Service (RSGS), an update on the Senior Friendly Hospitals (SFH) initiative was presented by the Senior Friendly Hospital LHIN Lead. The Governance Authority was very appreciative of the presentation which included a review of the mandate of the SFH initiative – to enable seniors to maintain optimal health and function while they are hospitalized so that they can transition successfully home or to the next appropriate level of care. The presentation also introduced the SFH Toolkit which is available online (www.seniorfriendlyhospitals.ca), covered

the five components of the SFH Framework – Organizational Support, Processes of Care, Emotional and Behavioural Environment, Ethics in Clinical Care and Research and Physical Environment – and reiterated the recommendations for LHINs from the Senior Friendly Hospital Care Across Ontario; (Summary Report and Recommendations Commissioned by Ontario's 14 Local Health Integration Networks by Ken Wong BScPT MSc, David Ryan PhD, and Barbara Liu MD FRCPC, Regional Geriatric Program of Toronto). The recommendations are as follows:

1) Provide support to hospitals to operationalize Senior Friendly Hospital action plans, ensuring coordinated implementation of evidence-informed practice across the province;
2) Ensure that leadership positions within each LHIN include Senior Friendly Hospital champions;
3) Convene a LHIN-wide organizing body (e.g. Steering Committee) to facilitate integrated service planning with respect to senior friendly care that supports the needs of the community and encourages cross-sector partnerships in health care delivery – consider including representation from hospital organizations, primary care, community services, LTC facilities, seniors, and their families;
4) Ensure alignment of the Ontario Senior Friendly Hospital Strategy with other provincial priorities and processes (e.g. Hospital Quality Improvement Plans); and
5) Identify metrics to assist hospitals in measuring the success of province-wide Senior Friendly Hospital initiatives.

It was suggested to the RSGS that they should consider the role they would like to play in supporting hospitals to participate in the SFH initiative in the future. To date, the LHIN is supportive of the SFH initiative and has supported the introduction of the SFH Initiative to Central East hospitals and encouraged alignment of SFH plans with hospital Quality Improvement Plans but has not formally requested participation.

Assisted Living Services for High Risk Seniors
The Assisted Living program offered by Community Care Durham (CCD) is making positive impacts in the health status of the clients being served. Clients with limited informal/family supports have come to rely on the regular services and care provided by the PSWs through the Assisted Living program. The program has gained in popularity in the hubs and CCD plans to recruit volunteers to assist in providing recreation activities to promote social interactions and reduce isolation and depression. CCD is currently serving 34 clients in Oshawa; 14 in the hub and 20 in the radius. There are 27 clients being served in Whitby; 9 in the hub and 18 in the radius. An additional number of 9 new clients will be transferred to the program shortly. 70 clients will bring CCD to about capacity.

23 clients in Scarborough, 42 clients in North Durham, 28 clients in Peterborough and 2 clients in Lakefield have started service with the VON program. 11 clients in Scarborough, 1 client in Peterborough and 5 clients in Lakefield are expected to be transitioned from the CCAC to the VON in the near future. The VON program is constantly demonstrating efficiencies gained around the processes, program structure and delivery.

Mental Health and Addictions

Discontinuation of OxyContin:
As noted in last month's report, the delisting and discontinuation of the drug OxyContin is an issue of great concern to the Ministry of Health and Long Term Care, and to the LHINs. Several initiatives were introduced in March to address any anticipated crisis situations related to system capacity that could arise as the result of the discontinuation of OxyContin. These initiatives included:

- Provider training via webinars and other electronic formats.
- Purchase of OTN equipment to increase system capacity.
- Opioid Alerts from the Ministry of Health and Long Term Care

- Real Time Surveillance of 70 Emergency Departments across Ontario.

Each of the four initiatives have been completed. The Fact Sheets have been received by the LHIN, and are posted on the Ministry of Health and Long-Term Care website. OTN equipment has been purchased. A Steering Group of LHIN Senior Directors, LHIN staff, MOHLTC staff and OTN staff has been struck to develop the distribution criteria and strategy for the Province. The Central East LHIN is represented on this working group. The first wave of OTN distribution has occurred, with the Pinewood Centre receiving one Clinical Unit. Central East LHIN staff are currently working with OTN to submit a list of suggested sites for the second wave of distribution.

The MOHLTC is now negotiating with Health Canada regarding the installation of the equipment for First Nations. As of the end of June, this matter was not resolved. The OTN Steering Group has held back a number of machines in the hope that they can be distributed to the First Nations at a future date. In speaking with the First Nations in the Central East LHIN, staff were advised that there are concerns regarding Opioid withdrawal. One First Nation community in particular has expressed a desire for an OTN machine that would permit their medical staff to consult with Pinewood regarding this issue. There has also been a desire to provide other clinical services, i.e. individual therapy and consultation via OTN. Without the financial support of the Federal Government, the First Nations in the Central East LHIN are unable to afford the ongoing OTN fees.

The weekly teleconferences with the Ministry have ended. The LHIN is continuing to submit bi-weekly reports in accordance with Ministry protocols. Staff have been communicating with Health Service Providers on a regular basis. There have been no substantive changes in the situation in the Central East LHIN in June.

Assertive Community Treatment Team (ACTT) Value Stream Mapping:
The Durham ACTT Network is working with Ontario Shores to develop a Business Case to move forward with implementing the Aims developed as a result of the Value Stream Mapping event, held in March. This work will be done under the auspices of the Transitions in Care Committee. The Business Plan is expected to be submitted to the LHIN by the end of July.

Nurses in Schools:
Central East LHIN staff attended a meeting with the CECCAC, District School Boards and Central East LHIN Mental Health and Addictions providers on June 26 at the CECCAC. The meeting was well attended by a cross-sectoral group of Service Providers. The purpose of this meeting was to discuss the implementation and ongoing operation of the Mental Health and Addictions Nurses in the School Program. Several ideas were discussed. Unfortunately, the timing of the discussion was rather problematic since it was so close to the end of the school year. The group will meet again in early September to consider next steps. The discussion centred around the Scope of Practice for the nurses and what enhancements they might provide to the Student Services Teams that currently support students. In the meanwhile, the CECCAC is in the process of hiring the 9 FTE Nurses who will provide the program.

