Central East Local Health Integration Network
CEO Report to the Board
May 23, 2012

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The following is a compilation of some of the major activities/events undertaken during the month of May in support of the Central East LHIN's Strategic Directions;

a) Transformational Leadership,
b) Quality and Safety,
c) Service and System Integration, and
d) Fiscal Responsibility.

Transformational Leadership: *The LHIN organization will demonstrate accountability and systems-thinking in all decision-making and leadership actions, reward innovation which is aligned with the Integrated Health Service Plan (IHSP) 2010 - 2013 and model fair, transparent, and honest interaction with one another and with Health Service Providers.*

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

The Central East LHIN is working towards achievement of the Strategic Aims of the 2010-2013 IHSP;
1. Save a Million Hours of Time Patients Spend in the Emergency Departments by 2013; and
2. Reduce the Impact of Vascular Disease by 10% by 2013 (2010-2013 IHSP).

Transformational Leadership

The LHIN organization will demonstrate accountability and systems-thinking in all decision-making and leadership actions, reward innovation which is aligned with the Integrated Health Service Plan (IHSP) 2010 - 2013 and model fair, transparent, and honest interaction with one another and with Health Service Providers.

Transitions in Care

The Central East LHIN Transitions in Care Steering Committee is a critical body at the pinnacle of a new and evolving strategic structure within the LHIN aimed at improving overall quality of care through better transition management of people and information by their care team. The Steering Committee is envisioned to bring together separate yet linked initiatives that, while targeting different aspects of the system, share similar goals. The intent is to provide improved cohesion of initiatives to promote outcomes for better care for patients/clients/residents and better health of the population as a whole. The Steering Committee is accountable to the Central East LHIN for the strategic guidance and quality improvement for emerging Transition Management priorities and for providing oversight to selected Transition Management quality improvement initiatives. In addition to patients/clients/residents, key stakeholders include health service provider leaders, initiative-specific provincial stakeholders and frontline healthcare providers.

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

guidance is provided by the Executive Sponsor, a member of the Central East LHIN Senior Team. The Home First Oversight Committee and the Resource Matching and Referral Oversight Committee report to the Transitions in Care Steering Committee. The Transitions in Care Steering Committee met on May 16.

Service and System Integration

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

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

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

The 2012 Spring Cycle Stocktake report template is scheduled to be published by the Ministry on May 14 and the completed report is due on May 28. Because the 2012-13 MLPA negotiation meetings for all LHINs will take place in June, there will be no Stocktake meetings with the Ministry for this cycle.

Home First:
The Home First philosophy and the business processes supporting it have been initiated at all eight Central East LHIN acute medical hospitals and at the Markham Stouffville Uxbridge site, which although physically in the Central East LHIN, is accountable to the Central LHIN. Planning for a modified roll-out to Ontario Shores Centre for Mental Health Sciences (OSCMHS) has begun—this rollout will complete the implementation phase of the Home First approach in the Central East LHIN. TRAC teams continue to meet regularly at each hospital site and to submit summary reports of ALC designations to hospital operational committees, which in turn identify trends to be reported to the LHIN-wide Home First Oversight Committee. The Home First Oversight Committee meets monthly.

Specialized Geriatric Services: Regional Governance:
On April 17, the Regional Specialized Geriatrics Services Governance Authority (GA) held its inaugural meeting for the 2012 fiscal year and unanimously approved several documents related to how it will go about its work i.e. principles, as well as initial policies i.e. conflict of interest guidelines. Extensive discussion took place concerning deliverables for 2012/13 and beyond. The GA will be submitting its initial high level content for the LHIN's next Integrated Health Service Plan (IHSP) by the end of September 2012 to be followed by a more detailed operational plan to be included in the LHIN's Annual Business Plan in January 2013. Areas of focus at this time include presentations from existing specialized services to be accompanied by an inventory document that will provide an environmental scan of existing services and how they are linked and configured. The target population is currently being defined through available data which will also lend to prioritizing work activities. The GA meets next on May 23, 2012. Northumberland Hills Hospital is continuing in their recruitment efforts for an Executive Director for the entity. Key informants have also provided valuable insight into the position summary and recruitment process for the part time medical director which will be posted in June.

Assisted Living Services for High Risk Seniors:
The Assisted Living program offered by Community Care Durham (CCD) is currently serving 20 clients in the Oshawa Hub and 18 clients in the Whitby Hub. A total of 38 clients are being served by CCD. Seven (7) clients in the Whitby Hub and two (2) clients in the Oshawa Hub are expected to be transferred to CCD.

Success is coming quickly to the VON program given the experience from the Durham project coupled with excellent relationships on the implementation team. In North Durham (Cannington), 13 clients have started service, 15 clients in Scarborough, nine (9) clients in Peterborough and one (1) client in Lakefield have all transitioned from CCAC to VON. A business case is forthcoming to the LHIN to bring a previous "Aging at Home" funded supportive housing program in Beaverton into the fold to realize a "North Durham Assisted Living Program." The implementation team sees the three hubs of Scarborough, North Durham and Peterborough all being at their target of 30 clients each within the next six weeks. The Lakefield Hub will take slightly longer as it is the final hub to come online.

Behavioural Supports Ontario (BSO) Program:
In April, Behavioural Supports Ontario (BSO) activity focused on rolling out Part 1 of the BSO value stream process to all long-term care homes in the Central East LHIN, starting with all Long-Term Care homes in the Durham Cluster. Staff from BSO Early Adopter long-term care homes led training sessions for three to five other Long-Term Care homes in the process with learning that had been generated through the development of the BSO model in Early Adopter homes. LHIN staff planned and facilitated these learning and training sessions that will be spread to all Scarborough and North East homes in May.

The Central East Community Care Access Centre has hired staff from the "Other Health Professionals" category of BSO staffing for which we were provided funding. The Project Manager and Improvement Facilitator Supervisor positions have been filled and hiring for other positions is ongoing.

The BSO Design Team, Education and Capacity Building Committee and Measurement and Metrics Committee continued to meet in April and have progressed their mandates. Also in April, the Central East LHIN participants in the provincial BSO Design Measurement and Evaluation Committee provided feedback and input into the draft Interim BSO Evaluation Report which reported up to March 31, 2012. The report is expected to be distributed to key stakeholder groups by the end of May.

NPSTAT (Nurse Practitioners Supporting Teams Averting Transfers) Program:
The Central East Community Care Access Centre (CECCAC), in conjunction with the NPSTAT Clinical Director, have been asked to complete an operational review of the NPSTAT program and to prepare and submit a business plan to the Central East LHIN outlining operational and governance suggestions for 2012/13. The proposal for a one-hub model and options for an expansion of the NPSTAT program was received and analyzed by Central East LHIN staff in April. Further revisions to the proposal have been requested and a meeting with The Scarborough Hospital has been set to discuss the relationship and role of The Scarborough Hospital (TSH) related to NPSTAT.

Transitional Care Program:
Q4 reports were completed by the four (4) sites hosting the transitional care program (Northumberland Hills Hospital, Rouge Valley Health System, Strathaven Lifecare Centre and Peterborough Regional Health Centre) and submitted to the Ministry of Health and Long-Term Care through the Transitional Care Program Reporting System. Further analysis of the data is ongoing for Q4 but an early overview of submissions indicated that the programs were continuing to operate efficiently and length of stay averages were well within target.

Mental Health and Addictions

Ontario Common Assessment of Need:

The Central East LHIN Ontario Common Assessment of Need (OCAN) local Steering Group did not meet in April. Implementation of the OCAN is proceeding according to schedule with no substantive issues noted. Given that the implementation is complete across the LHIN, the Steering Committee is investigating processes that will support the maintenance of the OCAN processes. Central East LHIN staff have been advised of an upcoming training event. Input will be sought from the OCAN Steering Committee regarding the potential of their recommendations regarding attendees from this LHIN.

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

- Provider training via webinars and other electronic formats;
- Purchase of OTN equipment to increase system capacity;
- Opioid Alerts from the Ministry of Health and Long Term Care; and
- Real Time Surveillance of 70 Emergency Departments across Ontario.

Each of the four initiatives has been completed. OTN has purchased the equipment and OTN staff are now working on a distribution strategy. The MOHLTC is now negotiating with Health Canada regarding the installation of the equipment on First Nations' locations. Although the province will provide the equipment itself, ongoing funding is required from the Federal government to pay the operating costs. The report of the Minister's panel is expected at the Ministry during the first week in May. The report and its recommendations will not be released until the Ministry has determined its implementation plan. Additional measures are expected during FY 2012/13, including expanded ED Surveillance, and the introduction of additional system indicators, specific to Opiates. It remains the direction of the Ministry that any systemic capacity needs that require attention will receive partial funding from the Federal Government.

