MOHLTC - HSAPD
Quarterly Stocktake Report

LHIN:	Central East LHIN
Report Date:	August 2011

Ontario

GUIDE: Strategies & Interventions within Central East LHIN

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LEGEND: Interpreting intervention performance

System Measures	Supplementary Measures	Baseline	Target	Quarterly Performance	Key Considerations
A set of measures associated with a specific intervention/strategy that are directly linked to one or more goals of the strategy	A set of measures associated with a specific intervention/strategy that are indirectly linked to one or more overarching goals of the strategy	The determined baseline will be inserted here and will remain the same each quarter	The determined target will be inserted here and will remain the same each quarter	Illustrates current performance with respect to the supplementary measure against defined targets. Graphs/charts are inserted by Access to Care.	Explains current performance and what proposed changes could be put in place to improve performance. Information is inserted by LHIN.

ER/ALC

LHIN VIEW: CENTRAL EAST LHIN

SYSTEM FOCUS: **Reduce time spent in the ER across Ontario**

Ontario

What is the problem?

Almost 50% of ER visits are made by patients with non-urgent or less urgent needs

Time spent in the ER is too long: 90% of patients are treated within 9.4 hours from triage to discharge

Time in the ER is five times longer for ER patients admitted to hospital (35 hrs); 75% of their total ER time (26 hrs) is spent waiting for an inpatient bed

GOALS

What are we striving to achieve?

1 Reduce ER demand

Reducing the number of non-urgent cases that present at the ER will enable emergency clinicians to focus on patients with critical needs

2 Increase ER capacity/performance

Improving triage and admission processes and reducing ambulance offload times will enable emergency clinicians to provide more efficient care

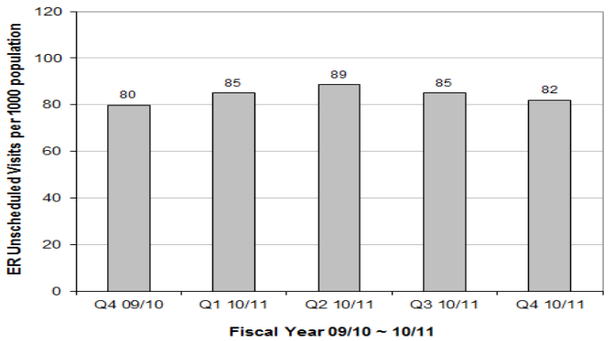
3 Improve Bed Utilization

Improving bed utilization expedites patient throughput and maximizes hospital capacity

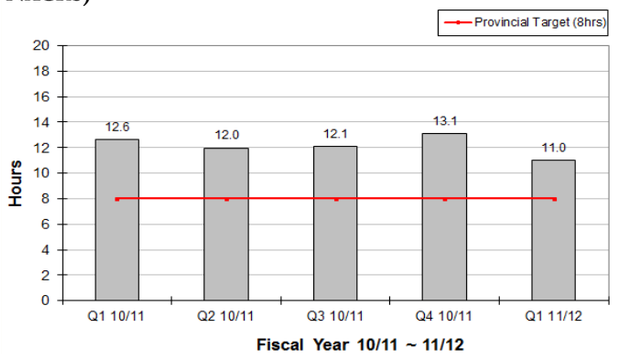
PROGRESS

Have we achieved our goals?

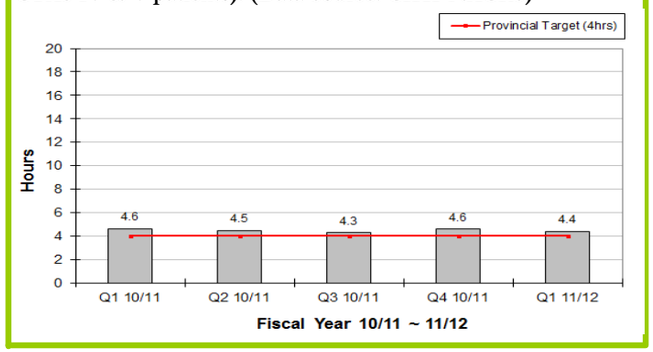
Number of ER Unscheduled Visits by quarter per 1000 population (Data Source: MoHLTC Provincial Health Planning Database & CIHI-NACRS)



