Central East LHIN

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Central East Local Health Integration Network
CEO Report to the Board
December 15th, 2009

The following is a compilation of some of the major activities/events undertaken during the month of November 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: Four proposals were received for the second wave of the 1% Challenge. Summaries of these proposals have been posted on the CE LHIN website and are being reviewed internally by staff based on the following criteria; 1) consistency with the goals and objectives of the 1% Challenge, 2) validity or reasonableness of the pre-proposal's assumptions, 3) targets and implementation plan, 4) alignment with CE LHIN Strategic directions and strategic aims, 4) and potential of an implementation/reinvestment partner. A more comprehensive report will be prepared for the Board at an upcoming meeting.

Alzheimer Society Voluntary Integration Proposal: The Central East LHIN received a Notice of Intention to Voluntarily Integrate Services between the Alzheimer Society, Peterborough and Area and the Alzheimer Society Kawartha Lakes on December 3rd, 2009. Briefly, the proposal intends to wind up the affairs of the Alzheimer Society of Kawartha Lakes and to rename the Alzheimer Society of Peterborough and Area to The Alzheimer Society of Peterborough, Kawartha Lakes, Northumberland and Haliburton. The consolidated organization will have an expanded geographic range, simplified administrative process, improved capacity to serve the client population and will be governed by one set of by-laws.

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.*

H1N1 Update: Current Influenza-like illness (ILI) activity is lower compared to the previous week. ILI primary care consultation rates decreased slightly; fewer hospitalized cases were reported. 95 deaths have been reported in Ontario for the year to date. MEOC remains on enhanced status and continues its weekly teleconferences with healthcare stakeholder groups, in which LHIN staff participates.

All nine hospitals report Emergency Department (ED) volumes that are closer to normal for the time of year, and reduced ILI rates as compared to October 2009. The Scarborough Hospital had opened a Flu Assessment Clinic, which has now been closed as of November 27, 2009 as it is no longer needed.

Critical Care: Daily reporting to the Critical Care Secretariat continues. The Influenza-like illness (ILI) data capture form has been revised to capture suspected ILI cases in Critical Care Units as well as confirmed cases.

Financial Pressures: The current financial climate does not allow the MOHLTC to make any funding commitments at this time, but health service providers need to ensure they prioritize and maximize existing financial and staffing resources in appropriately responding to the pandemic.

Peterborough PHU: The Pandemic Influenza Planning – Assessment Centres Committee held its last meeting on December 3, 2009, due to the decline in H1N1activity.

Ontario Health Quality Council (OHQC) Long Term Care Quality Improvement: The Residents First - Advancing Quality in Ontario Long-Term Care Homes is a bold new provincial initiative that brings together all stakeholders in the long-term care sector in a concerted effort to raise the quality of resident care to a level that is the best in Canada and comparable to leading jurisdictions the world over. The MOHLTC has authorized the OHQC to proceed with the rollout of this new initiative in partnership with LHINs. A governance structure has been put in place which includes representation from LHINs involved in the first year of implementation (2010). They include: Central East, Hamilton Niagara Haldimand Brant, Mississauga Halton and the North West. To achieve this, the OHQC is planning to provide an unprecedented level of support to homes. Expected outcomes include reduced adverse events and improved clinical outcomes, reduced visits to emergency departments, and a consistent and overall enhancement in both resident experience and staff satisfaction.

This approach will see the Ontario Health Quality Council (OHQC) working in partnership with local health integration networks (LHINs) over five years to enhance the knowledge and skills for continuous quality improvement within long-term care homes. Efforts will be guided by a provincial steering committee that includes the Ontario Long-Term Care Association (OLTCA), the Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) and over a dozen provincial organizations. They will be active participants in all aspects related to implementation, including communications. Continuous quality improvement is about empowering people for change. In keeping with this underlying principle, the participation of homes in this initiative is voluntary. The goal is to reach 100 homes in the first year.

Planning Partners Webinar: The CE LHIN is hosting a web-based seminar with our Planning Partners to support the rollout of the 2010-2013 Integrated Health Service Plan (IHSP). In addition to providing them with some key information on how we will work together to achieve the two Strategic Aims, we will also use this webinar to discuss the upcoming refresh of the LHIN's "Framework for Community Engagement" and how the Planning Partner teams can be re-tooled to support the implementation of the IHSP.