Central East LHIN staff have been participating in weekly teleconferences with the Ministry, and submitting weekly reports. Staff have been communicating with Health Service Providers on a regular basis. Although there has been a very slight increase in service requests related to OxyContin issues, providers are not describing the situation as a crisis. The increase in service has been noted in the Oshawa area primarily. On a Provincial Level, an increase in service requests has been noted in the North West LHIN and in Ottawa. There has also been a recorded increase in Neo Nates withdrawing from Opiates. However, the Ministry is not clear if this is an actual increase, or if reports from Health Service Providers have increased as a result of the publicity around OxyContin.

Health Advisory Circle Members discussed the OTN resources that were being provided throughout the province and made the statement that these resources would certainly be very useful to them. The issue in using OTN is related to the ability of the First Nation communities to afford the OTN Membership Fees. This is often beyond the ability of the individual First Nation to afford. Central East LHIN staff has brought this issue to the attention of the MOHLTC and OTN, but have not received a response to date. Central East LHIN staff will continue to carefully monitor this situation.

Addictions Supportive Housing (ASH) Beds:
The Central East LHIN received the final allotment of ASH Beds in April. This will add the last eight beds that were included in the 72 beds provided over the four year period of the project. Homestead in the Scarborough Cluster will receive eight beds, as will the Pinewood/CMHA-D partnership in Oshawa. The ASH providers have been continuing to meet as a Community of Practice since the project began. The last meeting of this group was on April 18, 2012. During that meeting several client stories were shared, and outcomes measures were discussed. The existing beds have been almost fully implemented.

Integrations

Apsley and District Homes for Seniors (ADHS):
The Apsley and District Satellite Homes for Seniors integration has been completed for the support service aspect of the project. Funding from the Central East LHIN will now flow to the Canadian Red Cross in accordance with an M-SAA approved at the Central East LHIN's March Board meeting. The transfer of the property has not been finalized. A Memorandum of Understanding (MOU) has been finalized between the ADHS Board and the Canadian Red Cross that will ensure continuous service for the residents of the Home until the property transfer to Peterborough Housing Corporation takes place. Central East LHIN staff are continuing to monitor this situation up to full implementation.

Community Health Services Integration Strategy:
The purpose of the project is to implement a facilitated integration process to achieve the 'Community First Strategic Aim' in each of Durham, Scarborough and the Northeast Service Clusters. Planning and implementation continues on this front, after the March 8th kick-off event.

On April 5, 2012, Phase 1 agency governors and CEO/EDs from the Durham Cluster convened for the first time. A staff team will facilitate the process - weekly meetings have been scheduled. Time commitment for HSP senior leadership is significant and required. This facilitated integration process is moving forward guided by the following Strategic Aim.

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

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

The project will result in the identification of preferred community health services integration model for each of Durham, Scarborough and the Northeast Clusters to increase value from the client and caregiver's perspective. The model will enable the Community Support Services sector to move from its identified 'Current State' to proposed 'Future State' while considering the opportunities of integration across Community Support Services and Community Health Centre health service providers. The three-cluster process will conclude in March 2015. An update will be included for the Board in the June report.

CMHA – Northeast Cluster Integration:
The CMHA – Joint Executive Governance Committee has been formed and is meeting every two weeks. Additionally, CMHA-Peterborough and CMHA-Kawartha Lakes have struck a Management Integration Team. Teams are making solid progress toward the implementation of the objectives set out in the Integration Plan approved in January 2012. Central East LHIN staff are monitoring the implementation process.

Central East LHIN Hospice Palliative Care Network (CEHPCN):
On April 19, 2012 the CEHPCN held an all-day Hospice Palliative Care Integrated Health Services Plan (IHSP) Strategic Aims Planning Session. The Network was successful in developing a Draft IHSP Strategic Aim: *"Increase the number of people who receive hospice palliative care in the community and die at home, by choice, by X% by 2016."* Another planning meeting will be scheduled to discuss next steps i.e. the establishment of strategic aim goals, leveraging of current resources and initiatives etc.
On April 20, 2012, LHIN CEOs, Senior Directors and the Ministry came together to discuss the completion of the palliative care template outlining 14 separate but aligned implementation plans reflecting a common end point for all LHINs over the next three years. Further to the discussions and suggestions received, Part 1 of the

Report Back document was revised to reflect the recommended changes. The LHINs were also asked to provide feedback on the revised document by April 30.

A formal poll of all CEOs was also undertaken regarding agreement to proceed with discussions with the Ministry based on the Palliative Care document. The Central East LHIN offered its approval pending the following document comments:

- The Central East LHIN does not support a peer group. This suggestion was made as a potential default should the Ministry not accept a "Declaration of Compliance" that they would, in fact, have a network and work towards meeting the relevant goals/structures.
- A compromise may be the establishment of a LHIN-Provider Community of Practice – leveraging the Provincial Hospice Palliative Care Network to support planning, evaluation and design principles.
- The Central East LHIN does not support an oversight structure similar to the current BSO project, rather a much leaner approach. One suggestion is to utilize the above proposed group as that leaner version of an oversight structure.

On May 1 and 2, the Provincial End of Life Care Network came together for their 2nd annual face-to-face meeting to discuss the Ministry Palliative Care document, "take stock" of each network's relationship to the LHIN and plans to move forward in collaboration Ministry priorities, provide updates re: the Speak Up Campaign etc.

Aboriginal Services

First Nations Health Advisory Circle and Métis, Non-Status and Inuit Health Advisory Circles:
The Central East LHIN Métis, Non-Status and Inuit Health Advisory Circle, and the First Nations Health Advisory Circle both met in April. Central East LHN staff have been working to reach out to potential members for the Métis, Non-Status and Inuit Health Advisory Circle.

There were several issues on the meeting agenda from April 11, including the Memorandum of Understanding between the Central East Community Care Access Centre and the Alderville First Nation, the continuing issue of data related to First Nations peoples and arriving at an agreement to access it, and a presentation from Eric Hong, Chair of the Central East Palliative Care Network regarding the Network's interest in working with First Nations peoples. Eric's presentation was well received, and an agreement was reached that the groups would share their minutes with each other. Circle Members showed great interest in providing input to the 2013-2016 IHSP. Therefore, the next scheduled Circle Meeting in June will take place over the full day in order to accommodate input from Circle and Community Members to the development of the IHSP.

The Métis, Non-Status and Inuit Health Advisory Circle met on April 12. Unfortunately the meeting was not well attended. Eric Hong did attend in order to discuss the Central East Palliative Care Network, and engaged in a very informative discussion with Natalie Lloyd of the Métis Nation of Ontario, the only member in attendance. Central East LHIN staff did meet in person with Liz Stone of the Niijkiwendidaaa Anishnaabekwewag in Peterborough. Liz has agreed to attend the Circle, and will speak with the new Executive Director of the Peterborough Friendship Centre as well. Central East LHIN staff have continued to liaise with Provincial LHIN partners, although the major focus of this portfolio has been on the local LHIN area.

Quality and Safety

Pharmaceutical Shortage:

The Sandoz Canada injectable drug shortage continues to be monitored province-wide and at all LHINs. During the Central East LHIN CEO's absence in late April and May, the Champlain LHIN CEO, Chantale LeClerc, is acting as the Lead LHIN CEO to work with the Ministry on the system wide response. The Central East team continues to provide support to the Champlain LHIN CEO during this time.

Provincially, the Drug Shortage Technical Advisory Committee has ceased regular meetings. The Ethical Framework developed by this group has been published to all stakeholders provincially, and Health Service Providers throughout the province are reviewing the document and determining how to operationalize it. The provincial Health Stakeholder calls led by the Ministry Emergency Operations Centre continue to be held weekly, but will stop by the end of May as responsibility for managing the provincial response is transferred to the Ontario Public Drug Program. Within the Central East LHIN, Health Stakeholder calls have been reduced to once every two weeks, but the Pharmacy group continues to meet via teleconference once per week. This group is to be commended for its mutual support, quick action when any member has a concern or query, and its development of a drug-sharing agreement that has now been shared provincially. Additionally, Lakeridge Health has developed a web-enabled Pharmacy Tracking Tool to manage inventory and flag impending shortages that is being shared both LHIN-wide and provincially.

Senior Friendly Hospitals:
The LHIN Lead Working Group for the Senior Friendly Hospital (SFH) initiative held its final meeting in April. Although the initiative will continue to be led by the Regional Geriatric Programs (RGP) across the province, the Toronto Central LHIN will not be leading a Working Group and each LHIN will follow their own independent implementation plan and link with the RGP as necessary. Currently, the Senior Friendly Hospital toolkit has been posted on the Senior Friendly Hospitals website – www.seniorfriendlyhospitals.ca – and covers the following areas:

- Organizational Support;
- Processes of Care;
- Physical Environment;
- Emotional and Behavioural Environment;
- Ethics in Clinical Care and Research;

At Central East LHIN, we continue to participate on the SFH Indicators Working Group and are planning our strategy for maximizing uptake and implementation of the SFH initiative in Central East LHIN hospitals.