Central East Mental Health and Addictions Network:
The Central East Mental Health and Addictions Network is working on the development of their Strategic Aim for people with Mental Health and Addictions issues. This will be submitted to the LHIN no later than September 2012. Central East LHIN staff will support the development of the Aim through several planning meetings to be held throughout the summer.

Children's Comprehensive Assessment Services in the Central East LHIN:
In FY 11/12, the Holland-Bloorview hospital was provided with a one-time amount of $52,200 to support the provision of comprehensive assessment services to children in Scarborough. This was a request that came via the Toronto Central LHIN and related to the fact that Holland Bloorview was experiencing significant pressures

in responding to requests for comprehensive assessment services for children residing in the Scarborough Cluster. The Central East LHIN requested that Holland-Bloorview report back to the LHIN regarding the services they had provided with these funds, and committed to supporting a planning process for the entire LHIN. Staff held a meeting with several providers of children's comprehensive assessment services in the Central East LHIN to discuss the current level of need for these services and to work toward a plan to address any identified gaps. The meeting was held on June 21, and was well attended by a cross-sectoral group of Providers. The next meeting of this group will be scheduled according to the participant's availability over the summer. It is anticipated that there will be three more meetings of this group who will determine a series of recommendations.

Exploring Opportunities to Serve People living with Acquired Brain Injury and Mobility related Disabilities meeting:
A meeting was held on May 30 to explore opportunities to serve people with Acquired Brain Injury (ABI) and those with Mobility related Disabilities. The meeting was facilitated by Central East LHIN staff, and well attended by a variety of Health Service Providers. This first meeting focused on exploring the services offered by each organization. The next meeting, which is scheduled for July 18 will explore the issues further with intent to work on a plan to improve the lives of service recipients by investigating service opportunities.

Integrations

Apsley and District Homes for Seniors (ADHS):
Although the funding is now being provided to both the Canadian Red Cross and the Peterborough Housing Corporation, the LHIN has not received word that the final property transfer has taken place.

Community Health Services Integration Strategy:
The purpose of the project is to implement a facilitated integration process to achieve the 'Community First Strategic Aim' in each of the Durham, Scarborough and Northeast Service Clusters. The project will result in the identification of a preferred community health services integration model for each service cluster.

Community Health Services (CHS) Strategic Aim
Design and implement a cluster-based service delivery model for Community Support Services and Community Health Centre agencies by 2015 through integration of front-line services, back office functions, leadership and/or governance to:

- *improve client access to high-quality services,*
- *create readiness for future health system transformation and,*
- *make the best use of the public's investment.*

Durham Cluster Process
In April 2012, the Durham Integration Planning Team (IPT) which includes CEO/EDs from the Durham Cluster and the LHIN team began meeting weekly. Each of 10 HSPs has identified one governor to be the identified 'liaison' to participate in 3-4 planned governance check-ins – this is **in addition** to regular updates provided by the organization's own CEO/ED.

The Durham Integration Planning Team (IPT) which includes CEO/EDs from the Durham Cluster and the LHIN team has been meeting since the end of April 2012. The team's work has focused on development of a current state through sharing of information on services provided by each of the 10 HSPs. Each HSP has identified one governor to be the identified 'liaison' to participate in 3-4 planned governance check-ins – the second of which occurred on July 9th complementing regular updates provided by the organization's own CEO/ED.

The Team initiated its month-long stakeholder engagement on July 10. During this time HSPs will be consulting with clients, staff and external stakeholders regarding the current state and collecting input on how to re-design the CHS system in Durham to strengthen client access to high quality services, build capacity for future investments in community services and make best use of the public's investment in CHS services.

Integration Planning Process in Haliburton County
Local organizations providing health care to the residents of Haliburton County are working together to improve access and ensure that their organizations are ready to meet the needs of a changing population by becoming part of a Central East LHIN Integration Planning Team (IPT).

Member organizations of the IPT include:

- Community Care Haliburton County
- Central East Community Care Access Centre
- Haliburton Highlands Health Services
- Haliburton Highlands Family Health Team
- SIRCH Community Services

Meetings in June concentrated on establishing the Critical Path for the project as well as beginning the process of understanding the current state amongst participating organizations. Opportunities for community engagement are being explored for the fall. Each organization has been asked to forward results of all recent community engagement activities they have either led or been party to that could inform the process. A news release has been drafted and will announce publically that this integration planning process is underway. An Integration Facilitator, supported through the Central East LHIN, will start early July.

CMHA – Northeast Cluster Integration:
The Joint Executive Governance Committee, (JEGC) and Management Implementation Team (MIT) are making solid progress toward implementation of the objectives set out in the Integration Plan approved January 2012. Progress of the integration process to date was assessed at the JEGC meeting held on June 12, using the schedule outlined in the approved Integration Plan. Although there has been some alteration in the achievement of the tasks, i.e. the Back Office Integration has not been completed; the overall progress does indicate that full integration will be achieved on schedule.

The new Corporation has chosen its new name: *CMHA: HKPR Serving the Counties of Peterborough, Haliburton, Northumberland and the City of Kawartha Lakes and Brock Township.* The organization has also determined its new staffing and service delivery structure. Although the group is making steady progress, there are some challenges that are being discussed with LHIN staff. Each of the Boards, (CMHA-P and KL) has been continuing to meet separately throughout this process. Decisions made by the JECG have been brought forward to each Board for their approval prior to finalization. This has presented some additional challenges.

Central East LHIN Hospice Palliative Care Network (CEHPCN):
The Steering Committee continues to be engaged in IHSP discussions regarding the Hospice Palliative Care Priority. On July 3rd the Network came together to review the IHSP Logic Model as well as identify and discuss priority activities and outcomes to help achieve the draft aim of *"Increasing the number of people who receive hospice palliative care in the community and die at home, by choice, by 10% by 2016."*

The Network is also working towards an updated Expression of Interest to support continual and appropriate Steering Committee membership. They are also reviewing their Terms of Reference to support current hospice palliative care realities/priorities such as the Ministry's Declaration of Partnership and the LHIN's 2013-2016 IHSP.