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

Surge Capacity Management: The new LHIN wide committee to help manage surge – the System Surge Management Committee - has been formed and has held two meetings to date, with the next meeting to follow on December 17th. This group has been developed in response mainly to the H1N1

surge issues seen in the LHIN hospital Emergency Departments and how that affects the system on a whole. The membership is compiled of senior CNE/VP representatives from all the hospitals and the CECCAC in the LHIN. Their focus will be to work together to develop strategies to support minor (provider specific) and major surge (multi-provider) management in the future.

Pay For Results: The third monthly report has been received from Year 2 Pay-for-Results designated Hospitals reporting performance. The "ED Pay for Results Sharing Experience, Achieving Results" day was held on November 26th with all CE LHIN hospitals where best practices were shared and planning to achieve our targets was discussed. The Quarterly Stocktake report was completed and submitted as part of provincial submission to MOHLTC of all the LHINs. Our meeting with Ken Deane to discuss the contents of the report took place on December 3rd.

Unattached Patients Initiative (UPA): Referral and assessment volumes are steady for the fixed site which opened in Scarborough at the end of October. The VON in Peterborough has filled its Nurse Practitioner vacancy in Bethany, so UPA will be moving out of that site and is considering where to site its next rural clinic. Sites under consideration include Havelock, Peterborough and Oshawa. Between September 14 and November 30, 2009, 265 patients were assessed at the Bethany site. More than 2/3 of the patients were aged 41-70 years. Most have not had an annual physical for more than 5 years. Seventy (70%) percent had an undiagnosed medical condition/advanced risk factors.

Nurse Practitioner (NP) Outreach Teams: NPs are seeing patients in LTCHs. One of three teams has had NP recruiting difficulties similar to those across Ontario. The NP Clinical Director position has been posted by the CCAC.

New Nurse Practitioner Led Clinics: An announcement was made by the Honourable Deb Mathews, Minister of Health and Long-Term Care on November 27th, 2009 regarding the eight new Nurse Practitioner Led Clinics (Wave 2). The Canadian Mental Health Association Durham will host a new team in the CE LHIN.

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

Telestroke: The Provincial Telestroke roll-out team started conducting weekly teleconferences to develop a letter for Deputy Minister Ken Deane for Ministry support of their recommendations. The letter was finalized, signed and sent by Mimi Lowi-Young, CEO of the Central West LHIN who sits as the Ontario Stroke Network Champion, Mr. Malcolm Moffat, Chair Ontario Stroke Network Provincial Coordinating Council, and Dr. Frank Silver, Medical Director, Ontario Telestroke Program. To date there has been no response to the letter from the Ministry. Failure to support the recommendations, specifically the recommendation providing support for physician-on call, will jeapordize the future of Telestroke in the very near future.

Provincial Diabetes Strategy: The Honourable Deb Matthews, Minister of Health and Long-Term Care and the Honourable Margarett Best, Minister of Health Promotion announced a broad range of programs under the Ontario Diabetes Strategy. First, and in keeping with other health priorities, the government announced provincial targets to ensure that Ontario's Diabetes Strategy is producing results for Ontarians. Those include 1) Attaching all people with diabetes to a primary health care provider, and 2) Ensuring that 80% of people with diabetes, aged 18 and older, have all three diabetes tests completed.

To help meet these targets, the province is moving forward with a number of new initiatives that will help people manage and prevent diabetes, including:

- Creating 51 new diabetes education teams across the province
- Expanding chronic kidney condition services, including additional clinic visits and increased dialysis treatment at home
- Creating up to 14 regional coordination centres to help better organize and manage local diabetes programs
- Expanding diabetes care and prevention resources, including new education tool kits for newly-diagnosed patients, community-based prevention programs for high-risk groups, enhanced services through EatRight Ontario and a new Stand Up to Diabetes website.

In line with this strategy, a number of health care providers across the LHIN have provided positive feedback regarding the Central East LHIN Diabetes Resource Guide which was recently re-printed to meet growing demand.