IHSP Strategic Aims
Save a Million Hours of Time Spent in the ER Department

ED Pay for Results (P4R) Year III (2010-2011):
Fixed Funding
MOHLTC communicated a proposed formula for calculating recovery of P4R Year III (FY2010) fixed funds on November 8, 2011. The proposed recovery formula relaxed the performance requirements that had been published in March 2010 for Year III. LHINs were given an opportunity to submit a performance explanation to MOHLTC, including any argument for a further reduction in recovery rates. The Central East LHIN did submit a performance explanation, recommending a further reduction in the recovery at RVAP, because of substantial volume increases at that site, and significant constraints on inpatient capacity. The amounts communicated by MOHLTC and suggested by the Central East LHIN are as follows:

Site	2010/11 One-Time Fixed Allocation	Initial Recovery	Proposed Recovery (MOHLTC)	Proposed Recovery (CE LHIN)
LHB	$740,700	$296,300	$74,100	$74,100

LHO	$841,700	$673,400	$420,900	$420,900
NHH	$399,000	N/A	N/A	N/A
PRHC	$840,000	N/A	N/A	N/A
RMH	$664,900	N/A	N/A	N/A
RVAP	$417,500	$167,000	$33,400	$6,300
RVC	$932,500	$186,500	$28,000	$28,000
TSB	$379,500	N/A	N/A	N/A
TSG	$379,500	$151,800	$30,400	$30,400
Totals	**$5,595,300**	**$1,475,000**	**$586,800**	**$559,700**

The timeline published by MOHLTC indicated that follow-up with LHIN's on the performance explanations would take place in December, and that recovery letters from MOHLTC to hospitals would be initiated in January 2012. As of May 2012, no response to the LHIN performance explanation has been received.

PIA Funding

Year III was the first year in which designated Pay-for-Results sites were also required to achieve a 10% reduction in the time to physician initial assessment (PIA) at the 90th percentile. Separate funding was allocated to achieve this reduction, and this funding was described as being subject to recovery, but no proposed formula for recovery of this funding has ever been published by the Ministry. Hospital performance and funding in this category for year III is indicated in the table below:

Site	Baseline	Target	FY2010	PIA Performance	PIA Funding Amount
LHB	2.8	**2.5**	2.7	-4%	$100,500
LHO	3.2	**2.8**	3.0	-4%	$255,400
NHH	3.7	**3.3**	3.6	-2%	$113,000
PRHC	4.6	**4.1**	3.7	-19%	$120,000
RMH	3.3	**3.0**	2.9	-11%	$148,000
RVAP	3.6	**3.2**	2.7	-24%	$130,300
RVC	4.1	**3.7**	3.5	-16%	$170,200
TSB	4.2	**3.8**	3.4	-18%	$105,300
TSG	4.6	**4.1**	4.3	-6%	$ 88,000
Legend	YTD performance meeting target				
	YTD performance improving, but not yet at target				
	YTD performance longer than previous year's baseline				

ED Pay for Results Year IV (2011-2012):

Fixed Funding

Final funding for Year IV of the Pay-for-Results program distributes the Central East LHIN fixed funding allocation as follows:

Central East LHIN	**$6,041,100**
Lakeridge Health Corporation - Bowmanville site	$1,003,500

Lakeridge Health Corporation - Oshawa site	$586,500
Northumberland Hills Hospital	$387,700
Peterborough Regional Health Centre	$630,900
Ross Memorial Hospital	$531,600
Rouge Valley Health System - Ajax/Pickering site	$852,200
Rouge Valley Health System - Centenary site	$1,334,700
The Scarborough Hospital - Birchmount Campus	$357,000
The Scarborough Hospital - General Campus	$357,000

Conditions of fixed Pay-for-Results funding require all designated hospital sites to achieve an aggregate reduction in 90th percentile Emergency Department Length of Stay (EDLOS) across three patient categories. The amount by which each site must reduce this time varies depending on fiscal year 2010/11 baseline performance. Although the MOHLTC Pay-for-Results program does not require patient stream-specific reductions, the Central East LHIN has established each hospital's H-SAA target as the Pay-for Results target[1]. Achievement of the H-SAA targets will result in achievement of the Pay-for-Results aggregate targets for eight of the nine designated sites.

Final 2011-12 performance for the nine designated hospitals against their H-SAA targets is as follows:

Site	Admitted 90th Percentile Time (interim provincial target 25 hours)			Non-Admitted High Acuity 90th Percentile Time (provincial target 7 hours)			Non-Admitted Low Acuity 90th Percentile Time (provincial target 4 hours)		
	FY2010 Baseline	H-SAA Target	FY2011 Performance	FY2010 Baseline	H-SAA Target	FY2011 Performance	FY2010 Baseline	H-SAA Target	FY2011 Performance
LHB	38.83	**34.42**	**26.32**	**6.05**	**6.05**	**5.18**	**3.92**	**3.92**	**3.38**
LHO	80.10	**61.45**	**67.57**	**6.82**	**6.60**	**7.20**	4.48	**4.00**	**4.85**
NHH*	**14.02**	**14.02**	**22.95**	**5.88**	**5.88**	**6.33**	4.23	**4.00**	**4.68**
PRHC	41.52	**38.43**	**46.82**	7.80	**7.60**	**7.85**	4.40	**4.00**	**4.45**
RMH	45.70	**37.38**	**39.08**	**6.72**	**6.72**	**6.53**	**3.92**	**3.92**	**4.08**
RVAP	77.60	**56.41**	**71.92**	**6.05**	**6.05**	**5.73**	4.17	**4.00**	**3.87**
RVC	50.82	**42.75**	**43.57**	**6.62**	**6.62**	**6.42**	4.78	**4.00**	**4.27**
TSB	30.03	**26.78**	**27.97**	8.32	**7.49**	**6.93**	4.92	**4.00**	**4.40**
TSG	40.53	**34.46**	**27.23**	8.28	**7.46**	**7.22**	5.20	**4.00**	**4.67**

Legend:	Baseline above provincial target
	Baseline below provincial target
	YTD performance meeting HSAA target
	YTD performance improving, but not yet at HSAA target
	YTD performance longer than previous year's baseline

*Note that NHH performance for patients admitted to an inpatient bed, although increased over last year's baseline, remains the lowest of the group, and below the interim provincial target of 25 hours, but still above the provincial standard of 8 hours.

[1] Northumberland Hill Hospital (NHH) is the exception to this practice, as its baseline performance in the admitted category was below the interim provincial target of 25 hours. NHH was assigned a P4R target in this category of 10% reduction over baseline, or 12.62 hours.

Final 2011-12 performance for the nine designated hospitals against their Pay-for-Results fixed funding aggregate targets is as follows, where green in the final column indicates that the site has achieved the required aggregate reduction, and red indicates that it has not:

Site	Admitted	Non-Admitted I-III	Non-Admitted IV-V	Performance Target	Overall Performance
LHB	32%	15%	14%	6.6%	60.2%
LHO	14%	-5%	-7%	8.0%	15.6%
NHH	-60%	-7%	-10%	6.6%	0.0%
PRHC	-10%	-1%	-2%	10.0%	0.0%
RMH	19%	1%	-6%	6.6%	17.2%
RVAP	7%	6%	8%	8.0%	19.8%
RVC	15%	3%	11%	8.0%	28.1%
TSB	7%	17%	11%	10.0%	34.0%
TSG	33%	13%	11%	10.0%	55.9%

The funding letters from MOHLTC made no indication of what the recovery formula will be for this year for any funding stream. However, it is reasonable to assume that hospitals that have achieved their fixed funding performance targets will have none of that funding recovered. Additionally, for the sites that are participating in ED-PIP this year, $250,000 of allocated funds are protected against recovery. Thus, potential recovery scenarios for fixed funding appear as follows:

Site	Final Funding Amount	Overall Performance	ED-PIP Participant	Maximum Possible Recovery
LHB	$1,003,500	60.2%	✓	-
LHO	$586,500	15.6%	✓	-
NHH	$387,700	0.0%		$387,700
PRHC	$630,900	0.0%		$630,900
RMH	$531,600	17.2%		-
RVAP	$852,200	19.8%	✓	-
RVC	$1,334,700	28.1%	✓	-
TSB	$357,000	34.0%		-
TSG	$357,000	55.9%		-

PIA Funding

Each designated Pay-for-Results site is also required to achieve a 10% reduction in the time to physician initial assessment (PIA) at the 90th percentile. As for Year III, PIA funding was listed as being subject to recovery in Year IV of the Pay-for-Results program, but with no indication of the recovery formula. Final 2011-12 hospital funding and performance in this measure is as follows:

