Central East LHIN

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Central East Local Health Integration Network
CEO Report to the Board
November 17, 2009

The following is a compilation of some of the major activities/events undertaken during the month of October 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. Although, maintaining the focus of the current 2009/10 Integrated Health Service Plan (IHSP), the Central East LHIN is beginning to work towards 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 by10% 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.*

1% Challenge: The call went out for 1% Challenge Submissions and four were received. These will be reviewed internally by LHIN staff and an update provided to the CE LHIN Board of Directors at the December Board Meeting.

Clinical Service Plan – One Acute Care Network: A Cardiac Services Integration Steering Committee has been established as the interim leadership body to commence addressing the action plan to implement the Clinical Services Plan Cardiac Services recommendations. The Committee membership comprises Dr. Peter McLaughlin and Jayne White from Peterborough Regional Health Centre and Dr. Joe Ricci and Bryna Rabishaw from Rouge Valley Health System. The Committee had its inaugural meeting on September 24th and focused on the draft Terms of Reference and integration priorities. Discussions are ongoing with the Central East LHIN to confirm the Committee's roles and responsibilities prior to finalizing the Terms of Reference. A second meeting is currently being scheduled to confirm the Terms of Reference, priorities and short-medium and longer-term objectives.

The Central East LHIN intends to recruit a Regional Cardiac Services Integration Consultant with responsibilities for coordinating, managing and leading projects/activities supporting an integrated Central East LHIN regional cardiac program as envisioned by the Clinical Services Plan. This position will take direction from the Central East LHIN and the Steering Committee. The job description has been prepared and advertisement for the position is expected in early November with recruitment by the end of November.

The Senior Director, PICE met with the Vice President of Clinical and Chief Nursing Executive from the Central East region in early October. He will continue to attend these meetings on a regular basis as this group discusses the Clinical Services Plan and the impact it has on their organizations and how they can assist with its implementation.

LHIN-Wide Credentialing: At a September 22 meeting with the Medical Leadership Group (MLG), the eHealth team presented the results of a Request for Information (RFI) pertaining to the development of an automated LHIN-wide credentialing repository. At the end of October, the eHealth Team presented the Medical Leadership Group (MLG) with a business case for a LHIN-wide credentialing repository. The business case was accompanied by a draft project charter for the project. When the Medical Leadership Group approves the business case and project charter, a RFP will be issued to vendors to develop a credentialing repository.

A current state assessment and process mapping is being undertaken in preparation for the project including:

- current credentialing process
- current projects that can be leveraged to support a LHIN-wide credentialing repository
- current CE LHIN hospital credentialing policies and procedures

ED Avoidance Strategy and Coalition: The MOHLTC/LHIN Minister's Ten Year MHA Strategy Meeting was held on October 6th. The Ministry recognizes the role of the Central East LHIN in implementing innovative strategies to address ED wait times.

An IHI ED Avoidance Strategy Event was held in Chicago from October 26th to 28th, at which the Mental Health and Addictions Lead presented quality outcomes for Mental Health and the importance of cross-sectoral linkages such as financial supports to enhance positive health outcomes. All ED Avoidance Coalition members attended either in person or via phone.

Urgent Priorities Fund Group: The Urgent Priorities Fund group had a meeting on October 8th to discuss the objectives and development of the group's Terms of Reference based on lessons learned. The Senior Director, PICE is part of a team established to develop recommended changes to the UPF process to the MOHLTC, with a focus more on project outcomes and less on inputs.

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.*

On the Aging at Home Year Two: The final proposal of the twenty-two originally submitted for Year two Aging at Home funding, was formally approved by the Ministry of Health and Long-Term Care on October 23, 2009. Comprehensive Geriatric Assessment in the Community (Scarborough/West Durham) can now begin implementation planning. With this approval for $2.4M, approximately 97% of Year 2 funding has been approved. The remaining 3% is in the process of being allocated to an existing project that qualifies for Aging at Home funding but was previously funded under Urgent Priority Funding.

Aging at Home Year 3 (Provincial): On October 9, 2009, the LHIN received formal correspondence from the Ministry re: funding amounts and priorities for Year 3 funding. Given the continued pressures in emergency departments and alternate level of care, LHINs are required to use 75% of their 2010/2011 allocation towards strategies that enhance community services for seniors and address ED wait times. The four provincial priority areas for investment include additional temporary care bed capacity, admission avoidance/timely discharge initiatives, enhanced home care and outreach teams. Each LHIN is now determining its own priorities within these areas. The remaining 25% of Year 3 allocations will be used to create a central fund that the MOHLTC will use to address system-wide pressures in 2010/11. The deadline for the Aging at Home Detailed Service Plan for 2010/11 is January 31, 2010.

Aging at Home Year 3 (Central East): The CE LHIN's Year 3 incremental allocation is now $6,628,584. Priorities for Year 3 in Central East include supportive housing, the spread of comprehensive geriatric assessment in the community and a senior friendly care initiative that resembles components of what is called a "Home First" program. While supportive housing will be included in a general call for proposals, the latter two priorities are being managed through a collaborative process that will result in a targeted proposal development process. The call is expected to be released later this month with the deadline for all proposals due to the LHIN

by early December. After this time, proposals will be reviewed and recommendations brought forward to the January 2010 Board meeting.

Aging at Home Strategy Provincial Evaluation: Throughout the summer months, the province has been designing an evaluation framework for the Aging at Home Strategy. Subsets of like-programs will be evaluated using researchers from various academic and external venues. LHIN staff will be working with these researchers in the evaluation process. While the exact projects to be evaluated are just being finalized, it is expected that two to three of Central East LHINs Aging at Home projects will be included.

H1N1 Update: Primary Care (PC) has been identified as the first line of defense against H1N1; its role is to assess, triage and manage influenza like illness in the community. Peterborough primary care providers are very well organized, coordinated and prepared. Toronto Public Health (TPH), Rouge Valley Health System and the LHIN are working to engage Primary Care physicians in Scarborough. The hospitals in Durham and HKPR are reaching out to those Primary Care physicians with whom they have a relationship. The Ontario Flu Bulletin and recent information provided at the MEOC teleconference indicates that Primary Care providers are seeing large increases in consultations by patients with symptoms of influenza like illness over the previous week's rates.