Focus on Population Health…

Mental Health and Addictions Strategy: The work of the Consumer Partnerships Theme Group Meeting is close to completion. The report from this group will go forward to the larger Minister's Advisory Group to be incorporated into the final Mental Health and Addictions Strategy: "Every Door is the Right Door".

Focus on Patient Experience…

Taunton Mills Transitional Beds: Over the first five months of this project, the TCU has contributed to patient flow at Lakeridge Health by saving 2,622 hospital days.

Focus on Accessible Health Care…

Aboriginal Strategy: The CE LHIN Aboriginal Strategy continues to move forward. The MHA Lead attended a very positive meeting of the Advisory Circle in Peterborough on November 19th, and participated in GTA and Provincial Aboriginal Networks. The next Aboriginal Advisory Circle meeting is planned for December 16, 2009 and the GTA Aboriginal Leads are meeting on December 14, 2009.

Enablers

HIS Consolidation Standards Project: This project was terminated in phase II by the Central East Executive Council on November 24th. To wrap up, the project team will create/update the draft dictionary standards documents, document the opportunities for clinical transformation, current and new workflow and business processes through onsite visits. The implications of the project termination include lost momentum and increased cost at re-startup. The work done with Ontario Shores to date may be leveraged for future applications.

eHealth Community Consultation: Membership of a task group has been determined, with representation from CCAC, Long Term Care, Hospice and Palliative, Community Health Centres, and Community Care. The first meeting was held in November to discuss their mandate and the issues specific to each sector. The next meeting in December will develop the issues and opportunities matrix for non-hospital / community agencies based on eHealth needs. This information will be shared with the eHealth Steering Committee in January.

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

H-SAA/L-SAA/M-SAA

Provincial L-SAA Committee: Compliance status is the sole performance indicator for 2010-11. A working group consisting of LHIN, Ministry of Health and Long-Term Care (MOHLTC) and sector (Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS), Ontario Long-Term Care Association (OLTCA), Association of Municipalities of Ontario (AMO) and City of Toronto) representatives was created to define the compliance indicator status and develop an indicator technical document. The group met on October 19th, 2009 and unanimously agreed to an interim definition for non-compliance for Phase 1: "Non-compliance for the purpose of the agreement is any status of either: enhanced monitoring; or enforcement; or cease of admissions." This definition was presented to the L-SAA Steering Committee on October 21st, 2009 and approved.

Centre for Research in Healthcare Engineering (CRHE): The contract for this project has been finalized between the LHINs and the University of Toronto, and the reconciliation of funding (former LEAP funding) has been completed. The next steps are to add the specific requirements to the contract schedule and execute the agreement. A new Steering Committee has been involved, and a hand-off meeting between the past Chair, John Lohrenz, and the new Co-Chairs was held in November. Further involvement of this LHIN will be limited to participating in the Steering Committee as a member only for one term.

Long Term Care – B & C Redevelopment Program: As noted in the November report, there are two homes in the CE LHIN that submitted applications for funding under the B-C redevelopment program. The Minister has not made the official announcement of homes approved for this phase. One of the applicant homes required the transfer of nine additional beds from another LHIN to move up to a viable 64 bed size. Although the beds could not be secured in time for the first round deadline of November 20th, the Ministry is expected to recommend a conditional approval for 64 beds based on the operator securing the additional beds at a later date.

Population Growth (75+) in CE LHIN: The Board during the presentation of LTC home education material inquired about the availability of more detailed information on the 75+ population in the LHIN. Staff followed up and requested additional more localized population data for the LHIN based on the 2006 census. The LHIN received this additional data, and looked at growth rates for the areas provided. It was noted that the overall growth rate of this population for the LHIN in the next 10 years is 22%, or over 26,000 additional people over 75. The planning target for beds was based on 100 beds for every 1,000 75+, assuming the current level of beds of 9,704, that planning target in 2019 is reduced to 74.28. The highest growth rate in the CE LHIN is in the Region of Durham at over 34%, or by 15,040 people.

Haliburton has a high rate of growth of 26%, but that only represents 510 people, followed by Northumberland at 22% (2,180), Peterborough at 16% (2,350), Kawartha Lakes at 16.4% (1,370) and by Scarborough at 11.5% (4,927). A presentation with this information (presented in both maps and graphs) is attached.