Community Palliative Nurse Practitioner Program
The Community Palliative Nurse Practitioner Program is moving along with implementation in both the North East and Durham Clusters. The LHIN receives regular project status reports and updates from the CCAC. An introductory letter has been sent out to physicians in the region who either know how to provide palliative care, have taken a palliative care course or who have been a MPR for a CCAC palliative client. The CCAC will also be sending out introductory letters to all of the FHTs, CHCs and Nurse Practitioner clinics in the regions. They will also leverage the Palliative Pain and Symptom Management Consultant contact channels to spread the word about the program.

LHIN Funded Palliative Education
Pursuant to an initial communication sent to stakeholders on April 17th by the Central East Community Care Access Centre, the delivery of Central East LHIN-funded palliative care education sessions is currently "on hold." Time is required to complete our due diligence and engage stakeholders on the new service delivery model. The Central East LHIN has communicated with all health service providers involved in the delivery of palliative education asking for their feedback.

Aboriginal Services

First Nations Health Advisory Circle and Métis, Non-Status and Inuit Health Advisory Circles:
The First Nations Health Advisory Circle did not meet in June as scheduled due to a death at the Hiawatha First Nations. The meeting has been rescheduled for July 27th. The Central East LHIN would like to congratulate Chief Phyllis Williams of the Curve Lake FN on her recent election.

The Métis, Non-Status Circle met at the LHIN office on June 13, and were pleased to welcome Liz Stone, the Executive Director of Niijkiwendidaa Anishnaabekwewag Services Circle, Wendy Phillips, the Executive Director of the Friendship Centre in Peterborough, and Maggie Asselstine of Toronto Native Family and Child Service, We were also very pleased to welcome Senator Andre Bosse back to the Circle. The meeting was very robust and featured some excellent discussion. The next meeting of this Circle has been scheduled for July 12, 2012.

The Central East LHIN Aboriginal Lead attended the following events:

- Opening of the Oshawa CHC Aboriginal Healing Garden on June 11.
- Meeting of the Oshawa CHC Advisory Circle on June 18.
- Teleconference with representatives of the Ministry of Children and Youth Services regarding the implementation of the Aboriginal Mental Health and Addictions Strategy in Schools on June 25.

Quality and Safety

Pharmaceutical Shortage:
The Sandoz Canada injectable drug shortage continues to be monitored province-wide and at all LHINs. Provincially, the Drug Shortage Technical Advisory Committee has ceased regular meetings. Within the Central East LHIN, Health Stakeholder calls are being held on an ad-hoc basis. Drug Shortage reports are still being submitted to the MOHLTC and supplies are being monitored provincially and nationally.

IHSP Strategic Aims

Save a Million Hours of Time Spent in the ER Department

ED Pay for Results (P4R):
No communication has been received from the Ministry regarding recovery from prior years of P4R specifically, Years III and IV.

ED Pay for Results Year V (2012-13):
A working group consisting of ED LHIN Leads, LHIN Senior Directors, Cancer Care Ontario and MOHLTC representatives has proposed a draft model for the Pay for Results program for Year V (2012-13) that will streamline funding and eliminate recovery. This model is going through the approval process at the Ministry, and as of June 2012, has not yet been published. This leaves hospitals in the precarious position of having to risk manage which programs, typically having been funded through P4R, they will continue.

Clinical Decision Units:
Clinical Decision Units (CDUs) are established at the following Central East hospital sites: LHB, NHH, PRHC, RMH, RVAP, RVC, TSB, and TSG.

CDU's must meet certain guidelines published by the MOHLTC, and are monitored by Access to Care on a monthly basis for compliance with two indicators:

1. the proportion of CDU patients with a total EDLOS (including CDU time) greater than 24 hours (not to exceed 10%); and
2. the proportion of CDU patients admitted to inpatient beds (not to exceed 30%).

When a CDU is not compliant with one or both of the above indicators, the LHIN is notified and an Action Plan is requested from the hospital that specifies the reasons for non-compliance and the steps that will be taken to return it to compliance. If monitoring indicates a chronic issue with non-compliance, there are further escalation stages inclusive of the potential to remove the CDU.

Hospital Scorecards:
Monthly scorecards have been developed, tracking the following seven Emergency Department/Alternative Level of Care (ED/ALC) indicators for all Central East LHIN hospitals:

- Emergency Medical Services (EMS) Offload Time;
- 90th Percentile ED Length of Stay (LOS) for Admitted Patients (*MLPA indicator*);
- 90th Percentile ED Length of Stay (LOS) for Non-Admitted Complex Patients(*MLPA indicator*);
- 90th Percentile ED Length of Stay (LOS) for Non-Admitted Minor/Uncomplicated Patients(*MLPA indicator*);
- 90th Percentile time to Physician Initial Assessment (PIA) (*P4R indicator*);
- ALC-LTC Volume (*HSAA indicator*);
- % Alternate Level of Care (ALC) Days (*MLPA indicator*); and
- % Hospital Discharges Before 11:00am.

Work is underway through the LHIN's Decision Support staff to better align various indicators into one product.

Emergency Department (ED) LHIN Lead:
Dr. Gary Mann, the LHIN's ED Physician Lead has continued to visit each of the hospital's Emergency Departments and speak with the Chiefs of the ED's as well as other staff. These visits have been a tremendous

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source of information on what each ED is facing in terms of challenges and opportunities. In addition, it has strengthened communication and networking. To wrap these visits up, Ross Memorial Hospital is scheduled for July 11th to be followed by Northumberland Hills Hospital soon thereafter.

Emergency Department Chiefs:
The ED Chiefs have not met for some time as a revised structure that considers the needs of the Chiefs as well as EMS staff is being vetted by the LHIN.

Reducing the Impact of Vascular Disease by 10% (save 10,000 patient hospital days) by 2013

Carefirst Seniors and Community Services:
Carefirst was awarded the RFP by the Heart and Stroke Foundation for the development of an Ontario Needs Assessment for Chinese Ontarians Living with Heart Disease or Stroke. The project has a very tight time line, with the final report due August 27, 2012.

Supporting an Integrated Roll-out of the Ontario Diabetes Strategy:
Standardized Referral and Intake Process
The Regional Diabetes Coordinating Centre has received approval from the MOHLTC Diabetes team to proceed with planning and implementation of centralized intake for diabetes education programs across the LHIN. Approval has been provided for 2 FTEs; 1 Case Manager/Intake and 1 Administrative Support position. The funds will flow through the Central East LHIN Diabetes Regional Coordinating Centre (DRCC) budget at the Charles H. Best Diabetes Centre.