Site	Baseline	Target	FY2010	PIA Performance	PIA Funding Amount
LHB	2.7	**2.4**	2.4	-11%	$100,500
LHO	3.1	**2.7**	3.1	1%	$255,400
NHH	3.6	**3.3**	3.9	6%	$100,000
PRHC	3.7	**3.3**	3.7	1%	$170,200
RMH	2.9	**2.6**	3.0	2%	$113,900
RVAP	2.7	**2.4**	2.5	-9%	$141,800
RVC	3.5	**3.1**	3.0	-13%	$148,800
TSB	3.4	**3.1**	3.1	-9%	$ 96,200
TSG	4.3	**3.9**	4.1	-5%	$130,300

Legend	
	YTD performance meeting target
	YTD performance improving, but not yet at target
	YTD performance longer than previous year's baseline

Short Stay Unit Funding

On 05 January, a 10-bed Short Stay Unit was implemented at RVAP, using a Pay-for-Results allocation of $571,500 ($320,300 from a specific Short-Stay Unit funding stream, and $251,200 from that site's Fixed Funding distribution). Performance requirements associated with this funding include: reduction of "Time to Inpatient Bed" to 8 hours, and maintenance of baseline "Time to Disposition." Final RVAP performance against these requirements for 2011-12 is as follows:

Time to Inpatient Bed (hours)														
FY2010 Baseline	**Target**	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**YTD**
69.4	**8.0**	**50.3**	**62.7**	**71.9**	**72.8**	**55.9**	**65.5**	**71.9**	**43.3**	**52.3**	**59.9**	64.3	54.7	**64.6**
Time to Decision to Admit (hours)														
FY2010 Baseline	**Target**	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**YTD**
17.8	**17.8**	**16.9**	**17.5**	**17.7**	**18.2**	**17.4**	**15.4**	**17.2**	**17.5**	**17.2**	**17.2**	17.3	17.9	**17.3**

In the table above, green indicates that the hospital has met the requirement, and yellow indicates improvement, but non-achievement of target.

Short-Stay Unit funding, as with other up-front Pay-for-Results funding, is described as being subject to recovery, but no formula or methodology has been identified to calculate this recovery.

Variable Funding

In Year IV of the Pay-for-Results program, designated hospitals are eligible to earn bonus funding each quarter by:

1. Increasing the volume of admitted patients admitted to an inpatient bed within the provincial target of eight hours
2. Increasing the volume of non-admitted CTAS IV-V patients discharged within the provincial target of four hours;
3. Decreasing the volume of admitted patients remaining in the ER over 25 hours.

In April, the LHIN received funding letters from the Ministry of Health and Long Term Care indicating bonus funding to be paid to LHIN hospitals for Q3 of fiscal year 2011-12, bringing the total variable funding flowed to date to the following:

Hospital	Q1 Bonus	Q2 Bonus	Q3 Bonus
LHC	$155,800	$99,300	$320,500
NHH	-	$32,700	-
PRHC	$68,000	$120,200	$23,100
RMH	$49,400	$63,000	$4,500
RVHS	$102,600	$214,200	$115,100
TSH	$222,400	$300,100	$293,300
Central East LHIN	**$598,200**	**$829,500**	**$756,500**

In Q3 and Q4, because of the establishment of the Short-Stay Unit, RVAP was not eligible to earn variable funding for either of the admitted categories (numbers 1 and 3 above)

Q4 performance indicates that an additional $465,100 has been earned by Central East LHIN hospitals in variable funding. The funding earned by site and the funding that each site could have earned if 100% of patients were treated within the provincial targets is as follows:

Site	Q4 Bonus Earned	Q4 Bonus Opportunity
LHB	$163,850	$303,100
LHO	$13,500	$1,173,050
NHH	$0	$118,250
PRHC	$0	$758,750
RMH	$900	$392,250
RVAP	0	$494,500
RVC	$35,300	$431,050
TSB	$20,250	$575,650
TSG	$231,300	$785,550
Central East LHIN	**$465,100**	$5,032,150

Formal notification of these funding amounts has not yet been received from MOHLTC, so these numbers are not yet final.

ED Pay for Results Year V (2012-13):
A working group consisting of ED LHIN Leads, LHIN Senior Directors, Cancer Care Ontario and MOHLTC representatives has proposed a draft model for the Pay for Results program for Year V (2012-13) that will streamline funding and eliminate recovery. This model is going through the approval process at the Ministry, and has not yet been published.

Clinical Decision Units:
Clinical Decision Units (CDUs) are established at the following Central East hospital sites: LHB, NHH, PRHC, RMH, RVAP, RVC, TSH–B, TSH–G.

CDUs must meet certain guidelines published by MINISTRY, and are monitored by Access to Care on a monthly basis for compliance with two indicators:

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

The purpose of measuring the two selected compliance indicators is to ensure that the hospital is not using the CDU to lower its ED length of stay for admitted patients artificially, as admission to the CDU stops the length of stay clock. However, analysis of the months during which Central East LHIN hospitals have breached either of the compliance indicators do not show a suspicious corresponding decrease in ED length of stay for admitted patients. Rather, those months reflect a lengthening of ED length of stay, suggesting that CDU performance is worsened during periods when the ER is struggling with all its performance indicators.

Additionally, having different thresholds for the two indicators, while theoretically sound, in practice merely means that operating within the compliance threshold for the second indicator can provide a false sense of security for the first. Up to 30% of CDU patients can be admitted to an inpatient bed without triggering a compliance issue, but only 10% of CDU patients can exceed an EDLOS of 24 hours. If the hospital's flow from the ED is impaired either because all its inpatient beds are occupied or because there is no most responsible physician (MRP) to admit to, all admitted patients, including the up to 30% that are allowed in the CDU, will have an EDLOS that is too long.

December performance resulted in the CDUs at both Peterborough Regional Health Centre (PRHC) and The Scarborough Hospital—Birchmount Campus (TSH–B) being escalated to Level 1 compliance. The indicator at issue for PRHC is percent of cases with ED Registration to CDU Discharge time greater than 24 hours—the hospital has continued to breach this threshold for January and February. For TSB the issue is percent of CDU cases admitted to inpatient beds—January and February performance dropped below the threshold of 30% once again. Action plans for these hospitals have not yet been submitted to Access to Care, as that organization has developed a new template for their submission. These plans will be submitted in Q1 of the 2012-13 fiscal year, along with communication of the problems with the compliance indicators noted above.

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

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

These monthly scorecards are sent to designated hospital staff accompanied by a LHIN request for a rationale for a given site's performance or a plan for how to correct underperformance when necessary. Scorecards for the remainder of the 2011-12 fiscal year will be sent out in May, and supporting documents will be posted on the new SharePoint platform.

For fiscal year 2012/13, a new scorecard is being developed that will be more closely aligned with the MLPA dashboard and the Stocktake report, and will track additional contributing measures at all hospitals. The new scorecard, when finalized, will be presented to the Board for approval.

Emergency Department (ED) LHIN Lead:
The ED LHIN Lead holds a bi-monthly meeting of the LHIN ED Chiefs, scheduled to correspond with the bi-monthly Pay-for-Results meetings. The ED LHIN Lead works with LHIN staff, Health Force Ontario, the Ministry of Health and Long Term Care, and when necessary, other ED LHIN Leads across the province to monitor ED staffing issues. The LHIN submits a weekly dashboard to the Ministry tracking any Emergency Departments at risk of closure due to physician staffing. Campbellford Memorial Hospital and Northumberland Hills Hospital continue to struggle with ED coverage on a month by month basis. This situation is being monitored closely by the LHIN and the ED Lead.

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

Supporting an Integrated Roll-out of the Ontario Diabetes Strategy:
Strategies to address barriers and gaps in diabetes care
In partnership with the Central East LHIN, the Diabetes Regional Coordinating Centres (DRCC) sponsored a two-day Value Stream Mapping and Analysis event on March 26th and 27th at the Tosca Banquet Hall in Whitby. Three streams were mapped including Adult Type 1, Type 2 and Gestational Diabetes. The Central East Diabetes Regional Coordinating Centre Steering Committee and networks are currently reviewing the improvement initiatives that resulted from the two-day event. A 'Plan on a Page' will be developed and information will be used to inform development of the Diabetes AIM for inclusion in the IHSP.

Standardized Referral and Intake Process:
At the Diabetes Value-Stream Mapping event, a centralized intake was identified as a priority project, acknowledging that it would have a high impact but also requiring high effort. Funding for this was built into the Complex Centre for Diabetes Care proposal submitted to the MOHLTC in June. In partnership the DRCC and Central East CCAC developed and are submitting a request to MOHLTC to support implementation of LHIN wide centralized intake and triage.

Chronic Kidney Disease (CKD) / Renal System Development

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

Q3 Highlights:
Slight incremental improvement in AV Fistula rates year over year (ORN compared the last three years) at LH and TSH, some decline at PRHC. Now that each program has a Vascular Access/Independent dialysis coordinator in place we should start to see an improvement in fistula rates. Home hemodialysis (HHD) continued growth in all programs. PRHC has a total of seven HHD patients at home, with 2 patients in training, LH has a total of 50 HHD patients and an additional two in training and TSH currently has 14 HHD patients with one in training.