Allocations: Funding letters and payments were processed for: a) final AAH project, b) Base MRI for LHC, c) OSC enhanced forensic services, and d) new LHC cash advance. Although additional funding allocations occasionally are sent to the various agencies and hospital, there continue to be challenges with some of the hospitals and with the CE CCACC in reaching a balanced position at year end. PCOP funding has been delayed and in the uncertainty of how much, or whether any, funding will be available, some hospitals are struggling to meet balanced expectations with their new service growth.

Year-end Surpluses: The health service providers have been asked, by CE LHIN, to provide preliminary forecasts of expected year-end surpluses by December 11th. A summary for the 2009/10 fiscal year will be compiled to include base funding as well as AAH and UPF projects surplus estimates. A process to evaluate P4R funding and potential surpluses has been completed with the health service providers in the last month of December. The reallocation of surplus funds depends on the accuracy and timely reporting for projects and base allocations from the community agencies. All surplus reallocations between sectors need to be reported to MOH by the Q3 December 31st deadline.

Health Infrastructure Renewal Funds (HIRF): Based on the Board approval of HIRF funding allocation to hospitals in November, all hospitals have provided their HIRF requests to the CE LHIN and met the November 30th deadline. LHIN must finalize the project authorizations by December 31st for the hospitals that have completed their submission requests so that the payment direction can be made in January 2010.

Annual Reconciliation Report (ARR): The 2008/09 ARR (Annual Reconciliation Reports) for the CSS and CMH community agencies have started and are being reviewed by staff as they come in. The recovery process for related surplus dollars in the 2007/08 fiscal year is well underway by MOHLTC.

Reallocations: A review is being done for the request to reallocate funds from the Alzheimer's Society of Durham to the Ontario Shores Centre relating to the Psychogeriatric Resource Consultant.

Central East Community Care Access Centre (CECCAC): *n*D Insights cost containment "value for money" review has been completed. The report results will be shared with the board (in January 2010). The CCAC met with CELHIN senior staff in November to review the results of the *n*D Insight consultation and to discuss required actions to achieve a balanced and reduced monthly spend rate ensuring that the accumulated deficit position does not increase and that full recovery of the accumulated deficit by March 31, 2011.

CHC: The CHC issue of under-funded occupancy cost shortfalls for the three CHCs currently facing this challenge (Youth Centre satellite, Port Hope and TAIBU) has been moved forward to the Ministry and we are still awaiting determination of the potential for additional funding to cover this (or not). The Port Hope CHC has opened their now fully functional dental suite and have begun services using available surplus base funds on a pilot project basis. There is the potential future risk of CHCs accommodation shortfalls once they are in their final premises. Some are leasing several temp sites, but are currently managing.

- Brock CHC is solving their rent issue with a capital grant from MOH to build their own building.

- City of Kawartha Lakes CHC is still in temporary quarters and in negotiations for a final location. They are trying to find a place within their budget and will not be in a pressure situation until this is finalized and they move (about 2012)
- The Port Hope CHC is still struggling to find permanent operating funding for their dental services suite which is now ready for clients and open as a pilot project only

Other Issues: The Q2 actual results from the HSPs have been delayed due to the implementation of the new CAT tool for community organizations. Training has been completed for the community agencies; however delay of the tool on the WERS system has pushed the Q2 reporting deadline to December 6th.

We are working with capital branch to review various on-going capital projects within our LHIN, as well as working with Capital Branch on knowledge transfer challenges. The LHIN will be discussing and reviewing "own source" capital projects with Ross Memorial, Northumberland Hills and Lakeridge Health hospitals. There may also be some discussions with Peterborough hospital.

Peterborough Regional Health Centre (PRHC) – Roger Street Site*:* The Peterborough Regional Health Centre recently sold their Roger Street site and there has been some media attention regarding the final purchase amount. Attached is the October 19th Press Release relating to the sale of the property. Included are additional details regarding the sale which was posted on the PRHC website.