Inter-professional collaboration - Diabetes Specialists supporting Primary Care
The inaugural meeting of the Kawartha Lakes Diabetes cooperative was held on June 5th. Recognizing the need for Diabetes Education Programs to work with other community based organizations providing diabetes care, Ross Memorial Hospital brought together a group of NPs, RNs and Diabetes Education Program staff to discuss forming a group for information sharing and to look at a way to work together.

The GTA YMCA is launching a Diabetes Prevention Program Pilot in Scarborough, Etobicoke, Toronto and Mississauga in the fall of 2012. Discussion and planning is just beginning in the three LHIN regions including Toronto Central, Central East and Central West with the YMCA staff. Within Central East, we will pilot this project and in partnership with Carefirst DEP to offer a 16-session group behavior change class that helps people at high risk for developing type 2 diabetes prevent the disease through healthy eating, increased activity and other positive lifestyle changes followed by monthly follow-ups for 8 months.

Chronic Kidney Disease (CKD) / Renal System Development

In 2010, the province created the Ontario Renal Network (ORN), organized to align to provincial LHIN boundaries. A Central East LHIN Advisory body comprised of medical and administrative leadership from the three (3) Regional Renal Programs: Peterborough and Area (PRHC), Durham (LH) and Scarborough (TSH) were established. The ORN Regional Director is Jay Wilson and the Clinical Lead is Dr. Andrew Steele.

New Chronic Kidney Disease Provincial Funding Model:
Education sessions for hospitals related to implementation of new the Chronic Kidney Disease funding are being held in July at each of the regional renal centres. Through this process the new funding level for hemodialysis has been increased to $263 from $199.50. This is an interim amount and will be revised again in

2013. The costing does not include the allied health costs (Lab and Diagnostic Imaging). In 2012-2013, in-centre and chronic kidney disease clinics will begin receiving funding based on 'service bundles'.

A similar funding approach for home modalities (service bundles) will be rolled out later in 2012-13. Within each dialysis bundle there are number of best practices identified for the patient. Programs should not see a major change in the funding this year unless they engage in more than six (6) follow-up clinic visits consistently for each patient. The hospitals are in the process of two large data captures for the CKD patients to support the introduction of this new funding approach.

The Scarborough Hospital:
The Home Hemodialysis four station transition unit launched June 7. The ORN utilized this opportunity to formally launch the Ontario Renal Plan (ORP). The ORP is now linked on the Central East LHIN website. June 8, TSH hosted mortality and morbidity (M&M) rounds for Nephrology within the Central East LHIN. Previously LH and PRHC had participated in joint M & M rounds, but invited TSH to join in. OTN was used to facilitate the presentation given by Dr. Tabo Sikaneta. The topic was Calcephalaxis. This is thought to be a calcium/coagulation disorder that affects dialysis patients. Up until 2008 there were 13 case reports; however it is becoming increasingly more common, so knowledge and awareness of this disease is important for early diagnosis. The symptoms may appear slowly, often as a small blotch on the skin. The patient has intense pain with severe vasoconstriction of the affected area. The treatment is IV sodium thiosulfate at a cost of $3,000 week. Early pain relief seems to be an early marker of success. Each of the three programs have cared for a few patients with Calcephalaxis. The topic was well received and there was a good discussion about adjunctive treatment. Approximately 100 staff/physicians participated via OTN.

Lakeridge Health:
Additional Operating Room time in July has been made available for renal patients – Dr. Thompson will support this service. LH renal team participated in the Evidenced Based Design work shop June 21, hosted by the Change Foundation and Cancer Care Ontario. LH's project is to improve the patient experience with AV fistula creation. Increasing AV fistula rates is a LHIN vascular and provincial priority.

ORN – Transitioning to new HSFR Quality Based Procedural funding:
All three regional programs have been busy registering their CKD (pre-dialysis) patients into the Ontario Renal Reporting System (ORRS) database. This is the baseline data required for the development of the CKD patient bundle funding.

Central East LHIN Renal Steering committee:
Dr. Jyu was invited to the Renal steering committee to discuss best ways to engage Primary Care. Two initiatives were proposed to bring forward to the PCWG for review. Dr. Steele/team will review and revise an Early CKD guideline that the primary care providers can use to help manage the early CKD patients. In addition, a communication fax back tool will be developed to be used between the Nephrologist and primary care providers, highlighting the pre work and recommendations from the Nephrologist for the primary care provider prior to the next Nephrologists visit.

ORN – Nephrologist- Family Physician Mentorship model
TSH was successful in their proposal to the ORN to be involved in a pilot mentorship model. The ORN has funded 6 pilot projects across the province. Dr. Tabo Sikaneta will be the Nephrologist mentor for the Scarborough cluster. Curriculum, tools and methods for the mentorship to be developed.

Dialysis Toronto Transit Commission - Wheel Trans Eligibility Task Force
ORN Regional Director Jay Wilson and a TSH social worker have been participating in a biweekly task force to develop recommendations for dialysis patient transportation who do not fit the revised criteria for TTC

Wheeltrans. This task force is hosted by the Toronto Central LHIN. The task force is nearing completion with the preparation of the final report. Project deliverables to date: development of mobility assessment tool and algorithm. Dialysis patients at risk for transportation underwent mobility testing and/or cognitive assessment as a baseline to determine volumes affected; Travel distance assessment using postal code data; costing analysis for Toronto Ride, Red Cross, and Taxi service.