Hospitals – EDs & Surge Management: Hospitals across Southern Ontario are reporting substantially higher volumes of ED traffic; a significant percentage of these volumes are patients with influenza like illness. CE LHIN hospitals are implementing various strategies to cope; including: establishment of "clean" and "cough" rooms in EDs; moving or cancelling ambulatory care clinics located close to the ED; setting up Flu Assessment Centres. In addition, several CE LHIN hospitals are reporting increases in staff calling in sick. In order to understand what information about key indicators (e.g. ED volumes; % of influenza like illness and number of staff calling in sick, etc) hospitals can provide, by what frequency and whether the data can be compared to the same data from previous time frames, a survey tool to gather this information was sent to them on October 23rd. Responses have been received from all but two hospitals and the data has been rolled up and circulated to the hospital CEOs on November 10th.

Hospitals – Critical Care: Daily reporting of Critical Care Unit H1N1 cases is now in place. The Critical Care Secretariat has purchased 216 ventilators (at a cost of $7 million); these are being allocated by LHIN and will be stored at one designated hospital within each LHIN. The CE LHIN has been allocated 13 ventilators, which will be stored at LHC Oshawa site. The Critical Care lead has instituted a thrice weekly teleconference between managers of the Critical Care Units and LHIN staff; the first was held on November 11th.

Management of Health Care System within CE LHIN: A CE LHIN Emergency System Response Committee has been established, with the first meeting held on November 11th. Its focus is the management of surge within hospitals, including CCUs, EDs and "other".

Long Term Care Homes (LCTH): When LTCHs are designated as being in outbreak, they are automatically closed to new and re-admissions. The CE LHIN has contacted the four MOHs in the Public Heath Units in the LHIN to ensure that the LHIN is aware of any LTCH which is in "outbreak", so that we can use this information to plan and manage hospital ALC accordingly with our key stakeholders.

Flu Assessment Centres (FACs): The status of planning for Flu Assessment Centres which will be funded by the MOHLTC is as follows:

- **Toronto Public Health Unit –Scarborough:** the FAC, which opened on November 11th, is sited at 3000 Lawrence E, next to TSH. TSH will be providing the nursing staff. A second site could be activated in the Malvern area, but it will be hard to find staff for a second site.
- **Durham:** both LH and RVHS will provide the site and nursing staff for Flu Assessment Centres. RVHS will be using space at its Ajax Pickering site. Lakeridge Health will open tents close to the EDs at each of their three sites.
- **Peterborough:** a site has been chosen and evaluated by the Public Health Unit.
- **HKPR:** the PHU is not involved in this process. The Northumberland Hills Hospital ED will become the "default" FAC. Port Hope CHC facilitated a meeting between local family physicians, HKPR PHU and the hospital to discuss setting up an FAC at the CHC site, to operate from 5:00 – 9:00 p.m.

Ministry Emergency Operations Centre (MEOC) teleconferences: MEOC has instituted weekly teleconferences and will increase the frequency if warranted.

Access to MEOC Stockpile: The stockpile of infection control supplies and personal protective equipment can now be accessed by all providers.

Vaccine: To date, MEOC has shipped 2,395,000 doses of the adjuvanted vaccine and 375,000 doses of the unadjuvanted vaccine to the PHUs (allocation by population). For the week of November 16th, Ontario expects to receive at least 700,000 doses. The current priority groups now include first responders, LTCH residents aged 65+ and correctional workers. The next priority group will be children age 5-18. It is expected that the vaccination program will continue at least until the end of December.

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

Surge Capacity Management: Every Wednesday in October the Surge Management Program group is meeting via teleconference to discuss surge as it relates to primary care. The Primary care Lead (staff) will be assisting the Senior Director, PICE with keeping informed and working in conjunction with the Critical Care Secretariat and our Critical Care Lead (Dr. Howard Clasky) and ED Lead (Dr. Cathy Chapman).

Pay For Results: The Year 2 Pay For Results (P4R) monthly performance report was received from designated Hospitals. LHIN staff, P4R hospitals and partnering community agencies met to discuss the results of the reports.

The "Sharing Experience, Achieving Results" day on November 26th will target all hospitals and partnering community agencies to plan for ED Pay for Results.

Unattached Patients Initiative (UPA): It is expected that the UPA project will continue to offer services in Bethany for the next 3-4 months; during this time staff will continue to visit other sites (including Dunsford and Coboconk). The Scarborough fixed site opened the week of October 26th, with a media release going out on November 4th. There has been extensive publicity regarding the Scarborough site to date, and posters have been translated into Arabic, Hindi, Tamil and Chinese. Discussions are underway with the Peterborough City County Health Unit to establish a site there; Oshawa and Havelock are also being targeted. Between September 14th and October 6th, 131 patients were assessed at the Bethany site. The age range was 20-80, with most having had no annual physical for more than 4 years. Roughly one third of the patients seen to date have a significant untreated (and often undiagnosed) medical condition that needs to be managed, including a patient who was discovered to be in heart failure.

Referrals to the Bethany site continue to be below capacity and a number of creative strategies have been implemented to address this issue. A small working group with representation from MOHLTC HCC, CCAC, LHIN and UPA staff met on November 6 in order to put in a process to address the lack of referrals from Care Connectors at CE CCAC to UPA. The target number of patients to be assessed was originally 5,000 by the end of this fiscal year. Due to delays in project start-up, project change requests have been submitted to extend the project to May 2010.

Reducing the Impact of Vascular Disease by10% (2010-2013 IHSP):

Diabetes Indicator Project: The need for organizations to seek review and approval of their Research Ethics Board or equivalent was not anticipated at the on-set of this quality improvement project. These reviews resulted in the need to extend the software license agreement to support a six month pilot project. The Pilot sites are finalizing approvals from their Research Ethic Boards and preparing to initiate data collection. The pilot phase will run until March 31st at which time, based on evaluation, a decision will be made regarding extending the pilot to other sites in the LHIN.

