



## Clinical Services Plan - One Acute Care Network

### The Vision

Improved and equitable patient access to an integrated hospital system that provides the highest quality of care across the Central East Local Health Integration Network

**CELHIN Board Update,**  
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**June 16, 2009**

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# One Acute Care Network...a Priority for CELHIN

- MOHLTC Transformation Agenda and Priorities
- CELHIN Strategic Directions (Confirmed at Board Retreat, May 2009)
- CELHIN Integrated Health Services Plan (IHSP Refresh 2010-2013)
- Hospital Accountability Agreements, Balanced Budget Requirements
- Health Human Resource Challenges
- Hospitals came together in Nov 2007 and identified a need to move forward as a group, on clinical services planning
- Hospitals agreed to 'one acute care network' (Apr/May 2009)

# Key CSP Decision Points ...

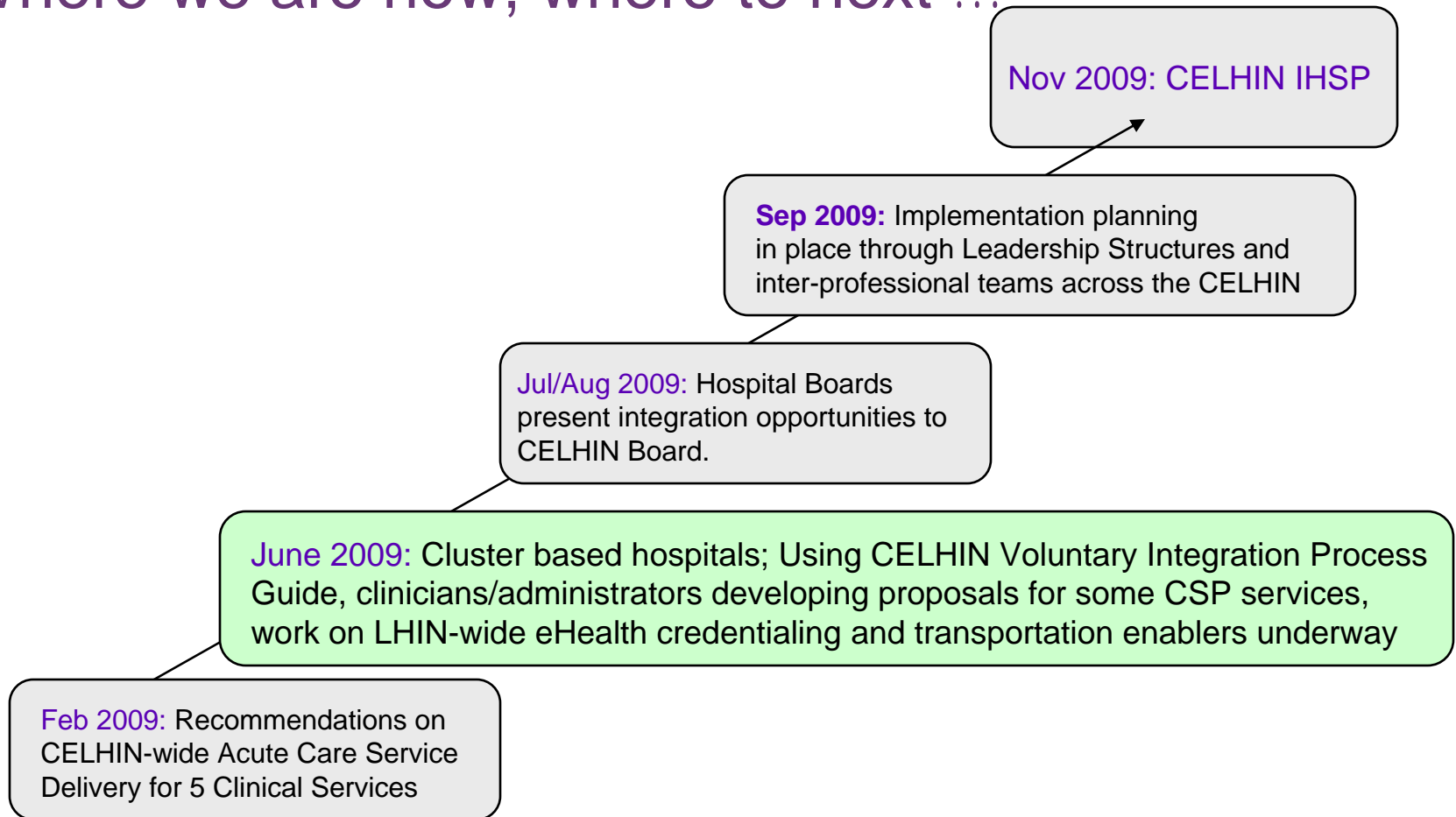
- CELHIN Board approves Clinical Services Planning (CSP) Project and CSP Steering Committee (June 2008)
- CELHIN Decision Making Framework<sup>1</sup> adopted by CELHIN Board, and CSP Steering Committee and its Advisory Groups (Aug 2008)
- CSP Steering Committee Report received by CELHIN Board (Feb 2009) then Community Engagement and Feedback (Mar/Apr 2009)
- Direction by CELHIN Board to 9 Hospital Corporation and CECCAC Boards to develop integration opportunities
- Nine Hospital and CECCAC Boards report back to CELHIN Board identifying integration opportunities
- Implementation of Clinical Service Integration Recommendations