Enablers – eHealth

eHealth Strategic Plan:
The Central East LHIN has begun the development of an eHealth Strategic Plan by building on the 2007 eHealth Strategic Plan and making revisions to address current and emerging needs and requirements in support of the LHIN IHSP and Provincial eHealth Ontario strategy. This revised plan should inform and enable the development of a GTA LHIN Cluster strategy. A Letter of Intent was issued on June 20th to Deloitte, the preferred vendor as a result of the RFP process, to conduct the GTA LHIN Cluster eHealth Strategy. The cluster is working on finalizing the contract and once the contract is signed, a Statement of Work and a Project Charter will also be drafted for the CEOs' review and consent.
The Central East LHIN eHealth Steering Committee met on June 22nd to discuss the pre-work done by the HealthTech consultants. Deloitte was invited to provide a brief overview of the Cluster eHealth strategy deliverables which include a current state assessment, individual LHIN strategies and an aggregated Cluster eHealth strategy, Roadmap, Change Management, Blueprint, Governance and Sustainability requirements for current initiatives in the Cluster to ensure implementation to their maximum potential.

cGTA – ConnectingGTA:
ConnectingGTA is a project with the five (5) GTA LHINs structured to "integrate electronic patient information from across the care continuum, and make it available at the point-of-care, to improve the patient and clinician experience". The ConnectingGTA project will allow 700 service providers to securely share patient health information across the five (5) GTA Local Health Integration Networks (LHINs). Currently, electronic health information is contained in silos within the system. Over time, all 700 service providers will be connected under one "electronic roof" – allowing patient information to move from one service provider to another within the system. Program activities will focus on populating the ConnectingGTA solution with clinical data and then providing clinicians, from across the care continuum, with viewing capabilities to use that data to improve patient care.

After a targeted expression of interest process, the program team is reaching out to an additional group of organizations to participate in the initial implementation phase for ConnectingGTA. Upon confirmation, clinicians from three new organizations as well as a few clinical information systems will be among the first to access electronic patient data from the ConnectingGTA. Working with the entire group of early adopters, ConnectingGTA will deliver clinical value by sharing data across the continuum of care including acute care, long-term care, mental health & addictions, rehab/complex continuing care, community support and primary care.

Resource Matching and Referral
The draft Provincial Standard Report is now available and includes the Minimum Data Sets. Not all areas included in the RAI-Home Care (RAI-HC) are included in the Minimum Data Sets. The data sets are different for CCC/Rehab and other patient groupings. The common definitions will follow at a later date. The RM&R Provincial Steering Committee discussed the standardized tool and expected outcomes. The conceptual framework for CCC/Rehab was discussed and five groups of patients' categories were reviewed. Conversations with the Ministry are ongoing in relation to the issues/problems with HSFR. The RM&R oversight committee at the Central East LHIN will work as a working group with subject matter experts. The focus will still be to

implement RM&R but also to implement a plan for the hips and knees. Two groups will be required, one to look at the 10% streamed to Rehab and the 90% streamed out to the Community.

Fiscal Responsibility: Resource investments in the Central East LHIN will be fiscally responsible and prudent

Funding and Allocations:
The following funding letters were issued in June to our Health Service Providers –

- *2012/13 Opening Base Allocations letters were issued to the following:* seven (7) Community Health Centres (CHCs) - $22,978,617; 32 Community Mental Health Programs (CMHP) - $58,618,481; 59 Community Support Services (CSS) - $45,542,132; and the Central East Community Care Access Centre (CECCAC) - $225,133,630.
- *2011/12 Care Connector Funding:* The CECCAC has received $255,100 in one-time funding. The CECCAC's obligation with respect to this funding is for three (3) CCAC-based Registered Nurses (RN) or Registered Practical Nurse (RPN) Care Connectors.

Web Enabled Reporting System (WERS)/Self Reporting Initiative (SRI) Update:
The Web Enabled Reporting System (WERS) became read only on June 30, 2012 as the reporting system transitions to the Self Reporting Initiative (SRI). Due to sporadic site access on WERS and Health Service Provider (HSP) staff turnover and training requirements, 5% of agencies were unable to upload their Year End reports by June 30, 2012. These agencies are required to follow the Ministry's guidelines for submitting outstanding reports.

Central East LHIN staff are currently downloading and reviewing HSPs' 2011-12 Q4 submissions for data quality issues in the financial and performance reports. Where a submission requires significant changes, the HSP will be required to resubmit their report following the Ministry's guidelines for submitting outstanding reports to ensure their corrected report is transferred into the SRI.

Hospital Service Accountability Agreement (2012/15 H-SAA):
Pursuant to the June Board Meeting, eight hospital H-SAA agreements have been executed. The ninth agreement (for Northumberland Hills Hospital) was extended to the end of July and will be signed once the hospital has the opportunity to reconcile the Health System Funding Reform information, and arrive at a balanced position.

The private hospital agreement was also extended due to the fact that legal counsel and the MOHLTC were trying to resolve the issue around whether or not private hospitals are subject to the 10% Executive Office Reduction requirement as legislated in the Public Hospitals Act. We have since received a confirmation that 10% Executive Office Reduction does not apply to private hospitals.

We would like to take this opportunity to thank the Central East LHIN Hospital Executives for working so closely with the Central East LHIN staff to manage this process, despite challenges associated with unrealistic deadlines, lack of clarity in provincial directions, and the introduction of Health System Funding Reform (HSFR).

Multi-Sector Service Accountability Agreement (M-SAA):
The current Multi-Sector Service Accountability Agreement (M-SAA) is a three year Agreement effective 2011 to 2014. In the absence of definitive ministry funding targets in 2011, HSPs completed the Community Annual Planning Submission (CAPS) based on a planning assumption of a 0% base adjustment for the first two years

of the Agreement. Year 3 of the M-SAA was marked "TBD" in anticipation of further information on planning targets from the ministry.

The M-SAA steering committee will be reconvened to begin the process of determining how this refresh will take place with negotiation process expected to begin in the early fall 2012.

Long Term Care Homes Service Accountability Agreement (L-SAA):
The 2013-17 L-SAA process has officially launched and a Steering Committee has been established with representation from the Ontario Long Term Care Association (OLTCA), Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS), Ontario Hospital Association (OHA), Association of Ontario Municipalities (AMO), as well as representatives from three LHINs and one from MOHLTC. To date, discussions have already been initiated with the associations (OLTCA, OANHSS, AMO, OHA), to set the stage for successful collaboration. The timeline is as follows:

2012/13 Long-Term Care Home Co-Payment Rate Reduction Program:
In January 2011, the Ministry implemented a new rate reduction program, which is enshrined in the new Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10 (Regulation). Since then, the Ministry has monitored the effectiveness of the new program and has found that there is room for improvement. As such, the Ministry is introducing minor amendments to the Regulation. These amendments to the Regulation will help ensure that our assessment more accurately calculates a resident's ability to pay.
The amendments will improve the effectiveness of the rate reduction program by:

- Ensuring an accurate assessment of a resident's ability to pay at the time of application;
- Improving the efficiency of the application process;
- Better recognizing residents' unique financial circumstances.