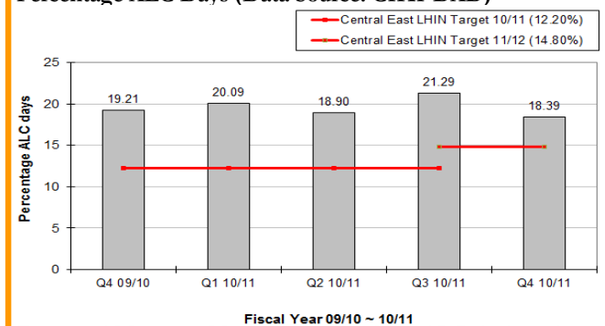
Time spent in the ER for high acuity patients (all admitted + non-admitted CTAS I, II, III patients). (Data Source: CIHI-NACRS)



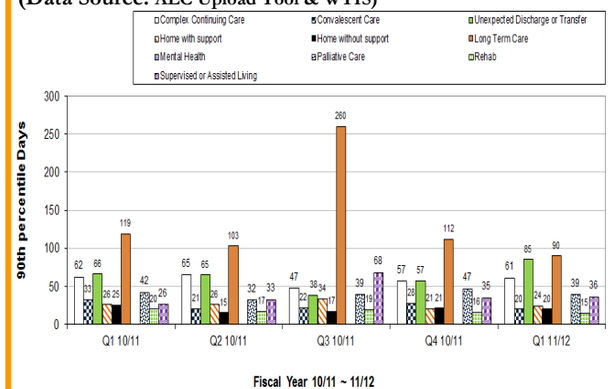
Time spent in the ER for low acuity patients (non-admitted CTAS IV & V patients). (Data Source: CIHI-NACRS)



Percentage ALC Days (Data Source: CIHI-DAD)



<u>Proposed Measure</u>: Number of days from ALC designation to discharge by discharge destination (90th percentile Days) (Data Source: ALC Upload Tool & WTIS)



HIGHLIGHTS

Evidence of achievements and/ or obstacles to progress

- The Number of ER unscheduled visits for the CE LHIN in Q4 10/11 has decreased when compared with Q3 10/11 but has increased over Q4 09/10 values. The total number of ER visits for the LHIN in Q4 10/11 was 126,547.

- Time spent in the ER for high acuity patients decreased by 1.6 hours when comparing with Q1 10/11, and by 2.1 hours when comparing with Q4 10/11.
- Time spent in the ER for low acuity patients has decreased by 12 minutes when compared with both the last quarter and the same quarter last year.

- Percent ALC days decreased in Q4 10/11 to its lowest point in the last year, but remains above the CE LHIN target of 14.8%.
- In comparison to Q4 10/11, Number of days from ALC designation to discharge to LTC has decreased by 22 days in Q1 11/12, to its lowest point in the last year.