AV Fistula	Year 1	Year 3
LH	30.97%	31.27%
TSH	30.4%	36.61%
PRHC	37.7%	31.72%

Ontario Renal Network:
A Strategic Planning Day was scheduled on May 3 where the Ontario Renal Plan was unveiled. The Scarborough Hospital and Lakeridge Health figured prominently in the plan with stories related to Home Hemodialysis (LH), Peer support (LH), Early Chronic Kidney Disease planning and the role of the multidisciplinary team (TSH). The plan is also now available on the Ontario Renal Network's website; see Appendix A for a copy. The plan focused on seven key strategies:

- Strengthen accountability to patients;
- Reduce the impact of chronic kidney disease (CKD) by improving early detection and prevention of progression;
- Improve peritoneal and vascular access for dialysis patients;
- Improve uptake of independent dialysis;
- Ensure Ontario has the necessary infrastructure to care for CKD patients;
- Strengthen Ontario CKD care through research and innovation;
- Align funding to quality patient-focused care;

The Scarborough Hospital:
A Transition unit is scheduled to open on May 23, 2012. The Modality Choice video is also now complete, the video is accessible on the Nephrology page of The Scarborough Hospital website – http://www.tsh.to/pages/Nephrology--Dialysis, the video has been offered to the Kidney Foundation of Ontario for their website as well. This video will be translated into Cantonese at a later day with the script and translation presently underway.

Lakeridge Health:
The Lakeridge Health and Peterborough Regional Health Centre teams will meet on May 30th to discuss strategies to improve vascular access for both LH and PRHC patients.

Central East LHIN Renal Steering committee:
The steering committee will refine the Assessment tool for General Practitioners as well as the "fax-back" tool which is used when the Nephrologist has seen the patient at this stage and sends a report to the family physician suggesting follow-up. Once these tools are refined, Dr. Christopher Jyu, Co-chair of the Central East LHIN's Primary Care Working Group, will bring these forward to the Primary Care Working Group for discussion and dissemination

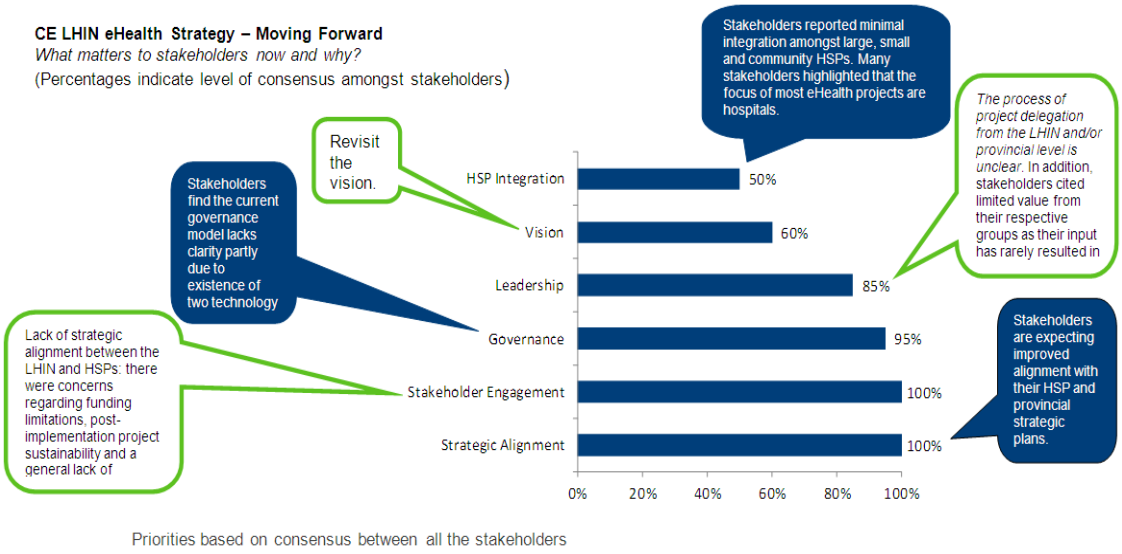
Community Care Access Centre – Central East LHIN Renal Task Force:
Registered Dieticians are working with the CCAC to increase awareness of Peritoneal Dialysis (PD) in the Long-Term Care homes within the Central East LHIN. The deliverables to date include the CCAC providing monthly waitlist statistics for PD in the Long-Term Care, providing updated and complete PD education to the agency service providers; revising the PD curriculum to develop consistent educational packages across the Central East LHIN; Additional deliverables are developing the CCAC process flow map for the PD patient referred in from the community, as well as the hospital and planning a Nephrology Awareness Day for Long-Term Care providers and service agencies for September 2012 to incorporate a diabetes component as part of the day.

Wheeltrans Eligibility Task Force:
Ms. Jay Wilson, Renal Director and a TSH Social Worker sit on this task force with the Central LHIN. The task group is currently developing an evidence-based assessment criterion that takes into account the patients' cognitive and physical functional ability. This tool will be tested on the HD patients who do not meet the eligibility

criteria for Wheeltrans. The survey is to be completed by June 15th. The results of the survey will provide a basis for the taskforce recommendations.

Enablers - eHealth

eHealth Strategic Plan:
The Central East LHIN has set out to develop an eHealth Strategic Plan by building on the 2007 eHealth Strategic Plan and making revisions to address current and emerging needs and requirements in support of the LHIN IHSP and Provincial eHealth Ontario strategy. Also, the revised plan should inform and enable the development of a GTA LHIN Cluster strategy. In order to build a framework, Healthtech has analyzed background information, reviewed the current state and conducted key informant stakeholder engagements to assist the Central East LHIN with the planning for the development of the eHealth Strategy Plan. The results of the data gathering and stakeholder engagement are summarized below:



Strategic Alignment	All HSPs are asking for better planning as most found themselves unprepared when they are considering a LHIN eHealth initiative. In some cases, the HSPs found LHIN eHealth projects lacked relevance at the organizational level; however, they continued with the adoption in support of the LHIN and provincial eHealth strategies. This culture of adoption is conducive to the overall eHealth Strategies at eHealth Ontario and the Central East LHIN; better coordination of projects with HSP

	involvement will lead to better outcomes.
Stakeholder Engagement	All HSP stakeholders reemphasized the importance of stakeholder engagement and recommended involving patient advocacy groups, community care and primary care to ensure seamless integration across all HSPs, which will result in improved care for patients.
Governance	Provide greater clarity on governance and decision making, including differentiating and communicating the roles and responsibilities of various groups in the Central East LHIN eHealth space.
Leadership	A LHIN eHealth decision making authority needs to be identified, to convey the purpose of each eHealth initiative to the committees and collect their feedback to incorporate into the projects as necessary. This approach will ensure the continuation of strengthening relationships between the HSPs and the Central East LHIN.
Vision	Create a shorter and more impactful vision.
HSP Integration	This not only creates an imbalance of eHealth adoption across various care domains but also limits collaboration as HSPs are at different stages. A culture of collaboration needs to be fostered amongst HSPs to develop integration across organizations and enhance care for patients. Over **50%** of the stakeholders recommended including community and primary care HSPs in the stakeholder engagement process to support the enhancement of the patient experience across the continuum of care.

Surgical Utilization Booking Management Integration Tool (SUBMIT):
SUBMIT is a web-based project geared to improve patient Wait List management and Wait Times reporting for surgeons and hospitals in the Central East LHIN. Ross Memorial Hospital (RMH), Peterborough Regional Health Centre (PRHC) and Northumberland Hills Hospital (NHH) are currently in their support phase as their go live date was at the end of March. Campbellford Memorial Hospital (CMH) is working through the implementation support and their go live date was moved to May 11 due to a lack of resources, of which all parties were in agreement. CMH does not have an operating room (OR) scheduling system and Novari is providing an electronic method.

The project team received approval by Cancer Care Ontario (CCO) for all Phase II hospitals to participate and move to a fully electronic Wait Time Information System (WTIS) reporting set up. Discussion with PRHC and Central East LHIN is in progress for the Meditech Operating Room Management (ORM) interface development. Novari has requested participation in a small working group over the summer to build enhanced reporting in the system based on our requests. Work is being continued to complete close-out and payment for the project.

Over the month of May, a business case for a Diagnostic Imaging (DI) module will be provided for review and feedback, and preparation of a site visit and meeting with Novari to build the scope for the decision to proceed or not. The LHIN has requested access and standard reports that highlight “red flags” for monitoring and follow-up. LHIN access will be completed by their technical support service (CGI). Staff will be formalizing the payment schedule of annual maintenance/licensing for the Novari system for presentation at the Chief Financial Officer (CFO) group meeting in May. A formal evaluation and close-out report will be provided to the Central East Executive Council (CEEC) at the end of May due to the move of the end date for full implementation. A presentation by Rouge Valley Health System (RVHS) of the system to Canadian Operating Room Leadership

Network (CORL) at St. Michael's Hospital was scheduled as well as an oral presentation at the Canadian eHealth conference in Vancouver in May 2012.