Focus on Population Health…

Wait Time Strategy Working Group: The monthly meeting of the Wait Time Strategy Working Group (WTSWG) involved the development of meeting materials & consolidation and analysis of monthly survey results (including current status of funded volumes completion, wait time performance, wait list triggers, operational capacity & resources, etc.).

The monthly WTSWG survey has been developed to gather pertinent information for the assessment and utilization of the Wait Time Strategy Working Group (WTSWG) members with regards to funded volumes and current wait times for each of the designated key service areas. The over-arching purpose of this survey is to ensure that the vision of the Wait Time Strategy Working Group is successfully achieved, focusing on the identified key objectives as per the WTSWG Terms of Reference.

The intent is to focus on various levels of outcomes and outputs with regards to the following items:

1. Wait Time Information System
    - i. Data Collection & Tools;
    - ii. Utilization of Procedures;
    - iii. Current wait lists; and
    - iv. Timely Submission of Current Wait times (progress in reduction and/or maintenance of);
2. Operational Capacity
    - i. Human Resources;
    - ii. Logistics;
    - iii. Equipment;
    - iv. Miscellaneous;
3. Volume levels
    - i. Base (YTD Actuals & YE Forecast);
    - ii. Incremental (YTD Actuals & YE Forecast);
4. Critical Mass
    - i. Ability/Inability to deliver current base & incremental initial;

ii. Ability/Inability to deliver volumes over and above initial funded volumes;
iii. Ability/Inability to deliver other services not in the designated WTS Key service areas (impact analysis);

5. Capital Considerations
   i. Equipment/Supplies;
   ii. Buildings & Grounds;
6. Impact Analysis
   i. Management & Reporting;
   ii. Best Practices;
   iii. Adverse Events;
   iv. Risks (financial/clinical);
   v. Other;

Through monthly review of this information and execution of related corrective strategies by the Wait Time Strategy Working Group the CE LHIN is beginning to see improvement in all wait time areas.

Focus on Patient Experience…

Self Management Training For Consumers And Caregivers: At the request of the Provincial Diabetes Implementation team, the CE LHIN Program leadership developed a comprehensive report on accomplishments and lessons learned for the Self Management Training for Consumers and Caregivers Project. This request supports the MOHLTC in their consideration of investments in self management initiatives at the provincial level. The Project Manager for the Self-Management project is also presenting on a plenary panel at the "Taking Charge of Our Health" Partnership Development Initiative on November 24th- 25th, 2009 at the Delta Toronto East Hotel.

Disordered Eating Priority Project: The Disordered Eating Project held two professional education events; one for Durham/Scarborough with 85 people in attendance, and one for Peterborough/Haliburton/Northumberland with 80 people in attendance. Participants at the two events included a mixed professional audience of teachers, mental health and addictions workers, primary health workers and Children's Aid Workers.

Focus on Accessible Health Care…

Aboriginal Strategy: Upcoming meetings of the Aboriginal Mnnamoozawin and LaSaantil Advisory Circle are dedicated to finalizing the terms of reference and formulating a work plan for the remainder of the year. Focus is on relationship building and working together on a project that the Circle believes to be relevant.

French Language Services: There has been a lot happening in regards to French Language Services (FLS) in the Central East. The Ministry is planning for each of the 14 LHINs to have their own FLS consultant devoted full-time to the LHIN. A GTA FLS Baseline Survey was conducted by a graduate student from University of Toronto (Rohan Gonsalvas); the report is forthcoming. The French Canadian Association of Ontario Durham-Peterborough has asked the Office of Francophone Affairs that Oshawa be designated under the French Language Services Act. An update will be provided on the outcome of this request.

Enablers

Data Centre Consolidation – 27 hospitals within 5 LHINs: An RFP for the Data Centre was submitted and responses were due Oct 30th, 2009, with follow-up vendor solution discussions scheduled with all respondents to discuss proposal and answer questions.

Clinical Informatics and Subcommittees: The Clinical Informatics Advisory Committee (CIAG) continues to meet monthly with direction of the CNE / VP Nursing Committee. They have asked for clarification on the Health Information System project and how CIAG supports the project to continue to move forward and support the Ontario Shores Meditech implementation. The Committee has provided direction to the Mental Health Subcommittee to continue and will await their clarification before the November meeting on the HIS Project direction for clinical documentation. The Committee has been presented with the current draft of the standards workbook and draft decision documents and has been asked to provide feedback to the Perot Project Team.

Mental Health Subcommittee – Clinical Informatics: The Mental Health Subcommittee (MHS) was tasked by the Clinical Informatics Advisory Committee (CIAG) to develop standards for Mental Health documentation for the CE LHIN hospitals. They have divided into five groups to develop the following areas::

- Crisis, ER and Triage
- Intake and History
- Discipline Specific Assessments
- Daily Flow Sheets
- Care Planning

The groups have categorized and developed a standardized list of elements common to all hospitals' paper and electronic mental health documentation which will be presented to the CIAG group and then the CNE / VP Nursing Committee for approval of the recommendations.

Scanning & Archiving Procurement: A vendor has been selected through a criteria evaluation process. Current contract negotiations are to begin shortly.

E-Forms Procurement: The procurement process for a standardized e-Forms product within the CE LHIN is in progress. Vendor demonstrations were scheduled on Oct 15th with Medirex, Access e-forms, Formfast, and 3M. The anticipated contract start date is Dec 1st 2009.

Eclipse (Solution Q) Portfolio Project Management: A refresh of the current data is being undertaken; a review of current users and projects has been sent to each organization to update access and projects. A review of the system standards is also being undertaken by the task group which will now include a member from CCAC. The task group will refresh the standards to accommodate new eHealth projects, CCAC projects and align the templates to OPS standards (used by the PMO office of the CE LHIN).