CENTRAL EAST LHIN

Goal: Increase ER Capacity/Performance

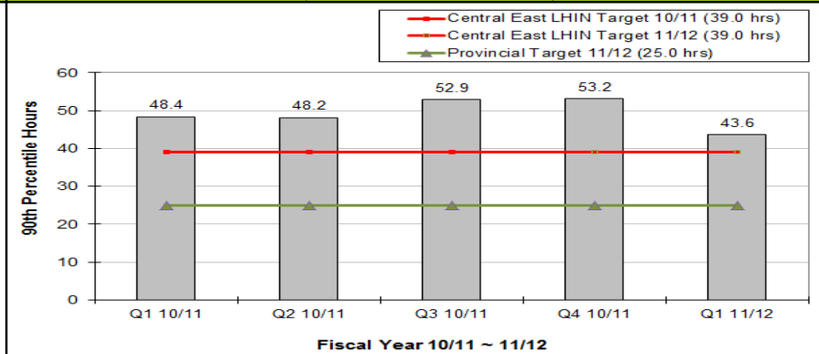
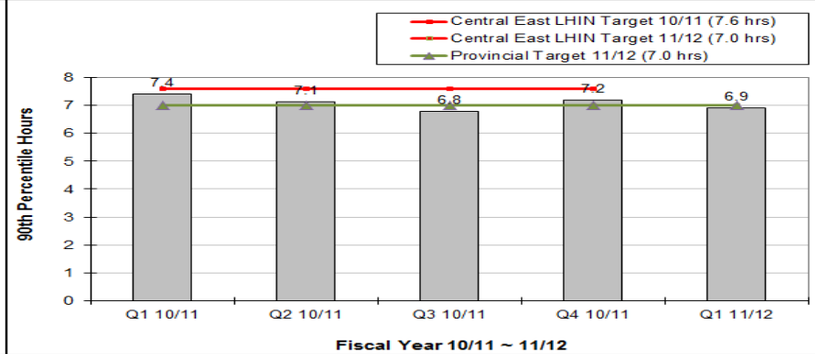
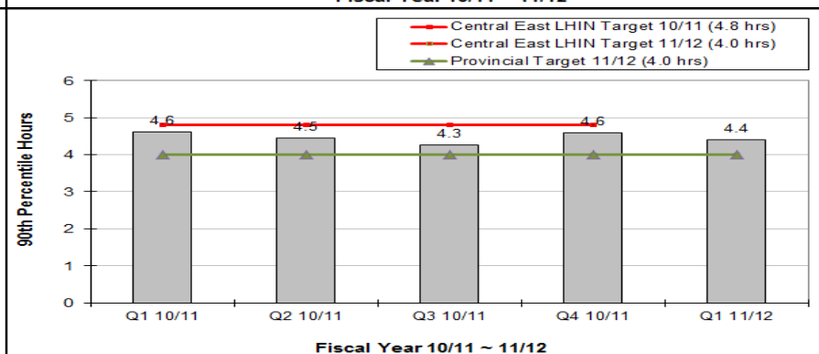
Intervention: ER Pay for Results Year 4 –

Continued P4R Initiatives from FY2010
- ED Navigators (LHB/LHO; RMH)
- Cardiac Assessment Zone (LHO)
- Direct to Assess Model (LHO)
- Community Crisis Initiative (NHH)
- Access & Flow Specialist (NHH)
- ER Porter (NHH)
- Enhanced Ambulatory Care Areas (RVHS)

New P4R Initiatives Implemented FY2011
- ED-PIP (RVHS and LHC)
- LEAN (RMH)
- Bed Turnaround Time Initiative (NHH)
- Flow Nurse (NHH)
- Inpatient Navigator (RMH)
- Social Worker (RMH)
- Best Medication History (RMH)
- Admission Nurse (RMH)
- Diabetes Inpatient Teaching (RMH)
- Housekeeping Surge (RMH)
- Clerical Support (RMH)
- Mobile Admission Team (TSH)
- Patient Flow & Access Steering Committee (TSH)
- Geriatric Mental Health Program (TSH)
- Mental Health ED Wait Time Reduction (TSH)

AAH Initiatives
- 9 GEM Nurses—8 funded through AAH
- Both GAIN and Home First are expected to have an impact on all P4R indicators as well as ALC
- These initiatives are described in more detail on pages 22 & 23