Table 1: Active Usage and activity on April 23, 2012

Organization	Physicians	Users	Procedures	WTIS Entry	Diagnosis	Live Since
LH	**76**	**104**	**3,453**	**5092**	**585**	**Nov 1, 2011**
TSH	**99**	**121**	**3,629**	**5207**	**709**	**Oct 15, 2011**
RVHS	**86**	**121**	**1,976**	**4038**	**334**	**Oct 1, 2011**
RMH	**12**	**16**	**854**	**809**	**219**	**Mar 31, 2012**
PRHC	**42**	**79**	**1,339**	**1756**	**213**	**Mar 31, 2012**
NHH	**11**	**29**	**333**	**426**	**153**	**Mar 31, 2012**
CMH	**6**	**0**	**0**	**0**	**0**	**Apr 30, 2012**
Totals	**332**	**470**	**11,584**	**17,328**	**2,213**	

Table 2: Overall Statistics.

OTHER STATISTICS To Date	
Internal Email Communication	> 4 million (internal surgical office, registration, OR booking, WTIS, PSS) Internal communication on the system replaces phone calls and additional faxes
Cases Completed To Date	> 90,000 procedures

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

Funding and Allocations:

The following funding letters were issued in April to our Health Service Providers –

- *2011/12 Hospice Palliative Care – Transfer of Funding:* Scarborough Centre for Healthy Communities (SCHC) received $155,377 in base funding to support the Hospice Palliative Care Transfer of Funding with the performance requirement attached that the SCHC agrees to serve 500 clients and to provide 7000 visits annually.

- *2011/12 Quarter 3 (Q3) one-time variable incentive funding for the Emergency Department (ED) Pay-for-Results (P4R) program at Lakeridge Health (LH), Peterborough Regional Health Centre (PRHC), Ross Memorial Hospital (RMH), Rouge Valley Health System (RVHS) and The Scarborough Hospital (TSH).* Payment is for the variable incentive component of the P4R program and must reflect treatment of more patients within four (4), eight (8) and twenty-five (25) hour targets as a performance requirement. The allocation to each hospital is indicated below:

Lakeridge Health (LH)	$320,500;
Peterborough Regional Health Centre (PRHC)	$272,900;
Ross Memorial Hospital (RMH)	$4,500;
Rouge Valley Health System (RVHS)	$115,100;
The Scarborough Hospital (TSH)	$293,300.

- Base funding for Mental Health and Addiction (MH&A) Sessional Fees: Health Service Providers (HSPs) have received base funding for fiscal year 2011/12 and have been advised of their total

annualized base funding for fiscal year 2012/13. The following HSPs that received funding are outlined in the table below:

Health Service Provider	Fiscal Year 2011/12	Fiscal Year 2012/13
Hong Fook Mental Health Services (HFMHS)	$1,131	$1,939
Haliburton Highlands Health Services (HHHS)	$901	$1,545
Canadian Mental Health Association – Peterborough Branch (CMHA-PB)	$2,295	$3,934
Lakeridge Health (LH)	$33,684	$57,744
Rouge Valley Health System (RVHS)	$27,885	$47,802
Ross Memorial Hospital (RMH)	$1,807	$3,098
Peterborough Regional Health Centre (PRHC)	$24,314	$41,682
Durham Mental Health Services (DMHS)	$4,638	$7,952
Four Counties Addiction Services Team Inc. (FCASTI)	$1,819	$3,119
Canadian Mental Health Association – Durham Branch (CMHA-DB)	$2,295	$3,934
The Scarborough Hospital (TSH)	$28,375	$48,643
The Governing Council of the Salvation Army in Canada Toronto (GCSACT)	$1,902	$3,261
Scarborough Centre for Healthy Communities (SCHC)	$28,375	$48,643
Canadian Mental Health Association – Kawartha Lakes Branch (CMHA-KLB)	$2,295	$3,934
Northumberland Hills Hospital (NHH)	$2,938	$5,036
Campbellford Memorial Hospital (CMH)	$2,122	$3,639

Web Enabled Reporting System (WERS)/Self Reporting Initiative (SRI) Update:
The 2011-12 Community Access Tool (CATLite) and Annual Reconciliation Report packages are available on WERS. The CATLite Q4 report will be submitted to WERS by June 7, 2012 and the ARR is due June 30, 2012. WERS will be replaced by SRI and agencies will submit their quarterly reports using the system starting in Q2 of 2012/13 fiscal year. SRI was implemented on May 1, 2012 as a field test of SRI and Patient Safety Public Reporting. Training sessions covering SRI overview, submissions and user registration were held April 26 – May 7, 2012 by the SRI project team.

Ministry-LHIN Performance Agreement (MLPA) Performance Requirements and Risks:
As a result of a number of Central East interventions such as purchase of additional volumes, funding for data quality improvement and clean up, and the introduction of Surgical Utilization Booking Management Integration Tool (SUBMIT) software, the Central East LHIN achieved outstanding March results for fiscal year 2011/12 for Diagnostic Imaging (DI) and Surgical Wait Times.

See Appendix B for the Central East LHIN MLPA Performance Indicator Dashboard which are reflected in the "green" status for all 90th Percentile DI and Surgical Wait Times indicators.
This stellar regional performance, which is measured against both the Central East LHIN starting point and targets for 2011/12, has been due to enhanced efforts on the part of all parties involved in these important hospital-based services.

Clinical and administrative staff at Central East LHIN hospitals have made serious efforts to reduce wait times. Working through the Central East LHIN Wait Time Strategy Working Group, the DI Working Group, the Wait Time Coordinators Working Group, and the Orthopaedic Quality Working Group, hospital and Central East LHIN staff deployed multiple strategies to surpass even the most aggressive Ministry targets. Because of these collaborative efforts, the Central East LHIN currently ranks among the best performers in Ontario.

The Central East LHIN will continue to work with hospitals to sustain the gains.

Hospital Service Accountability Agreement (2012/15 H-SAA):
The H-SAA Steering Committee provided a webinar presentation to the LHINs on April 17, to discuss the Hospital Annual Planning Submissions (HAPS) and H-SAA Process for 2012/13 (July 1, 2012 – March 31, 2012). The 2008-10 H-SAA will be amended for another one year term to cover 2012/13 with updates to comply with legislative changes. We can expect to see those templates in three to four weeks (from April 17). It is important to note that there have been a few changes to the accountability indicators which will be negotiated for the agreement that will come into effect on July 1 and will be retroactive to April 1, 2012. These include the addition of five new quality indicators which hospitals have already been publically reporting through Health Quality Ontario.

The HAPS process was officially opened with this presentation on April 17, however the hospitals have not been provided with any data to begin planning. Instead they have been provided with an indicative planning number (IPN) which is a percentage indicating how much a hospital's allocation, under the new Health System Funding Reform (HSFR) model, falls below or above their current allocation.

The IPN includes two components, the firs being the Adjustment for Clinical Quality Groupings (Hips, Knees, Cataracts and Chronic Kidney Disease (CKD)), where base volumes and funding have been carved out and redistributed, along with incremental volumes, and comprise 6% of the provincial hospital budget in 2012/13. The Health Based Allocation Model (HBAM) was also applied to 40% of these funds. These are very preliminary numbers and have not been provided to the hospital, and as they are subject to further revision.

Despite the challenges with obtaining timely data from the Ministry, the LHIN will once again begin the H-SAA negotiation process with the six hospital corporations affected by HSFR. Campbellford Memorial Hospital, Haliburton Highlands Health Services and Bellwood Health Services are not affected by HSFR and their agreements will be based on the targets negotiated in the late winter / early spring.

Multi-Sector Accountability Agreement (M-SAA) Indicator Working Group:
The M-SAA Indicator Working Group has been meeting to ramp up the Community Health Centre (CHC) indicator refresh. In addition, a joint implementation plan has been accepted that, where applicable, accountability indicators will be retroactively effective as of April 1, 2012 and be reported in the first required scheduled reporting deadline of Q2. In addition to the three existing accountability indicators, the following will be added:

1. Influenza vaccination rate;
2. Breast screening rate;
3. Periodic health exam rate; and
4. Vacancy rate (nurse practitioners and physicians).

As detailed in the Communiqué received from the Ministry of Health and Long-Term Care (MOHLTC), the anticipated timeline to amend the SAAs is September 2012.

Long-Term Care Service Accountability Agreement (L-SAA):
On March 1, 2012, the MOHLTC announced the extension of the 2011 interim measure in the Long-Term Care Home (LTCH) Occupancy Targets Policy with amendments. The purpose of the interim measure is to provide

relief to LTCHs experiencing occupancy between 90 and 97 percent, provided that the LTCHs meet certain conditions.