The Ministry is also extending the amount of time residents and LTC homes have to submit rate reduction applications to the Ministry from 30 to 90 days. These minor changes to the rate reduction application process will also take effect on July 1, 2012.

The Ministry of Health and Long-Term Care (MOHLTC) issued a memo to all Long-Term Care Homes (LTCH) pertaining to Accommodation Charges and Rate Reduction changes effective July 1, 2012 wherein the co-payment that residents pay for LTCH basic accommodation will increase from $53.23 per day to $55.04 per day, an increase of $1.81, consistent with recent increases due to inflation. These increases will not affect low income LTC residents. LTCH residents receiving a rate reduction will continue to pay only what they can afford based on their income. However, residents will be required to reapply for a rate reduction as of July 1, 2012. In addition, the MOHLTC has undertaken a review of the preferred accommodation premiums.

Currently, a premium of $8 per day for semi-private, and $18 per day for private accommodation, is applied on top of the basic co-payment to determine the maximum amounts that can be charged. These premiums of $8 and $18 per day have not been increased since they were introduced in 1993. To help address inflationary pressures, a modest increase is being implemented to the preferred accommodation premiums. The increases will only apply to newly admitted residents on or after July 1, 2012 and only to those residents admitted into a bed that is classified as “New” or “A”. Effective July 1, 2012, the premium will increase from $8.00 to $9.00 for semi-private and $18.00 to $19.75 for private accommodations. Preferred accommodation premiums are not increasing for any residents currently residing in beds classified as “New” or “A” or those admitted to older structural classification beds (“B”, “C”, “D” or “Upgraded D”).

Quarterly Report Highlights – MOHLTC:

LHINs are required to submit quarterly reports in Q1, Q2 and Q3 to the MOHLTC as required under the Ministry-LHIN Performance Agreement (MLPA). The blank templates are posted in the Directory of Networks (DoN) by the Ministry. The templates include 1) Local Health System Update, 2) Forecast by Sector, 3) Balance Sheet Forecast, 4) Reallocation Forecast, 5) LHIN Operations Forecast and 6) Risk Summary.

The completed Q1 Quarterly Reports were due to the Ministry by June 29, 2012 and were successfully uploaded in DoN by the due date.

The components of the quarterly report are:

- Transmittal letter (required from the CEO of Central East LHIN to the Ministry acknowledging the fulfillment of the reporting requirement);
- Local Health System Update (required in Q2 only showing an update on the progress of the LHIN’s commitments, activities or initiatives outlined in its Annual Business Plan);
- Status Update on Special Initiatives (ministry may request a status update on special initiatives in any quarter). There was no update required in 2012/13 Q1;
- Status update on Integration Activities (required in Q2 only);
- LHIN Quarterly forecast by sector: This is the Transfer Payment expenditure forecast for fiscal year-end by sector;
- Quarterly Balance Sheet Forecast Table: This is required for central agency’s reporting purposes to consolidate Central East LHIN’s financial position to the province;
- Reallocation tables: These include planned or actual reallocations within sector, between sectors and between LHINs;
- Risk Summary: This is a tool which focuses attention on the key risks to the achievement of the LHIN’s objectives. It includes risks, opportunities related to financial, government or local key priorities or MLPA obligations. All risks noted must include a mitigation plan that can range from monitoring to the requirement of implementation of a risk management plan; and
- Report on LHIN operations: This is Central East LHIN’s revenues and expenses. It is organized to align with the Ministry’s standard accounts.

The Central East LHIN was successful in mitigating four risks covering community sectors. These mitigated risks included:

1) Scarborough Centre for Healthy Communities (SCHC) received base operational funding of $680k to assist them in providing full time operational services at both their satellite sites;
2) Manse Road group home was successfully transferred to the Toronto Central LHIN;
3) The Ministry provided telemedicine nursing funding while the Central East LHIN was able to provide additional telemedicine equipment for the various community organizations; and
4) Relating to Behavioural Supports Ontario (BSO) funding that was received late last fiscal, the Ministry provided authorization for the surplus funds to be used for additional transportation and training of the nurses as well as for back fill positions while the BSO staff went to training.

There were seven new risks added in the Q1 Risk Summary Report for hospital and community sectors valued at approximately $1,090,000 which includes working with two hospitals and the Ministry relating to major capital needs of the hospitals due to aging infrastructure and facilities, informing the Ministry on potential risks relating to Quality Based Procedures (QBPs) and Wait Time Strategy (WTS) challenges, alignment of resources (funding, human resources) to achieve optimal standardized and accountable delivery of Palliative Care Education services, etc.

Long-Term Care Service Accountability Agreement (L-SAA):
The Central East CCAC has been conducting its quarterly engagement sessions with the long term care sector. The LHIN contributed messaging around the Central East LHIN process for addressing revisions to the LTCH Occupancy Targets Policy and the Behavioural Supports Project updates.

Central East Community Care Access Centre (CECCAC) Performance and Risks:
Although the Home First client volumes continue to increase, the CECCAC is holding the total client services at a steady level. This is due to their increased standardization pertaining to the level of services rendered and maintaining the hours of care for similar clients at standard levels. A more detailed review of cases has helped to determine an optimal level of care. With their strategy, the CECCAC is hoping to achieve a zero growth rate in service costs over time in the home first program.

The CECCAC will also be reviewing various other strategies for improved efficiencies and improved client care while still ensuring a balanced budget for 2012/13. Meanwhile the CECCAC is implementing three new nursing programs (mental health in school boards, rapid response, and integrated palliative care) as well as the Behavioural Supports Ontario and Diabetes care programs (See Appendix A).

Hospital Performance, Risks and Capital Issues:
For 2012/13, the Central East LHIN has been able to negotiate balanced budget compliance with all of its hospitals except for Northumberland, for which one month extension has been provided pending the completion of negotiations.