L-SAA: November was a relatively quiet month for LAPS, the LHIN focused on designing the internal review process for the LAPS and LSAA. The due date for LAPS was November 20th, and all but the Extendicare Homes were able to commit to the deadline. Extendicare requested an extension to November 27th to coincide with its public reporting timelines. The LHINS collectively decided to allow this extension, but will reinforce with all providers the importance of providing materials on time. As of November 26th, the CE LHIN had 52 of 68 LAPS submitted (76%), excluding the 10 exempted homes, our return rate is over 90%. The LHIN created a sign-off and review process for key staff, and have dedicated resources to ensure the agreements are not delayed. At the provincial level, the technical definition for the Compliance performance indicator (the only performance indicator) was finalized on November 27th, but some work remains to prepare interpretation guidelines for the LHINS and the field.

H-SAA: The uncertainty around the HSAA process was finally resolved with the decision to extend the existing agreement, and the release of MPRR, or 'Management Planning and Risk Reporting' documents. These documents are intended to document hospital level strategies to maintain a balanced position (in each of a 0%, 1% and 2% funding scenarios), which is their obligation under the Commitment to the Future of Medicare Act (*CFMA).* Because the LHIN met with the hospital sector in June and agreed on its planning assumptions, much of the work needed to complete these reports has been done by the hospitals already. The LHIN has asked the hospitals to send their draft reports for review by December 4th. The purpose of the review is to assess the total system impact of balancing strategies on the LHINS IHSP directions and priorities. Adjustments to individual strategies will be made by December 8th; the final reports will be submitted to the LHIN December 15th. These reports are considered confidential hospital reports submitted to the LHIN.

2008/09 Year End H-SAA Performance Assessment Dashboard: The Hospital Service Accountability Agreement Dashboard enables CE LHIN to accurately monitor and assess the current status of each public hospital. This is a requirement of LHIN/Provincial priorities and strategies as well as the 2008-10 Hospital Service Accountability Agreement (e.g. Schedules). A copy of the H-SAA Performance Assessment Dashboard is attached and will from this point forward be posted each quarter on the CE LHIN website.

M-SAA: Although the MSAAs for the community sector have been executed, the accountability process to date has been informal and includes regular monitoring of the agreements through meetings with health service providers to discuss performance and financial related issues. Regular meetings have been scheduled with the CHCs and the CE CCAC to discuss performance issues. No meetings were held in November, but steps have been taken by the CHC ED group to create a CHC indicator group with LHIN participation

2009/10 M-SAA Performance Assessment Dashboard: An automated Multi-Sectoral Service Accountability Agreement (M-SAA) Dashboard is currently being developed to assess the current status of each community health service provider within Central East LHIN in accordance with established priorities and strategies. This will facilitate individual Health Service Provider reviews that will be conducted for each reporting period (fiscal quarters & Year End) and will be consistent with LHIN specific performance obligations as negotiated as part of Schedule E (2009-11 Multi-Sectoral Service Accountability Agreement). It is expected that the dashboard will be completed by *January 2009.*

CE LHIN Peer Comparison Report: An automated benchmarking report has been developed for Peterborough Regional Health Centre utilizing the hospital's self-selected peers to evaluate and study their organization's current performance in relation with other similar hospitals (department-level focus). This report uses both financial and statistical information within a cost & operational efficiency perspective to identify & learn from their peers (any discernable areas/practices/processes) that may be of benefit to their own hospital's current internal processes and practices.

The report provides an automated in-depth analysis of a hospital at both a global (corporate) and department (functional centre) level which provides a multi-faceted view.

It is hoped that the CE LHIN Peer Comparison Report can assist a hospital in the identification of any real or potential cost savings and efficiency (operational & utilization) with the findings of this study established on a "Relative Order-of-Magnitude Estimates" (not be applied for any other purposes other than a methodology for establishing priorities).

Ministry/LHIN Accountability Agreement Performance Assessment Dashboard: A 2009/10 Q2 Performance Variance Report has been completed and sent to the Ministry of Health & Long-Term Care detailing performance for two of the seven MLAA Performance Indicators that are above the performance corridor, 90th Percentile Wait Times for both MRI & CT (MLAA Indicators 8 to 11, as listed below, are reported via Stocktake Report).