<sup>1</sup> Adapted from Ontario Health Quality Council's *Attributes of a High Performing Health System*

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# One Acute Care Network ...

## Where we are now, where to next ...



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# Status of Recommendations ... Overarching (4)

1. Recruitment and retention of physicians and staff for 5 clinical specialities
  2. Geographic cluster planning/service delivery
  3. Overarching Leadership Structures/accountability
  4. Access to services supports
    1. Three MLG Frameworks
    2. Creation of 'centralized bed registry'
    3. 'Single point of entry' for providers
    4. Referral points of entry for elective and/or community based services for programs
1. Assessing need for additional specialists in all 5 clinical services
  2. Providers in each cluster organizing referral agreements, transfer protocols, etc.
  3. CELHIN framework being developed, Medical Leadership working with CEOs within clusters
  4. CELHIN-wide access:
    1. RFI released for credentialing e-tool
    2. With LHIN eHealth Lead, exploring options to support networked registry
    3. 1-800 numbers, referral hubs by cluster, etc.
    4. Collaboration with CECCAC on community based services, and family physicians networks for elective referrals

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# Status of Recommendations ... Clinical (5)

1. Cardiac
  2. Maternal Child and Youth
  3. Mental Health and Addictions
  4. Thoracic
  5. Vascular
1. RVHS-C and PRHC consolidating PCI and Rehab proposals as per CSP
  2. Providers within each cluster discussing potential solutions to organizing paediatric and neonatal care.
  3. WMHC reaching out to other hospitals and community partners during launch of new identity and strategic plan. Group of MHA providers leading on possible eHealth solutions; bed registry, 1-800 access, and clinical informatics development
  4. LHC – MRCC working with LHIN partners on physician coverage
  5. PRHC and TSH surgeons working on cluster model issues

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# Key initiatives needed to realize desired outcomes ...

- LHIN level medical and administrative leadership for all programs
- Grouping of service delivery areas in 3 regional hubs: 'Clusters'
- Some program consolidations supported by regional outreach programs, clinics, and/or stabilization units, and supported with standardized processes & procedures
- Human resource capacity improvements through integrating care teams, shared credentialing
- Rethinking/reworking of revenue streams, reallocation of funds



# Leadership issues to be resolved ....

- Engaging governance in the change process - including potential changes in governance resulting for realignment of clinical programs?
- Defining new accountabilities for regional programs/leadership (Board, administration, physicians).
  - What mechanisms are required to ensure confidence / trust / effectiveness in an environment of collaborative service delivery?
- What tools (processes, resources, messages) are required by the CEOs to move the change agenda forward?
- What level of support/degree of activity is required by the LHIN to assist CEOs and hospitals in the above?

## Leadership issues to be resolved ....

- How can the CEEC take responsibility for implementing the CSP (negotiation, selecting leadership, reporting)?
- How will the collective CEOs work with individual leaders in managing change, resistance, and political pressure?
- What responsibilities do individual hospitals have to each other when considering changes to their own clinical programs?
- What are the emerging priorities for CSP #2?

# Ongoing communication with stakeholders ....

- Continue discussion on CSP Steering Cttee Report with many groups/individuals; clarification of recommendations, receive feedback
- Report on Community Engagement and Feedback, frequently asked questions to be posted week of June 15<sup>th</sup>
- Meeting with key stakeholders for discussion on network development,
  - CECCAC on hospital care/discharge planning, alternatives for care
  - FHTs, CHCs and other family physician groups on referral pattern issues, access to care
  - All hospitals in the LHIN on advancing clinical services plan recommendations
  - Other surrounding LHINs and their hospitals regarding recommendations and potential impact on all
- Speaking engagements/meetings to share information on CSP process and recommendations, coordinate multi-LHIN CSPs and learn form each other



CSP Steering Committee Report, Community Engagement and  
Feedback Report now online at

[www.centraleastlhinc.on.ca](http://www.centraleastlhinc.on.ca)

Click on Clinical Services Plan

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