The Central East LHIN may provide a waiver, if necessary, to a hospital if it is unable to find savings for transition costs resulting from realignment of volumes for the four quality-based procedures that have been implemented in 2012-13 (Hip, Knees, Cataracts, and CKD).

During 2012/13, the Ministry is proceeding to implement funding based on 40th percentile, which is considered best practice. At this rate, hospitals may be unwilling to perform volumes, and would have to develop an exit strategy, which may require transition costs to be incurred.

For 2013/14, the Hospital sector faces significant risks in meeting the balance budget requirement:

a) The one-time mitigation assistance provided by the Ministry in 2012/13 related to quality-based procedures will be reduced;
b) The number of quality-based procedures will increase substantially in 2013/14 and 2014/15, the final year of implementation;
c) A 0% increase will have to be assumed again in 2013/14.

As a mitigation strategy, Management plans to enter into 2013/14 hospital accountability agreement negotiations this fall, ahead of the normal Ministry process, in order to have an early reading of the hospital pressures, challenges, and risks. The Central East LHIN is in the initial planning stage for a "Capital Day" with our hospitals to assist the LHIN in identifying capital priorities within the LHIN system rather than by individual hospital. Further information will come as the plan starts to materialize.

Wait Time Strategy Working Group (WTSWG):
The Central East LHIN has not yet received the final Wait Time allocations for 2012/13. Hospitals have indicated that operating without confirmed allocations poses a risk to the hospitals. In order to provide some stability to the hospital sector, the Central East LHIN approved 50% of the preliminary volumes.
The group met at the end of June and expressed concern due to the delay of the final Wait Time Strategy incremental allocations for cancer surgery, general surgery, CT and MRI from the Ministry and the Central East LHIN-led QBP planning process for hips, knees and cataracts. The hospitals discussed that they find it challenging to plan patient bookings with the lack of volume commitments, and therefore, expect wait times to increase. Once volumes are finalized, they are concerned that they may not be able to deliver volumes at the end of the year due to cut-backs earlier in the year. The hospitals also expressed that the volumes performed by the hospitals are limited by the amount of funding received, and this impacts Health Based Allocation Model (HBAM) allocations.

Mitigation plans include:
a) Central East LHIN management plans to monitor wait time performance very closely in 2012/13;
b) Central East LHIN management plans to seek reasonable MLPA targets for cataract and MRI as part of upcoming discussions with the Ministry in July.

Orthopaedic Scorecard:
On April 11, 2012, an Orthopaedic Quality session was held in the Central East LHIN. In attendance were physician representatives from Central LHIN hospitals. The purpose of engaging the physicians in this session was to gain their support in the achievement of performance targets. Positive feedback was received from those in attendance. Some of the suggestions made included:

- Taking into consideration that an allied health team would be a benefit;
- Ensuring that there is clear messaging to patients which will lead to improved results; and
- The need to educate family physicians was raised.

Hospital-Community Care Access Centre Financial Leadership Group (HCFLG):
HCFLG group is seeking nominations from the members for Chair and Vice-Chair roles which will be finalized in next month's meeting.

A Project Charter/Terms of Reference for 'Options for $50-70 M Hospital Savings Per Year' project were approved which included guiding principles given by the Central East Executive Committee. The Charter will be

submitted to CEEC for their approval. If approved, the membership list will be sent out and nominations for additional members from the Chief Nursing Executive group will be requested.

Quality Based Procedures Working Group (QBPWG):
The combined HCFLG and Chief Nursing Executive Group has been more appropriately named the Quality Based Procedures Working Group (QBPWG). Hospitals and the CCAC unanimously agreed to continue to pursue the consultative, system-based process, utilizing the LHIN decision making framework, to determine optimal service delivery models for Quality Based Procedures in the Central East LHIN. A consensus model will be utilized for all decision-making.

All hospitals are included in the consensus model, not just hospitals providing the service. The CCAC is also included in the voting because they will be affected by the hips and knees rehabilitation discussion and potentially other outcomes. It was agreed that QBPs would be handled sequentially beginning with cataracts and for each procedure, hospitals/CCAC will be asked to indicate their interest in providing the procedure. If hospitals decline, their data will not be included in the ranking exercise to manage any conflicts of interest.

We are now at the stage where five (5) criteria have been selected and weighted for cataract procedures. Each hospital participating in the program will be evaluated as follows:

Criteria for Cataract Procedures	Measurement
Alignment with MLPA **(Wait Times)**	Proposed wait time
Alignment with provider system role (**Capacity**)	Proposed capacity - provided by hospital
Potential Population Impact **(Need)**	Demographic analysis - calculated by LHIN
Sustainability	* See below
Quality **(Good Outcomes, Low Readmission Rate)**	MOH QBP measure

* The MOHLTC has informed us that QBP prices will be revisited every three years. Prices are set to the 40th percentile and in the next three years, as hospitals adjust to the new prices and lower costs, the revised 40th percentile costs will be reduced. This question asks what is the maximum percentage reduction from the current QBP price that an organization will be able to operate at (i.e. sustain the program) beginning fiscal year 2014/15.

At the June meeting, the group also identified five (5) models of service delivery for cataract procedures and is in the process of defining criteria for the models:

- Status Quo (Volumes and providers are unchanged);
- Volume Optimization Model (providers unchanged; volumes redistributed);
- Cluster Model (fewer providers, volumes & providers redistributed);
- 2 Providers (fewer providers, volumes & providers redistributed); and
- 1 Provider (fewer providers, volumes & providers redistributed).

Once the delivery model has been selected, the highest ranking hospitals, as determined during the first measurement and ranking process, will be applied against the successful model. At the July meeting, the group will be prepared to advance on to stage 4 of the discussions which investigates impacts on the system, health human resources, access, etc. and will provide valuable inputs into the business case stage. In order to keep this project moving along, we are concurrently entering into the initial stages of the Hip and Knee procedure allocations to select criteria.

Diagnostic Imaging (DI) Working Group:
The DI Working Group co-hosted with the LHIN, an engagement session directed towards Diagnostic Imaging (DI) Department Chiefs and/or Medical Directors across the LHIN. The purpose of the session was to educate and update the LHIN, Diagnostic Imaging Working Group and Wait Time Strategy Working Group initiatives and to solicit feedback and input. Paul Barker led the session with an introduction to the Health System Funding Reform, including Quality-Based Procedures and the potential impact on diagnostic imaging in the Central East LHIN.