This year, the policy stipulates the active involvement of the LHINs in working collaboratively with LTCHs to ascertain the root cause(s) of their occupancy challenges, review and endorse Action and Implementation Plans developed by the LTCH to address their occupancy issues, and evaluate the effectiveness of those plans. If the LHIN endorses the Home's Action and Implementation Plans, and provided the evaluation of those Plans is positive, funding will be provided as follows:

- For occupancy between 90% to less than 94% - actual occupancy + 1% of maximum resident days; and
- For occupancy between 94% to less than 97% - actual occupancy + 2% of maximum resident days.

As part of this process, the LHINs have committed to ensuring that a consistent approach is used provincially to address the occupancy challenges experienced by some LTCHs. To that end, the Central East LHIN staff participated on a pan-LHIN working group to develop this approach. Any LTCH which the Ministry has identified to have a history of low occupancy (there are currently four in the Central East LHIN), or those at risk based on Community Care Access Centre (CCAC) data, will be asked to submit data to the LHIN. This will be compared against CCAC data and collectively the LHIN and the CCAC will meet with providers to discuss the root cause and the mitigation strategies for improvement. The LHIN will then determine whether the plans produced by the LTCH are appropriate and will determine whether to provide an endorsement to the MOHLTC. The deadline for the endorsement is June 2013.

Central East Community Care Access Centre (CECCAC) Performance and Risks:
The CECCAC will show an overall surplus of about $1.8M for the 2011/12 fiscal year. This surplus includes funding that was received or approved for implementation of new programs or initiatives late in the fiscal year. This funding has specifically defined outcomes and could not be used for any other purpose (i.e. Mental Health (MH) nurses in District School Boards ($425K); Rapid Response Nursing program ($546K); Nurse Practitioner (NP) Integrated Palliative Care program (340K); Behavioural Supports Ontario (BSO) ($556K); etc). As a result approximately $1.8M will be returned to the MOHLTC through the Annual Reconciliation Report (ARR) process.

The CECCAC continues to develop strategies to ensure a balanced budget in 2012/13, given the current spend rate is unsustainable. The spend rate is totally attributable to the success of Home First. Home First is a philosophy that is fully supported by the CECCAC and is essential in an environment where hospitals are working with a 0% budget increase. Home First requires the provision of significant service levels to be successful and reduce the hospital patient days. This means that the CECCAC must find savings in other areas which undoubtedly will have an impact on our ability to service community referrals.

The provincial budget describes a minimum 4% increase to community health care. A 4% increase would minimize the impact of any strategies to be implemented to balance the 2012/13 budget. The CECCAC would still need to continue to use personal support and adult therapy waitlist strategies through 2012/13 as the next fiscal year is shaping up to be a challenging year in the community. The CECCAC will focus its efforts to help ensure the overall Central East LHIN health system operates efficiently.

Central East LHIN Performance, Finance & Risk Management (PERFORM) Database:
The PerFoRM database is in operational mode and many users are contributing information. After using the database to facilitate the process of Provider Reviews with the Provider Issue Escalation (PIE) list and the quarterly risk reporting to the Audit Committee, it has been updated to ensure it is more efficient with respect to those processes. The output after a month of operation is quite extensive and multiple uses for the information is becoming apparent.

Hospital Performance and Risks:

As of Q3, 2011/12, hospitals were tracking to balance and operate within negotiated corridors. The Central East LHIN is currently waiting for the submission of March 31, 2012 results to review performance for fiscal year 2011/12 and determine potential issues going forward.

The key hospital risk in 2012/13 is ability of the hospitals to function within balanced budget requirement without significant reduction in services. For 2012/13, hospitals are facing a number of financial challenges which include a 0% increase to base budget for inflationary component when hospitals are experiencing approximately 3.5% for negotiated union settlements and other inflation pressures in 2012/13 and changes in funding and volume allocation for four Quality Based procedures represent a challenge to the hospitals as they now need to deliver at a new 40th percentile price.

The Ministry has not yet provided final numbers for these changes. Final hospital numbers are expected in the middle of May. As a mitigation strategy, the Central East LHIN is arranging to meet with its hospitals to discuss final allocation, issues, and challenges.

Wait Time Strategy Working Group (WTSWG):
On April 25, 2012, the Central East LHIN Board approved the preliminary allocation of 50% of total Quality-Based Procedures (e.g. hips, knees, and cataracts) and 50% of total Diagnostic Imaging (i.e. CT and MRI) Wait Time Incremental allocations to the Central East LHIN hospitals. This preliminary allocation was communicated at the WTSWG meeting on April 26, 2012, and the Hospitals were subsequently notified of their six month preliminary allocation.

The preliminary 2011/12 annual and Q4 results were also reviewed and all hospitals performed well overall. Some areas of concern include TSH for cancer surgery and knee replacement wait times, and PRHC for cataracts and knees. For Magnetic Resonance Imaging (MRI), the majority of hospitals were below the LHIN target of 63 days for Q4. A new monthly survey template will be implemented to collect supplementary wait time information for 2012/13 once feedback is received from the group, and will be utilized starting with the May meeting.

Orthopaedic Scorecard:
Last fall, the Ministry indicated its plans to introduce two new MLPA indicators: Average Length of Stay (LOS) target of 4.4 days and Proportion of Patients Discharged Home target of 90%. To meet the challenge of complying to the new standards, the Central East LHIN implemented the Orthopaedic Quality Workgroup. An information session was held on April 11 with representatives from London Health Sciences Centre and Queensway Carleton Hospital. One of the objectives was to engage physicians to participate and to gain their support in the achievement of performance targets. A key outcome is that TSH and RVHS are exploring the possibility to have a single outpatient unit to provide services once patients are discharged from the hospital.

The following is a table of current and past performance. Performance is reviewed as a standing item by the Workgroup. Hospitals are asked to explain any slippage and plans to improve:

Facility	Q3 FY 10/11	Q4 FY 10/11	Q1 FY 11/12	Q2 FY 11/12	Q3 FY 11/12	Projected Q4 FY 12/13	% Change Q3 FY 11/12 vs. 10/11
Average Length of Stay (Days)							
LH	3.5	3.4	4.0	4.5	3.1	≤ 4.4	11%
PRHC	4.0	4.2	4.0	4.0	3.9	≤ 4.4	2%
RMH	4.9	4.7	5.1	4.4	6.1	≤ 4.4	-24%
RVHS	4.7	4.8	4.9	4.9	4.8	≤ 4.4	-2%
TSH	3.7	4.0	3.9	4.0	4.0	≤ 4.4	-7%
LHIN	**4.0**	**4.1**	**4.1**	**4.2**	**4.1**	**≤ 4.4**	**-4%**
Proportion of Patients Discharged Home (%)							
LH	61.6	63.4	85.3	78.9	63.3	≥ 90	3%
PRHC	92.8	96.4	95.6	95.9	94.6	≥ 90	2%
RMH	71.6	81.5	77.4	83.3	94.8	≥ 90	32%
RVHS	51.3	36.5	47.2	46.2	61.4	≥ 90	20%
TSH	83.5	76.3	75.1	75.0	76.4	≥ 90	-8%
LHIN	**73.8**	**71.8**	**75.0**	**75.2**	**77.0**	**≥ 90**	**4%**

Improvement in Q3 FY 11/12 vs. Q3 FY 10/11
Reduction in Q3 FY 11/12 vs. Q3 FY 10/12 and below target
Reduction in Q3 FY 11/12 vs. Q3 FY 10/13 and above target

Variance Explanation:
RVHS: Average LOS worsened slightly from 4.7 to 4.8 days. The main cause was that the hospital was internally using the target of 5.0 until the provincial benchmark was announced. The hospital is taking measures to improve, and the performance in Q4 has improved to 4.2 and 67%.

RMH: Average LOS worsened from 4.9 to 6.1 days but the proportion of patients discharged home improved from 71.6 to 94.8. The main causes were: (a) the co-morbidity/complexity of patients may have been higher; and (b) the LOS for at least one patient was very high (14 days) which may skew the results – the cause of the increased LOS was unavailability of rehab beds to transfer to. A chart audit is being undertaken to confirm findings.

TSH: Average LOS worsened from 3.7 to 4.0 days and the proportion of patients discharged home also worsened from 83.5 to 76.4. The main cause was that the volume of work increased. This was a temporary blip. Improvements are being worked on to meet targets.

Hospital-Community Care Access Centre Financial Leadership Group (HCFLG):
The HCFLG recently struck a sub-group with representation from many of the hospitals and chaired by Natalie Hovey of Lakeridge Health. The group has met on two occasions to develop the scope and Project Charter / Terms of Reference (TOR) to present to the HCFLG group as well as the Central East Executive Council (CEEC) Group. The aims of the group are to develop a plan to identify savings year over year at a system level, (across the nine public hospital corporations),which will mitigate the impact of an anticipated 0% increase in funding, Health System Funding Reform (HSFR) and annual increases due to collective agreements and utilities, etc.