Ontario

System Measures	Baseline FY 10/11	Target (MLPA)	Current Performance	Quarterly Performance (Data Source: CIHI-NACRS)	Key Considerations
90th percentile ER length of stay for admitted patients	51.6 Hours	Provincial 25.0 Hours LHIN 39.0 hrs (FY 11/12)	43.6 Hours		**Past (FY2010):** ▪ 90th percentile length of stay in the Emergency Department for Admitted patients remained longer than the provincial and LHIN target for all quarters. **Current (Q1 11/12):** • 90th percentile length of stay in the Emergency Department for Admitted patients has decreased over every period of the last year. CE performance remains longer than that of any other LHIN in the province. ▪ Provincial performance in this indicator for Q1 was 30.4 hours, 13.2 hours shorter than CE LHIN performance, although this difference has decreased by more than 4 hours over the previous quarter. In Q1, four LHIN's met the provincial interim target of 25 hours. **Future (Q2-Q3 11/12):** ▪ Length of stay for Admitted patients remains the area where Emergency Departments have the least control—CE time to disposition is 3.4 hours longer than provincial performance, but the time to inpatient bed is nine hours longer. ▪ The LHIN-wide Home First roll-out is now complete. Initial uptake at PRHC and LHO was incomplete, but PRHC performance has improved in the last quarter, and LHC is now on a formal improvement plan.
90th percentile ER length of stay for non-admitted complex patients	7.4 Hours	Provincial 7.0 Hours LHIN 7.0 hrs (FY 11/12)	6.9 Hours		**Past (FY2010):** ▪ Performance in this indicator has had little fluctuation over the last year. **Current (Q1 11/12):** ▪ 90th percentile length of stay in the Emergency Department for non-Admitted high acuity patients in Q1 11/12 met the CE LHIN FY2011 target of 7.0 hours. ▪ Provincial performance in this indicator for Q4 was 7.5 hours, with six LHIN's meeting the new provincial target of 7.0 hours. CE LHIN performance was the 6th shortest in the province for this quarter. **Future (Q2-Q3 11/12):** ▪ CE LHIN hospitals are expected to maintain their current excellent performance in this indicator. We hope that continued good performance will not result in a further shortening of the provincial target beyond an evidence-based recommendation, thus resulting in clinicians having less time to spend providing evaluation and treatment for patients.
90th percentile ER length of stay for non-admitted minor/ uncomplicated patients	4.5 Hours	Provincial 4.0 Hours LHIN 4.0 hrs (FY 11/12)	4.4 Hours		**Past (FY2010):** ▪ Performance in this indicator has had little fluctuation over the last year. **Current (Q1 11/12):** ▪ 90th percentile length of stay in the Emergency Department for non-Admitted low acuity patients decreased in Q1 11/12 as compared to the same quarter in 10/11 as well as the previous quarter, but is longer than the CE LHIN FY2011 target of 4.0 hours. ▪ Provincial performance in this indicator for Q4 was 4.4 hours, with six LHIN's meeting the provincial standard of 4.0 hours. CE LHIN performance was the 10th shortest in the province for this quarter. **Future (Q2-Q3 11/12):** ▪ Pay-for-Results and ED-PIP initiatives at RVHS and LHC are expected to further shorten 90th percentile length of stay for this cohort.

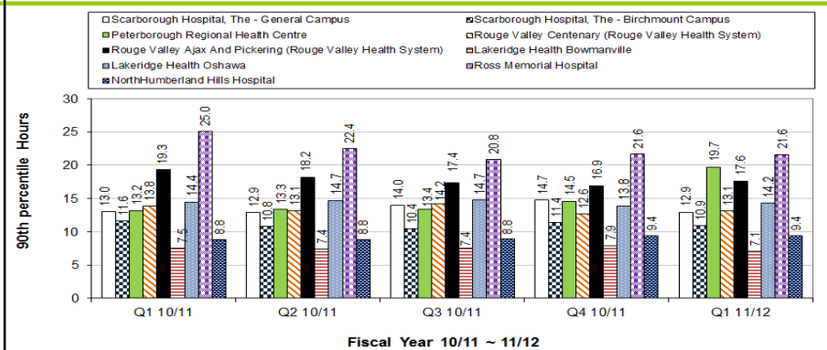
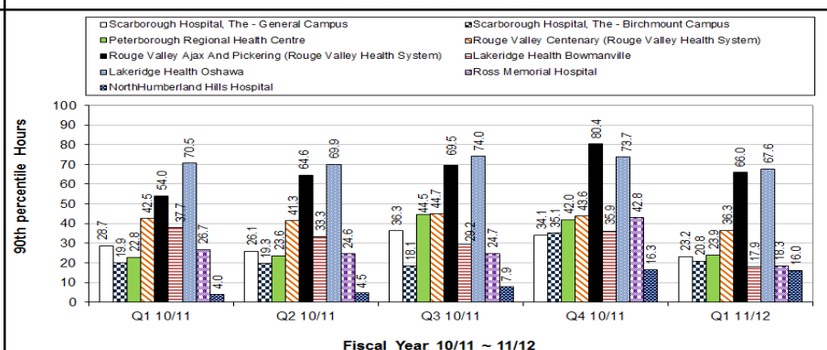
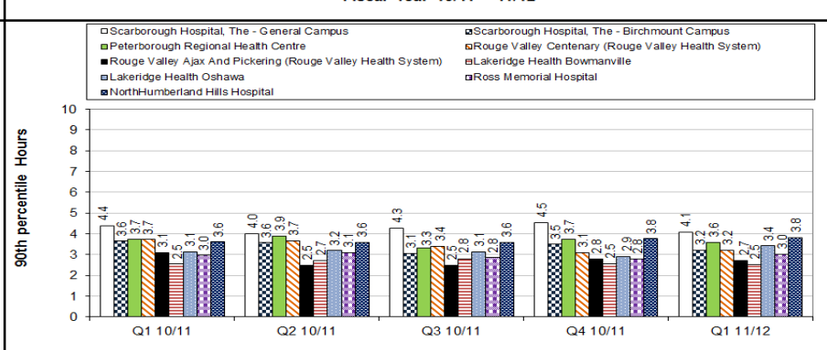
CENTRAL EAST LHIN