Lydia Antalfy, Chair, DI Group, provided a summary of the CT and MRI performance and the accomplishments of the DI group, the Wait Time Strategy Working Group (WTSWG) and the LHIN in developing strategies to manage DI performance at a system level. Karol Eskedjian, Lakeridge Health (LH), conducted a demonstration of the Surgical Utilization Booking Management Integration Tool (SUBMIT) program and discussed the plans and consultations underway regarding the potential development of a DI Module (DIRECT). There was considerable interest in this project and the potential for elimination of unnecessary paperwork, protocol and follow-up with prescribing physicians for missing information. The LHIN will continue to engage with this group Through the DI group with a quarterly communiqué and future face-to-face engagements, as required.

Community Engagement

Community Engagement is the foundation of all activity at the Central East LHIN. Being more responsive to local needs and opportunities requires ongoing dialogue and planning with those who use and deliver health services. Engagement with a wide range of stakeholders can be conducted at various levels including informing and educating; gathering input; consulting; involving and empowering.

To assist us in tracking our Community Engagement activities, an ongoing Calendar of Events is kept up to date and shared weekly with staff. It documents all engagement activities with a wide range of stakeholders. Many of these events are also posted on the Central East LHIN website: www.centraleastlhin.on.ca/showcalender.aspx.

Below are listings of recent activities that the Central East LHIN staff have been involved with:

- On June 14th, Wayne Gladstone and Deborah Hammons joined the Minister of Health Deb Matthews and MPP Soo Wong as they celebrated the grand opening of the Alternate Care Settings Clinic in Scarborough. Alternate Care Settings (ACS) are ideal solutions for those eligible CECCAC clients who are receiving nursing care and who prefer the convenience of booking their appointments to fit in with their schedule rather than wait at home for a nurse to arrive.
- On June 18th, mental health and addictions service providers came together at a Durham focused summit, hosted by MPP Tracey MacCharles and attended by all Durham MPPs as well as senior staff from the Central East LHIN. The event was intended to draw on the expertise of key stakeholders who provide mental health services in Durham with the goal of building on the important gains that have been made in the sector, and encouraging future collaboration within the Region. The afternoon included a presentation from the Central East LHIN and breakout discussions. MPP Tracey MacCharles' office is following up on some deliverables that came out of that meeting and will continue to work with the LHIN on an ongoing basis.
- On June 21st, David Sudbury represented the Central East LHIN at the launch of the telemedicine site at Lakeridge Health Port Perry.

- On June 22nd, David Sudbury again represented the Central East LHIN at the ribbon cutting for the new van being supplied to the Oshawa Senior Citizens Centre.

Other Announcements:

North Simcoe Muskoka LHIN CEO Bernie Blais accepts new position: Mr. Blais has been appointed as the new president and CEO for Bruyère Continuing Care in Ottawa. Bruyère provides complex continuing care, palliative care, rehabilitation, care of the elderly, long-term care, research and family medicine. One of the largest health care centres of its kind in Canada. Bernie will be ending his tenure as CEO on August 31, 2012 and we wish him the greatest success.

Operations

Finance and Operations:

The Advertising and Creative Communications Services (ACCS) Report 2011-12 was submitted to the MOHLTC on June 25, 2012, this report included a breakdown on procurement, value and management of all such services during each fiscal year. The Central East LHIN also completed the Broader Public Sector Accountability Agreement (BPSAA) Attestation and Report on the Use of Consultants, which was approved by the Board and submitted to the Ministry on June 29, 2012.

The Q1 Consolidated report covering from April 2012 to June 2012 was completed and was tabled at the Audit and Finance Committee for review as well as the Board Governance budget, travel expenses and per diem claims. These reports are reviewed on a quarterly basis by the Audit and Finance Committee as identified in the Audit and Finance Committee work plan.

In managing the Minister of Health's request for all LHINs to publish expenses from quarter one (Q1) for the Board of Directors, CEO and Senior Directors, the Central East LHIN has completed Q1 expenses which will be posted online to support our commitment in being accountable and transparent. This information will be available online pending approval from the Audit and Finance committee.

The LHIN Shared Services Office (LSSO) has confirmed program support and user licenses for the software Microsoft Dynamics Contact Resources Management (CRM) for all LHINs; Central East has been identified to receive support to facilitate the implementation of the CRM software utilization in the office, licensing will be provided to staff as well as training to continue using CRM as an issues management tool but also expand to a contact management database for the organization. A Project Charter has been completed to support the roll-out and a CRM Implementation Team has been struck and will be meeting biweekly with the expected roll out date to all staff in September 2012.

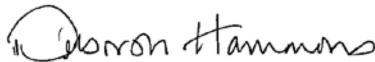
The Records Management protocols are being reviewed and implemented by the Business Support Unit, a 'paper' records inventory is slated for completion during the summer. The transition to the new financial system Microsoft Dynamics GP 2010 is now complete and the business unit continues to process purchase orders, accounts payable invoices and the month-end cycle using the new system. Training for the Human Resources Information System (HRIS) module was offered to LHIN staff in May through the LHINs Shared Services Office. The implementation committee continues to design and configure the system according to the needs specified by all 14 LHINs in preparation for the employee web-based portal, which is scheduled to go live in September 2012.

In May 2012, the Audited Financial Statements were presented to the Audit and Finance Committee and approved by the Board. The final bilingual version will be published in the Central East LHIN Annual Report and

submitted to the Ministry of Health and Long-Term Care on May 30th, this report included the financial statements and schedules regarding assets and transfer payment reconciliations.

Staffing Announcements:
Ajay Thusoo has stepped down from his position as Senior Financial Consultant with the Central East LHIN; we wish him continued success in his endeavors. Naj Hassam has left the LHIN in his role as Team Lead, Performance and Accountability.

Respectfully Submitted,



Deborah Hammons
Chief Executive Officer
Central East Local Health Integration Network

Appendices

Appendix A

CCAC Report.pdf

Appendix B

MLPA_CEEC_Dashboard_May_2012_2.pdf

Appendix C

HSAA Newsletter July 2012.pdf