******A 2009/10 Q2 refresh is in progress and will be available December 1st, 2009.***

Current 2009/10Q2 Status:

1. 90th Percentile Wait Times for Cancer Surgery:
   - Below Performance Corridor & LHIN Starting Point, wait times slightly increasing **(4.3%)** from Quarter 1.
2. 90th Percentile Wait Times for Cataract Surgery:
   - Below Performance Corridor & LHIN Starting Point, wait times slightly decreasing **(-1.6%)** from Quarter 1.
3. 90th Percentile Wait Times for Hip Replacement:
   - Below Performance Corridor & LHIN Starting Point, wait times slightly decreasing **(-5.8%)** from Quarter 1.
4. 90th Percentile Wait Times for Knee Replacement:
   - Below Performance Corridor & LHIN Starting Point, wait times slightly increasing (4.9%) from Quarter 1.
5. 90th Percentile Wait Times for Diagnostic MRI Scan:
   - Above Performance Corridor, wait times significantly increasing (20.7%) from Quarter 1.

Note: Wait Times for MRI Scans are challenged as volumes have increased significantly for 3 CE LHIN hospitals (RVHS – influx of referrals, TSH – influx of referrals and via ED, NHH – negative impact of reduced incremental hours from prior fiscal year). The 4th hospital's (LHC) increase in wait times as of Q2 due to equipment issues on aging MRI machine but expected to improve with commissioning of 2nd MRI machine). Volumes remain on track to be completed by end of the fiscal year and all hospitals are committed to performing in accordance with the CE LHIN 2009/10 Target. Due to budgetary concerns, one or more hospitals are budgeting the delivery of volumes to funded levels where applicable as historically they have delivered MRI services over and above their funded volumes.

6. 90th Percentile Wait Times for Diagnostic CT Scan:
   - Above Performance Corridor, wait times significantly increasing (23.5%) from Quarter 1.

Wait times for Diagnostic CT Scan have increased due to increasing volumes via referrals and ED (also driven by an increase in the complexity of patient medical conditions services such as Colonography). A further complication is a decreased capacity due to equipment issues (old machines requiring frequent repairs). A third component impacting wait times is the reduction of incremental volumes for CT Hours from the prior fiscal year. Due to budgetary concerns, one or more hospitals are budgeting the delivery of volumes to funded levels where applicable as historically delivered CT services over and above their funded volumes.

7. Median Wait Time to Long-Term Care Home Placement -All Placements:
   - In Performance Corridor, slightly above LHIN Starting Point but wait times significantly decreasing (-17.0%) from Quarter 1.
8. Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution
9. Proportion of Admitted patients treated within the LOS target of <= 8 hours
10. Proportion of Non-admitted high acuity (CTAS I-III) patients treated within their respective targets of <= 8 hours for CTAS I-II and <= 6 hours for CTAS III
11. Proportion of Non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of <= 4 hours

Health Provider News:

New psychiatrists join Rouge Valley Ajax Pickering Site: As part of the hospital's effort to expand outpatient mental health services, two psychiatrists have joined Rouge Valley Health System's (RVHS) Ajax and Pickering hospital campus and will focus on expanding mental health outpatient services for patients in the west Durham area. "We are pleased with the additions of Dr. Drandic and Dr. Omoruyi to

our mental health team here at Rouge Valley. As we continue to develop our outpatient mental health services for our patients in the west Durham region, we know that they will both become much valued members of our medical team here," says Dr. Steven Fishman, chief of psychiatry, RVHS.

Carefirst Seniors, Community Services Association and Scarborough Regional Dialysis Program: The project aims to integrate the efforts of different health care sectors to improve the quality of client care for individuals who suffer from or are at risk for chronic renal disease through: prevention, early detection, enhanced referral and case management, timely assessment/diagnosis and treatment, and chronic disease education and support toward client self-management.

St. Paul's L'Amoreaux Centre Seniors for Law Enforcement Together (SALT): This program, which was first implemented by the Ontario Provincial Police in Orillia, identifies and raises awareness of crime prevention methods, legal education and personal safety strategies for seniors in the community and helps to reduce crime against seniors. At St. Paul's L'Amoreaux Centre, the senior-run project brought the initiative to a wider, culturally diverse audience.