The Chief Nursing Executives (CNE) group is meeting with the HCFLG on May 18 to take part in the initial discussions and program review of the 2012/13 Quality-Based Procedures (i.e. hips, knees and cataracts).

Diagnostic Imaging(DI) Working Group:
The DI Working Group has been focusing on planning for a Radiologist Engagement Meeting on May 24 at the Central East LHIN. The purpose of the meeting will be to engage the Radiologists in the work of the LHIN, their role in achieving our DI MLPA targets and to introduce them to other wait time initiatives such as SUBMIT. This will be the first time the Radiologists have come together to engage with the LHIN and it is anticipated that the outcomes will result in sharing of best practices and an increased understanding of how DI services might be further improved system-wide.

Community Engagement

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

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

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

- On April 14, Deborah Hammons participated as a panel member at the Scarborough MPP sponsored 26th Annual Scarborough Renaissance conference. The topic of the panel discussion was health care reform and sustainability.
- On April 18, the Central East LHIN hosted an MPP breakfast at Queen's Park. This successful event provided an opportunity to update our MPPs on the status of our current IHSP, the development of IHSP #3, our integration strategy and also provided them information regarding the Health System Funding Reform. We were honoured to have the Minister of Health Deb Matthews attend a portion of the meeting with her staff. Seven of our thirteen MPPs attended, and those that were unable to attend were sent the presentation with an offer to update them at another time.
- Katie Cronin-Wood and Karen O'Brien attended a Provincial LHIN Communicator Face-2-Face session in Toronto on May 3. This annual session provides an opportunity for all LHIN communicators to share best practices and innovative ideas, with their LHIN colleagues.
- James Meloche, Jai Mills and Karen O'Brien attended a preliminary planning session with all Durham MPPs on a proposed Mental Health event. This event is being sponsored by MPP Tracy MacCharles, who has requested that the Central East LHIN offer guidance and support as the planning for this event gets underway.

Website

The Central East LHIN website continues to be a primary vehicle for both communication and engagement with our stakeholders. From April 1 - 30, 2012 there were 6,678 visits made by 3,950 unique visitors. There were

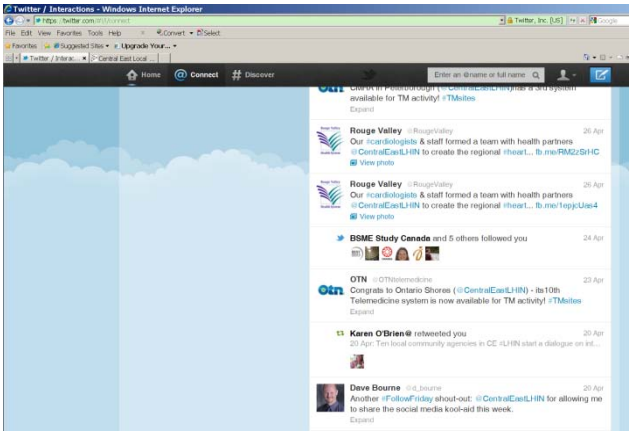
21,053 pages viewed. Over 80% of the traffic to the Central East LHIN website heads to the Home Page first, with 26% then heading to the Careers page, 13% heading to the About our LHIN page and 10% heading to the Board of Directors page. An analysis of traffic spikes shows that on April 2nd, 163 people visited the Planning page when new content was added announcing a Care for the Elderly Funding Program and on April 26th, 185 people visited the LHIN's Behavioural Supports page after the content was updated to announce additional activities to build capacity.

A number of new pages were added to the Central East LHIN website including the Community Services Integration Strategy page – see http://www.centraleastlhin.on.ca/report_display.aspx?id=21752. This subscribable page will be used to share information with stakeholders from across the LHIN on the activities underway to support the development of a new service delivery model for community health services in the Durham cluster. A web-enabled feedback form has been posted to the site and is being monitored.

Social Media

The LHIN continues to post new tweets to its Twitter Account @CentralEastLHIN.

The Central East LHIN Twitter account now has 193 followers after staff made a concerted effort to increase the number of accounts we were ourselves following. This expanded our profile and attracted interest from a variety of stakeholders.



Tweets in April

April 20, 2012: Ten local community agencies in CE #LHIN start a dialogue on integration, improving #access2care for aging population http://bit.ly/yY5zyY

April 26, 2012: New hire 4 #palliative network, important area of focus in CE#LHIN for next IHSP

April 27, 2012: Latest CE #LHIN board meeting materials highlight system #leadership #quality #integration and #fiscal responsibility

April 30, 2012: Learn lots "@CPCCentralEast: Only 10 more minutes to go!! RT @AndieHynes: Getting ready to start the #caspr2012 conference!"

April 30, 2012: RT "@ScarboroughHosp: Congrats to our own Rhonda Seidman-Carlson, appointed President of the Registered Nurses' Assoc of Ontario (@RNAO)"

April 30, 2012: MT speaks to system leadership "@RougeValley: cardiologists & staff, health partners create regional #heart... http://fb.me/RM2zSrHC"

April 30, 2012: MT amz'ng support 4 new sites across the #LHINs @OTNtelemedicine: CMHA in Peterborough has a 3rd system available for TM activity! #TMsites

April 30, 2012: Sharing system expertise @ScarboroughHosp & @PRHC1 on #CKD leads 2 better care for CE #LHIN residents

April 30, 2012: MT vital partner in #transformation @TheChangeFdn new report seniors/caregivers speak out on improving patient exp. http://bit.ly/JlLUNc"

Communications staff shared the Board approved Social Media and Communications policies with Central East LHIN staff in April so that they are aware of the guidelines. The documents were also shared with Central East LHIN and provincial LHIN communicators as a best practice. A pan-LHIN Social Media policy is now in development.

We continue to encourage people to subscribe to the website and to follow us on Twitter in order to be alerted to new content and new information as it is posted. This will ensure our communities are informed, educated, can provide input, be involved and consulted on the work being done to create an integrated system of care that provides better care, better health and better value for money.

Central East LHIN Operations

Finance:
As the fiscal year-end closes the preparations progress for the external Audit, a full report was scheduled to be presented at the Audit Committee on May 15, 2012. The Audit Committee met on April 13 and reviewed the quarterly reports including the Board expenses and per diem claims as well as the quarterly Declaration of Compliance report, where staff reported that there were no exceptions to report.

We are very happy to share with all that our annual audit has been completed and once again it was “clean”. In other words we have been fully compliant in all areas of accountability throughout the 2011/12 fiscal year. It is important to acknowledge the tremendous amount of work involved to managing the areas that are reviewed during the audit process at the Central East LHIN every fiscal year.

The Business Support Unit and members of the Financial Team in SFPM worked extensively with the auditors to facilitate this outcome. Once again the Central East LHIN has demonstrated its probity by maintaining transparency and demonstrating the appropriate use of public funds.

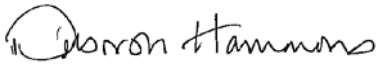
Staffing Announcements:

Lauren Chitra was selected as the Central East Hospice Palliative Care Network (CEHPCN) Coordinator and began this position on April 23. Ms. Chitra worked with the Central East LHIN as a Health Planner prior to this new position and was with the office since October 2011. She previously worked with the Canadian Institute for Health Information, Health Canada and the Canada School of Public Service. As the CEHPCN Coordinator, Lauren will be responsible for the development and implementation of activities that will enable the Central East Hospice Palliative Care Network to successfully fulfill its vision and mission. In addition, Lauren will provide local leadership and develop collaborative partnerships across the region to achieve better outcomes for people requiring hospice and palliative care services.

Dieufert Bellot joined the System Design and Implementation unit as the French Language Services Coordinator on May 7, 2012. Prior to joining the Central East LHIN, Dieufert has worked at the French Canadian Association of Ontario and has taught at the University of Western Ontario in Professional Communication and Business French and has held the Executive Director position at the French Regional Community Centre of London. Dieufert has a Bachelors of Economic Degree and Agri-Food Management Degree from the University of Guadalajara and a Masters of Public Administration in International Management from the University of Quebec.

Elizabeth Salvaterra has accepted another position outside of the Central East LHIN and ended her tenure as the Emergency Department/Alternative Level of Care Lead in mid-May. Elizabeth's dedication to the strategic aims of the Central East LHIN has been unprecedented, in her time with this office; she established very strong relationships with our health service providers and has been key to reducing the ALC rates in our hospitals. Her contributions will remain appreciated and we wish her the best in her new ventures.

Respectfully Submitted,



Deborah Hammons
Chief Executive Officer
Central East Local Health Integration Network

Appendices

Appendix A


Ontario Renal Plan.pdf

Appendix B


Ministry-LHIN Performance Agreem

Appendix C


M-SAA Communique.pdf

Appendix D


HH Issue 17 Focus on Patient Safety API

Appendix E


9 Central East LHIN Report.pdf