Microsoft Enterprise Agreement

Hospitals: In October, there was information provided to the IT Directors on the workshop and benefits and information available. The Reseller is currently working with each hospital to maximize the benefits on a 1:1

basis. Current discussion with IT Directors is on potential areas for consolidated purchasing and use of benefits (i.e. the interface engines for Meditech).

There will be a quarterly check-in (next one in December) with the Reseller (face to face meeting) to ensure the Large Account Reseller (LAR) and Microsoft (MS) are doing their best supporting the hospital. Any administration issues are being supported by CE LHIN eHealth.

Provider: Discussions with Microsoft are ongoing, and a recommended provider list was submitted to MS to confirm their availability for the enterprise license and beneficial pricing. Microsoft is identifying those providers that can be included and CE LHIN eHealth is identifying those providers that already are tied to a current Microsoft Agreement (i.e. CCAC). A draft agreement will be developed in November.

Request to participate letters will go to providers in early November. This will include a quick survey of what products they use now, procurement methods and/or other contractual obligations; and where their interests are on product. This will be gathered and used to reference the draft contract. A subsequent information meeting will be held in late November to discuss the potential agreement with interested provider parties.

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

H-SAA/L-SAA/M-SAA

L-SAA: October was again an active month for the LTC LAPS both locally and at the provincial level. The indicator strategy was previously approved, but additional work was needed to define the performance indicator for the first year of the agreement. A meeting was held in Toronto in October to define the status of "a LTCH operator that was in non-compliance". The group defined the indicator and work is underway to develop its technical definition. Staff met with the LTCH sector on October 8th for a half-day education session in Oshawa to present the LAPS Guidelines and other material. This event was followed by a follow-up web session for those homes that could not attend on the 8th. The deadline for LAPS submission is still November 20th. Staff developed a process to manage the LAPS submission and creation of the LSAA, based on the success of last years MSAA process. The team is developing standard board materials on the LTCH sector to ensure the Board is kept current on the status of the process.

H-SAA: The HSAA process continues to be unresolved while LHINs wait for a decision by the MOHLTC on the sector's financial targets for the term of the next agreement. As soon as targets and a process for H-SAA execution has been decided at the provincial level, the CE LHIN will quickly move to educate the sector on the new process. The previously planned education session was put on hold pending resolution of key issues. A process will be prepared, similar to the LSAA and MSAA processes, to provide summary information for the Board on each hospital and the current status of the overall process to complete these agreements by March 31st, 2010.

M-SAA: Although the MSAA's for the community sector have been executed, the accountability process to date has been informal and includes regular monitoring of the agreements through meeting with health service providers to discuss performance and financial related issues. Regular meetings have been scheduled with the CHC's and the CE CCAC to discuss performance issues.

Performance, Contact & Allocation- Filing System: The new structure of the filing system both hard copy and electronic was presented at the Executive Support Team. As well as some basic "ground rules" on what should be filed and where, there is still fine tuning to this process and determination needs to be made in regards to who should have read/write access to these files and who should have read/only.

CRM/Share Point Project: The CE LHIN has been chosen as one of the pilot sites for the deployment of the CRM and the project charter has been finalized. The internal CRM team has met to discuss resources and strategies to accommodate the roll out process and has completed the gap analysis of the current data supplied by the Executive Support team. The CE LHIN CRM Lead continues to work with the LSSO and their project manager in finalizing the timelines and training options. The tentative Go-Live date is December1st, 2009. The provincial team continues to work on the allocation tracking and future governance models.

Centre for Research in Healthcare Engineering (CRHE):
As noted in the September Status Report, the other LHINS have agreed to financially support the Population Based Allocation Model. The direction from the Senior Directors was to create a new project management steering committee, and transfer responsibility from CE LHIN to a broader group. A new steering committee for the project, now called 'PBAM' for Population Based Allocation Model, was created and held their first meeting on October 28th.

Long Term Care – B & C Redevelopment Program:
The two homes that have submitted applications for the program have been ranked by the CE LHIN. CE LHIN staff had a follow-up meeting with the MOHLTC to discuss the rankings in late October. One home's development is contingent on receiving an additional nine beds, and the LHIN has been in contact with the provider to offer our support for the new licenses. There is a system-wide challenge for all LHINS to redevelop their LTCH's where additional beds are needed to bring the project to a viable size. Understandably, most LHINS will not allow the transfer of existing licenses to another LHIN. This impediment has been raised with the Ministry, and new licenses will have to be issued in many cases to allow these projects to go ahead.

Long Term Care Home Beds: In response to the Board request for additional information regarding the number and location of long-term care beds in the LHIN by geographic location and population projections for age 75+, please refer to the appendix for more information.

Allocations

Funding Letters: Funding letters were processed and we are awaiting sign-backs for:

a) HIRF 2009/10;
b) WTS-In-home Rehabilitation Services;
c) OSC-Forensic Services;
d) MRI Services Operational costs; and
e) AAH: Comprehensive Geriatric Assessment.

Payments were processed for

a) Cash Advance-LHC;
b) WTS-In-home Rehabilitation;
c) CKD/Cardiac Services 2009/10; and
d) ED P4R.

Health Infrastructure Renewal Funds (HIRF): Hospitals have been informed of HIRF amounts and the LHIN is waiting for hospitals to submit their projects (deadline is November 30, 2009).

Annual Reconciliation Report (ARR): Only a few Community agency programs' 2007/08 Annual Reconciliation Reports (ARR) are still outstanding. The 2008/09 ARR process has now started and 8 agencies are completed.

Reallocations: A review of HSP expenditure forecasts is being conducted to identify potential year-end surplus funds available for one-time re-allocation.

Central East Community Care Access Centre (CECCAC): Insights, third party cost containment "value for money" review is complete and the CCAC will report finding to the LHIN in early November.

CHC: Port Hope Dental Suite pilot project is moving forward utilizing surplus funds (in non-protected envelopes) – letter and support from CE LHIN has been sent.

NOTE: The Ministry is now accepting business cases for CHC dental suites across the province and is reviewing potential impact for future years.