Rouge Valley Health System: Last but not least, this Neonatal and Paediatric Orientation program was developed in 2006 in response to the government nursing strategy: The New Graduate Initiative. This gave Rouge Valley Health System (RVHS) the opportunity to hire new graduate nurses full time for six months in specialty areas. The program provides a comprehensive knowledge base to enhance caring for the sick neonate, children and their families through a lab setting and by working alongside an experienced mentor in the Neonatal Intensive Care Unit & Paediatric specialty areas. Congratulations to the team at RVHS who were the proud recipients of one of this year's innovation awards!!!!

Accessibility for Ontarians with Disabilities (AODA): In June of this year, the Lieutenant Governor in Council, the Honourable David Onley, appointed Charles Beer to conduct an independent review of the Accessibility for Ontarians with Disabilities Act 2005 (AODA). The review, which will conclude later this year, is intended to provide a comprehensive review of the effectiveness of the AODA, the regulations, and the Standards Development Process. The AODA mandates change to help improve the lives of people with disabilities, with the goal of achieving accessibility for Ontarians with disabilities with respect to goods, services, facilities, accommodation, employment, buildings, structures and premises on or before January 1, 2025. In the coming years, designated public sector organizations, including hospitals, will be working towards ensuring that their policies and practices not only identify barriers towards accessibility, but work towards removing these barriers. Beginning January 1, 2010, the Customer Service Standard (Regulation 429/07) under the AODA will apply to hospitals. This means that hospitals, as well as other designated public sector organizations, will need to ensure that they comply with the requirements of the Standard, and file an Accessibility Report by March 31, 2010 to demonstrate this compliance. The LSSO is leading a process of developing pan-LHIN policies and procedures that will align with the requirements to attain compliance with the AODA.

CECCAC CHRIS Deployment: In 2007, the Ontario Association of Community Care Access Centres introduced the development of a web-based case management software system that is designed to replace all legacy systems (CARE, PMI, OASIS and CMIS) currently in use across the CCACs by 2009. As of November 30th, the last of the CCAC sites have implemented the new provincial

CHRIS system which will provide a single integrated record based on the concept of a "one client, one record" platform for CCACs and their clients. It will enhance communication between the CCAC, and both the client and healthcare partners through efficient electronic documentation, as well as facilitate secure electronic communication between service providers and CCACs.

Core Business Requirements – LHIN Operations

Accounts Payable: As of November 2, 2009, the accounts payable process previously managed by an external supplier is now being managed in-house.

CRM/Sharepoint: CRM/Share Point Project: The CE LHIN was chosen as one of the pilot sites for the deployment of the CRM and the project charter has been finalized. Administrative Training took place at the LSSO on November 26, 2009 in which the CE LHIN sent two individuals. The internal CRM team is working with the LSSO on training materials for the CE LHIN staff over the upcoming weeks for CRM deployment. As well, the data gathering and verification process has been a lengthy undertaking, but is expected to be completed by the first week in December. The data will then be verified and uploaded into the system for final review before the go-live date, which is expected for late December, early January.

Communications: Communications and Community Engagement continued to support the development and rollout of the 2010-2013 Integrated Health Service Plan by finalizing the document with the graphic designer and updating the Corporate Communications Plan with activities related to the rollout of the IHSP. Events attended by Communications and Community Engagement staff included the GTA Primary Care Symposium and the "Celebrating Innovations" Expo at the OHA Health Achieve event. In addition, a meeting of the full CE LHIN Communications Network was held and communication representatives from the four public health units were invited to discuss H1N1 communications and the supportive role that CE LHIN communicators could play to support their public health colleagues. Planning for the 2010 Symposium has confirmed the location at the Ajax Convention Centre on May 5, 2010. The incoming president of the OMA, Dr. Mark MacLeod has been confirmed as the keynote speaker, with the support of Dr. Chris Jyu.

Communications and Community engagement staff supported the engagement of three of our Board to Board Clusters.

Respectfully submitted,

Deborah Hammons
Chief Executive Officer

Appendix A

CE LHIN Population Estimates, 75+ Cohort and Long-Term Care Home Locations

Appendix B

2008/09 Year End H-SAA Performance Assessment Dashboard

Appendix C

PRHC October 19th Press Release