Other Issues:

1) The Revised CAT (Community Analysis Tool) training for LHIN staff will be done early November;
2) CAT files and instructions have been sent to Finance staff at all community agencies;
3) Schedule 9 of the MLAA with MOHLTC's MIKE updates as of 30th September; 2009, has been reconciled;
4) Reconciliation of 2008/09 Chronic Kidney Disease (CKD)/Cardiac funding;
5) Results based Planning (RBP) 2009/10 report submitted to MOHLTC on October 31st, 2009 deadline; and
6) Final Aging At Home funding allocations Geriatric Assessment has been approved and funding letter sent to agency.

ARR: The 2008/09 ARR process has just started. We are proactively reviewing the audited statements we have received to date from community agencies and hospitals.

CHC: There is a continuing potential future risk of CHCs accommodation shortfalls once they are in their final premises.

Overview of CE LHIN Healthcare System: A summary of Central East LHIN's Health System and services intended to provide content for the Integrated Health Service Plan (IHSP) was prepared this month.

One Source System (OSS) Business Intelligence Tool: A web-enabled Business Intelligence Tool has been developed and will be maintained by the Ontario Ministry of Health & Long-Term Care, Health Data Branch which will provide an all-in-one (one source) tool which will house and calculate various streams of data.

The One Source Tool will be timely, dynamic and easily accessible to all end users and will be utilizing standardized health performance indicators & methodologies that can be used to assist each organization in identifying and providing insight at the system and lower level details, provide evidenced-based information for decision-making and enable users to drive further improvements at the LHIN and Provider level.

Each organization will be able to submit their external files that are already sent to various bodies such as the Ministry of Health & Long-Term Care, Canadian Institute for Health Information, Cancer Care Ontario, Ontario Hospital Association, etc. The One Source System Tool has been developed with the following

principles/priorities; 1) Quality, 2) Usability, 3) Efficiency, 4) Security, 5) Reliability & Permanency and 6) Cost-Effectiveness.

2008/09 Year End Hospital Service Accountability Agreement (H-SAA) Dashboard: The Hospital Service Accountability Agreement Dashboard has been developed to determine the current status of each public hospital within Central East LHIN in accordance with established priorities and strategies in their respective service accountability agreements. The 2008/09 Year End Dashboards are currently being finalized and will be available in the second week of November 2009.

The primary objectives for the H-SAA Monitoring Dashboards are:

1. Assessment of performance (all domains/quadrants for designated performance requirement/obligations):
    a. Meeting negotiated targets/performance standards/corridors,
    b. Comparison of actuals vs budget and;
    c. Funding reconciliation;
2. Identification of emerging issues/pressures/risks both at the organization level and how this impacts at the system level;
3. Work collaboratively with each Hospital and other internal/external stakeholders in the development of innovative solutions to address and resolve identified issues where applicable.
    - Dialogue and subsequent follow-up where required and in accordance with the "Prioritization Framework" and principles contained within the H-SAA (e.g. Performance Management and Improvement, Section 9.0).
    - Development/Implementation of recommended solutions and outcome assessments going-forward (analysis of impact).

These reports allow the CE LHIN to develop a better understanding of each Hospital's performance for each indicator in each quadrant as well as in relation to the pressures they are facing and how this is impacting at various levels. Updated copies will be provided in a future CEO report.

2009/10 Wait Time Strategy Q2 Re-Allocation: The 2008/09Q2 Re-Allocations (in-year) have been finalized with the resulting outcome that all initially funded volumes allocated to Central East LHIN hospitals at the beginning of the fiscal year 2009/10 will remain within Central East LHIN with some minor adjustments intra-LHIN (i.e. between hospitals).

In the first half of October 2009, the Central East LHIN Wait Time Strategy Working Group (WTSWG) held a meeting to discuss and develop a methodology that would optimize Central East LHIN hospital resources and capacity while continuing to be responsive to patient requirements within our localized catchment areas. This has been successfully completed and due notification to the Wait Time Strategy Office has been communicated.

Currently as of 2009/10 Q1, all key priority service areas are within the Central East LHIN Wait Time targets/corridors/standards with each hospital on track to meet their initial funded volumes. Hips and Knees have been re-allocated intra-LHIN from Rouge Valley Health System (RVHS) & Ross Memorial Hospital (RMH) totaling 156 Hips/Knees volumes to Lakeridge Health Corporation (LHC). Furthermore, after a thorough analysis of various factors (e.g. wait lists, wait time performance, capacity & resources, etc.) each of the CE LHIN hospitals

have identified further ability to complete more volumes *(for further details, please* see Appendix-Central East LHIN Request for Additional Volumes 2009/10).

Ontario Case Costing Initiative: The Ontario Case Costing Initiative (OCCI) is driven by the Ontario Ministry of Health & Long-Term Care with the objective to collect hospital case costing information in order to provide standardized, quality data for evidenced-based decision-making as well as to enable the development of hospital funding methodologies.

For those hospitals that elect to participate, there is a standardized costing methodology (case-specific) that has been developed by the Ministry's OCCI to ensure that data submitted is of good quality. The Ontario Case Costing Initiative (OCCI) collects the submitted data on acute inpatient care, day surgery care as well as ambulatory care cases (plan to collect mental health data which still pending). Case Costing information utilizes MIS standards for both the CIHI version as well as the Ontario-specific version (MOHLTC's Ontario Healthcare Reporting Standards, OHRS). Standards are implemented to ensure that there is comparability in the case costing methodology across hospitals.

Lakeridge Health Corporation is (already fully compliant and one of the original 12 case costing hospitals), Campbellford Memorial Hospital, The Scarborough Hospital, Rouge Valley Health System and Peterborough Regional Health Centre have been participating in the OCCI. In addition, the CE CCAC participates. Of the remaining hospitals (excluding Ontario Shores for Mental Health Sciences), there were 3 who elected to opt out of the Case Costing Initiative: Northumberland Hills Hospital, (NHH), Haliburton Highlands Health Services (HHHS) and Ross Memorial Hospital (RMH).

All 3 hospitals had originally accepted the start-up funding associated with becoming OCCI-compliant in March 2006 (agreement was signed March 31st, 2006) with the Ontario Ministry of Health & Long-Term Care. Subsequent discussion and follow-up with each hospital was initiated by Central East LHIN staff at the request of the Ministry. Resulting outcomes were varied as both NHH and RMH (due to a small pool of resources and other submission/implementation demands) have regretfully declined for now. As of October 2009, Haliburton Highlands Health Services has agreed to become OCCI-compliant and will begin OCCI implementation (communicated to the Ministry's OCCI staff). Hospitals which have signed agreements with the Ministry and have elected to opt out of OCCI implementation will be required to return the start up costs that were provided by the MOHLTC back in March 2006".

Peer Comparison Report: An in-depth hospital analysis tool, using data solely from the Ministry's Healthcare Indicator Tool, has been created as part of the ongoing discussion with Peterborough Regional Health Centre. The analysis is carried out at both a global (corporate) and department (functional centre) level. This was supplemented with a peer perspective as well as with a historical trend review.

The 2008/09 Peterborough Regional Health Centre CE LHIN Peer Comparison (21 peers) Report is available, at the hospital's discretion, to assist in the identification of any potential cost savings and efficiency (operational & utilization). The findings of this study establish a "relative order-of-magnitude estimate of potential savings" and should not be applied for any other purposes other than a methodology for establishing priorities. This methodology should be used in conjunction with further analysis and research before any related implementation strategies are developed. To achieve a portion of these potential savings, a hospital should thoroughly review their overall processes, staffing resources and activities for each functional centre with a comparative perspective to their self-selected peer hospitals in order to best determine the extent of any identified potential savings that can be realistically achieved.

Currently, staff are developing an automated version of this report with the potential to have this peer report (using self-selected peers) generated for all Central East LHIN hospitals at their request.

Health Provider News:

Primary Health Care Services of Peterborough: Primary Health Care Services of Peterborough is the proud recipient of the 2009 Peterborough Chamber of Commerce Business Excellence Award in the category of Health and Wellness. The award was presented at the Chamber of Commerce awards ceremony on October 21st,2009. The Peterborough Business Excellence Awards publically recognize and honour local businesses that have demonstrated a passion for excellence. The Health and Wellness category is in recognition of a business in the health and wellness sector that promotes wellness and vitality in our community and demonstrates recognition of the importance of educating and inspiring individuals to achieve optimal health (as reported in the Peterborough Examiner October 22, 2009).

Lakeridge Health Corporation Mental Health Beds: The Code Grey resulting from the September 9, 2009 incident at the Inpatient Mental Health Program, has officially been terminated. The Inpatient Mental Health Program (3M) is fully back in operation. The Mental Health Director extends a special thanks to all individuals and teams who participated in the coordination of remediation efforts.

Health Care Connect: The Health Care Connect Program continues to produce results, with 42% of the registered patients referred to a family health care provider since February 2009. With 3,800 individuals registered, the Central East LHIN has the second highest number of individuals registered in the Province.

LHIN Collaborative (LHINC) Communiqué: Please find attached the LHINC Communiqué for the month of September 2009.

Core Business Requirements – LHIN Operations

Human Resources: Join me in welcoming back Karen Ouellette from her leave of absence effective Monday, October 26th, 2009.

Policies are currently being developed on the use of blackberry devices, meetings and working from home.

Respectfully submitted,

Deborah Hammons
Chief Executive Officer
Central East Local Health Integration Network

Appendix A

Central East LHIN Request for Additional Volumes 2009/10

Appendix B

LHINC Communiqué

Appendix C

CCAC Report

Appendix D

Hospital Standardized Mortality Ratio [HSMR]

Central East LHIN Request for Additional Volumes 2009/10

HSP	Cancer Surgery	Cataract Surgery	Hips/Knees	MRI	CT	General Surgery	Paediatric Surgery	Colorectal Screening
LHC	0	500	0	500	2,563	0	0	823
NHH	50	200	0	493	205	0	0	0
PRHC	0	0	0	0	0	0	0	0
RMH	0	0	0	0	200	0	0	0
RVHS	0	50	0	551	22	0	0	0
TSH	0	204	0	1,680	0	0	0	0
Total	50	954	0	3,224	2,990	0	0	823

Additional Volume Request - Due Diligence

All CE LHIN hospitals underwent a thorough analysis of their organization's operations and patient requirements which resulted in the requests for additional volumes per key service area as listed in table above:

1 - WT performance considerations based on CE LHIN targets, how it impacts at the CE LHIN-level and Patient demand (higher service demand where demand is higher than the rest of the LHIN) and if # of patients waiting utilizing CE LHIN performance to see if within 90th percentile;

2 - Have the extra capacity and resources (e.g. surgeons, OR blocks, etc.) to do more of these re-allocated services (should be done with existing capacity);

3 - Wait list trigger established, can't take the volumes but don’t have the patients.

Surplus One-Time Incremental Volumes (unmet)

At this time, Central East LHIN Hospitals are on-track to complete all funded one-time incremental volumes as of each respective hospital's September 2009 year end forecast. Central LHIN will not be returning any one-time incremental volumes for 2009/10.

Of all 5 key service areas, Hip and Knee Replacements will be re-allocated in-year from Rouge Valley Health System (RVHS) = 20 & Ross Memorial Hospital (RMH) = 136, total of 156 to Lakeridge Health Corporation (LHC).

LHIN Collaborative (LHINC)
Communiqué
September 2009

This is the third communiqué of the LHIN Collaborative (LHINC). It provides information on the LHINC Council and LHINC activities.

In the interest of open and transparent communication, we invite you to broadly share this communiqué with individuals, health service providers and associations.

LHINC COUNCIL

The selection of members for the LHINC Council is now complete. The Council includes LHIN management, members of provincial associations within the LHINs' mandate, as well as representation from cancer care, public health and primary care. Members were selected from nominees provided by associations in each sector. Council membership will be reviewed after the first year.

The chart below lists the Council members, their sector and the associations/agencies in each sector.

Sector	Member	Associations/Agencies
LHINs	Bill MacLeod, Chair	▪ Mississauga Halton LHIN
	Matt Anderson	▪ Toronto Central LHIN
	Deborah Hammons	▪ Central East LHIN
	Paul Huras	▪ South East LHIN
	Alan Iskiw	▪ Hamilton, Niagara, Haldimand, Brant LHIN
	Chantale LeClerc	▪ Champlain LHIN
Cancer Care	Michael Sherar	▪ Cancer Care Ontario
Community Care Access Centres	Cathy Szabo	▪ Ontario Association of Community Care Access Centres
Community Health Centres	Bill Davidson	▪ Association of Ontario Health Centres
Community Support Services Organizations	Susan Thorning	▪ Ontario Community Support Association
Hospitals	Kevin Empey	▪ Ontario Hospital Association
Long-Term Care Homes	Donna Rubin	▪ Ontario Association of Non-Profit Homes and Services for Seniors ▪ Ontario Long-Term Care Association
Mental Health and Addictions	David Kelly	▪ There are a number of associations that represent mental health and addictions services providers.
Primary Care	Dr. Tim Nicholas	▪ Ontario College of Family Physicians ▪ Ontario Medical Association
Public Health	Tracy Allan-Koester	▪ Association of Local Public Health Agencies ▪ Ontario Public Health Association

Next Steps:

One of the first tasks of the LHINC Council will be to determine priorities for the next year. LHINC is currently consulting with LHINs, provincial health services associations and the Ministry of Health and Long-Term Care (MOHLTC) to identify key areas that should be addressed.

Four value streams aligned with the LHINs' mandate will guide LHINC's work:

- Planning, Integration & Community Engagement
- Allocation Methodology
- Accountability and Performance
- System Alignment and Coordination

STAFF RECRUITMENT

The LHINC Secretariat is currently seeking qualified candidates for the following positions:

- Senior Consultant
- Project Consultant
- Executive Assistant, LHINC and LSSO

Additional information is available in the Careers section of the Toronto Central LHIN's website at: www.torontocentrallhin.on.ca

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LHINC OVERVIEW

LHINC was formed to strengthen relationships between service providers/associations and the LHINs and to support system alignment. It is a LHIN-led organization and advisory and accountable to the LHINs. Its role is to support the LHINs in:

- Fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system;
- Their role as system manager;
- Where appropriate, the consistent implementation of provincial strategy and initiatives; and
- The identification and dissemination of best practices.

LHINC is funded by the LHINs with support from the MOHLTC. It is lead by a Council whose role is to set priorities for the organization. It is supported by a secretariat whose role is to provide:

- Analysis, research and coordination;
- Project management support;
- Coordination and administrative support for LHINC committees; and
- Support for communications to LHINs, system stakeholders and the MOHLTC.

LHINC is currently involved in the following initiatives:

- Hospital Service Accountability Agreement development
- Long-Term Care Service Accountability Agreement development
- The MOHLTC's Long-Term Care Funding Review
- Engaging People. Improving Care. - EPIC website (www.epicontario.ca)

For additional information, contact:

- Mario Tino, *LHINC Executive Director* (mario.tino@lhins.on.ca , 416-489-8097)
- Liane Fernandes *LHINC Senior Consultant* (liane.fernandes@lhins.on.ca , 416-480-1515)
- Location: 120 Eglinton Avenue, East, Suite 500, Toronto, ON M4P 1E2

Connecting you with care
Votre lien aux soins

CCAC CASC

Community Care Access Centre

Centre d'accès aux soins communautaires

CECCAC Report to the CE LHIN Board of Directors
November 1, 2009

The many cost containment strategies implemented over the past six months have resulted in some savings in terms of personal support utilization reduction and the new wound protocol. However, the cost containment measures have not been effective at totally offsetting the relentless service volumes for clients admitted from the acute sector and thus the CECCAC continues to incur month over month deficits.

*n*D Insight has completed the first phase of the Cost Containment Value For Money Review and has identified ten projects aligned within three implementation clusters; Standardize Service Allocations, Ensure Organizational Clarity, and Strengthen Stewardship & Relationships. These projects are in addition to and complementary to cost containment initiatives already implemented by CECCAC and align well with our overall strategy.

The Cost Containment Review highlights that a cumulative balanced budget at March 31, 2011 requires that CECCAC must hold spending in line with funding allocations over the next 18 months and fully implement the cost containment strategies and projects in a rapid fashion. This projection is based on the forecast to March 31, 2011 done by nD Insight that projects a 2009/10 year end deficit of ($6.2M) in addition to the 2008/09 deficit and a cumulative balanced position at March 31, 2011.

The key assumption as noted above is the absolute requirement to quickly lower service volumes to be in line with funding allocations and successful implementation of the cost containment strategies. The CECCAC will strive to make the recommended changes but we continue to believe the CECCAC requires a base funding adjustment to address many of the existing pressures that are before us.

While the CECCAC will become a very efficient operation through implementation of the cost containment strategies, the achievement of a balanced budget does have profound implications including:

- An extensive community personal support waitlist that already has more than 1,300 persons waiting for service and will continue to grow over the next 18 months.
- Waitlists for adult therapy will be necessary to hold volumes to allocations
- Ministry/CELHIN priority projects that result in volume growth must be fully funded to include the service volume piece. An example is the very successful initiative to place case managers in the emergency departments of three hospitals sites.

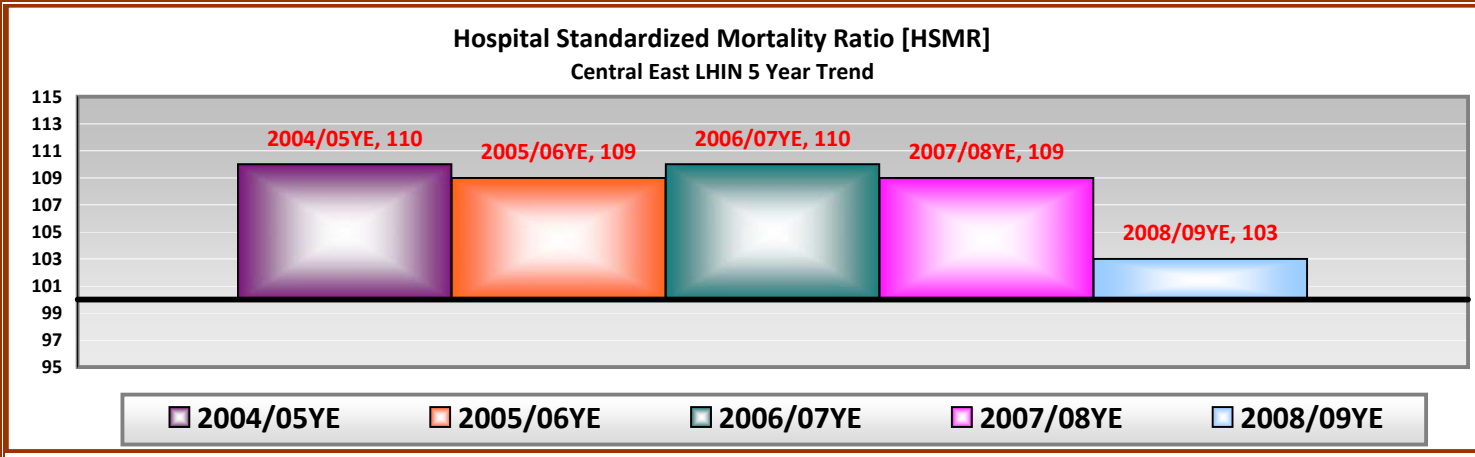
The results of the *n*D Insight work to date will be presented to the CECCAC Board on November 11, 2009 and to the CELHIN subsequent to that date. The presentation will highlight the three key issues:

1. Cost containment opportunities
2. Base budget adjustment requirement
3. Appropriate funding adjustment for new programs/services as brought in

The CECCAC fully understands that we must balance the budget by March 31, 2011. This will require a concerted effort by CECCAC staff, our service providers, the CELHIN and other community partners.

Hospital Standardized Mortality Ratio (HSMR) Trend
CE LHIN 2008/09 - Current Status

Definition



Methodology:
The Hospital Standardized Mortality Ratio (HSMR) is an indicator which calculates a ratio that calculates 80% of inpatient mortality, number of actual deaths (observed) versus the number of expected deaths based on each fiscal reporting period's national mortality rates. This calculation includes variables which have a significant causal effect such as age, gender, length of stay and types of admissions.

Ancillary Details:
1 - Actuals deaths are counted and summed based on a number of factors which includes a patient's co-morbidities (other medical factors aside from main reason for patient's stay) along with the patient's most responsible diagnosis (main reason for patient's stay) and other ancillary variables such as transfers to and from an acute care facility and various inclusions/exclusions (e.g. elective and/or considered urgent patients, non-Canadian residents, length of stay capped at 365 days, cadavers, stillborns, etc.).
2 - Expected deaths are derived from calculating the "probability of in-hospital deaths for each record" where a weight is applied to determine each of the actual deaths that occurred in each hospital, in comparison to national information (patient's record compared to other patients with similar attributes and medical conditions), what is the predicted likely outcome.
****All actual & expected mortality rates are based on pre-defined diagnosis & co-morbidity groups, re-admissions & the above-mentioned variables such as age, sex, LOS, etc.*

Interpretation:
Outcomes should be used to identify and plan/implement key areas for improvements (e.g. action plans). The outcomes indicate performance where mortality rates are higher than expected at the various reporting levels (actuals vs expected). In essence, it can assist any organization in how to track changes over reporting periods within designated medical clusters (patients with similar medical conditions). It speaks to "quality of care" within a hospital site and should be used as a launch point for further investigation (if actuals are above the expected number of deaths for each clinical cluster).
Ratio = 100 indicates comparable to average national rate, above 100 indicates higher ratio than national average rate, below 100 indicates lower than national average rate.

Supplementary HSMR's (based on Peer Groups):
In addition to Site-Level HSMR results, the Canadian Institute for Health Information has developed lower-level HSMR's to better "identify more specific areas of improvement".
Each Supplementary HSMR utilizes specifically-calculated statistical models "fitted for each HSMR Peer Group".
1 - Medical & Surgical HSMR:
2 - ICU-Related HSMR Cases:
3 - HSMR excluding Transfers:

Process in Identification of Drivers:
1 - Examination of patient charts.
2 - Where the hot-spots are (e.g. program clinical clusters, department levels, major clinical categories) that are driving the site-level outcomes.
3 - Development and implementation of teams to review and address (finding innovative solutions) where clinical practices are in question.
4 - Coding practices (e.g. Data Quality Review).
*****Coding practices and data quality issues may be a significant driver which can skew outcomes. First step in any higher than expected results should be to investigate and address/rule-out reporting practices.*

Excerpt from "HSMR: A New Approach for Measuring Hospital Mortality Trends in Canada" (CIHI Document), focus is on prevention where possible, utilizing recommended operational practices/processes such as:
- *Improved Care for Acute Myocardial Infarction*
- *Prevention of Central Line-Associated Bloodstream Infection*
- *Medication Reconciliation (prevent adverse drug events)*
- *Rapid Response Teams (for patients progressively failing and receiving services outside the ICU)*
- *Prevention of Surgical Site Infection*
- *Prevention of Ventilator-Associated Pneumonia (implementing a set of interventions known as the "VAP bundle.")*

In accordance with CIHI findings as related to Mortality, it was noted that the 10 most prevalent factors accounting for 44% of deaths reported at the national level are:
1 - Acute Myocardial Infarction;
2 - Heart Failure;
3 - Pneumonia;
4 - Chronic Obstructive Pulmonary Disease;
5 - Septicemia;
6 - Malignant Neoplasm of Bronchus or Lung;
7 - Stroke (not specified as hemorrhagic or infarction);
8 - Cerebral Infarction;
9 - Respiratory Failure;
10- Hip Fracture;