Goal: Increase ER Capacity/Performance

Intervention: ER Pay for Results Year 4

Time to PIA Initiatives
- Physician Process Improvement (LHC, RVHS)
- Nurse Practitioner (NHH)
- See & Treat Model of Care (PRHC)
- Physician Assistant (RMH)
- Extra Physician Hours (RMH, TSG)

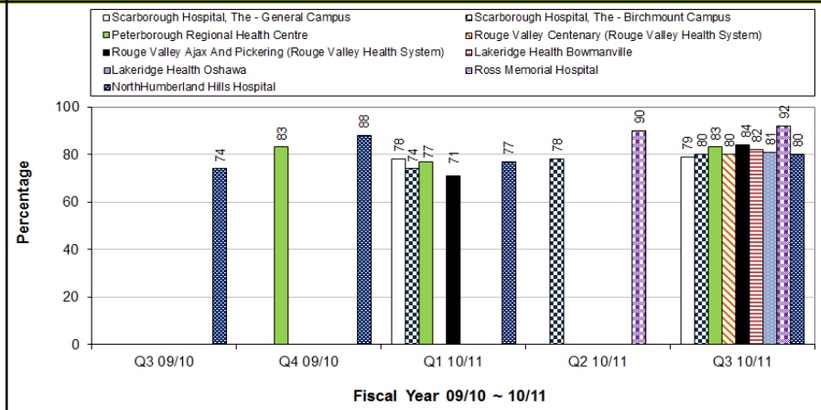
Ontario

Supplementary Measures	Baseline FY 10/11	Target TBD	Current Performance	Quarterly Performance (Data Source: CIHI-NACRS)	Key Considerations
Time to Disposition Decision: Registration or Triage date/time to disposition date/time (admitted only)	14.4 Hours	TBD	15.4 Hours		**Past (FY2010):** • The time to disposition decision did not change substantially over the past year for most CE LHIN hospitals, although it was consistently longer for RMH than for other hospitals. **Current (Q4 FY2010):** • Q1 performance is not substantially different at most CE LHIN hospitals, with the exception of PRHC, where it has increased over all of last year's performance periods. • CE LHIN performance has lengthened by 1 hour from baseline in Q1. • Comparison with provincial performance or other LHIN's is not possible, since this indicator is not provided in the provincial view. **Future (FY2011):** • CE LHIN will work with providers to continue to move toward the provincial target of 8 hours for non-CDU patients. • Consultation with designated P4R hospitals suggests that matching time to disposition indicators with the time to PIA indicator would provide valuable context for what is happening in the ED.
Time to inpatient Bed: Disposition date/time to Left ER date/time	43.9 Hours	TBD	33.9 Hours		**Past (FY2010):** • This indicator was not a performance indicator in FY2010. **Current (Q1 FY2011):** • No Central East LHIN hospital is participating in the Short Stay Unit stream of Pay for Results for which this measure is a performance indicator. • Provincial performance in this indicator for Q1 was 23.6 hours. CE LHIN tied with Central LHIN for longest performance in this measure for this quarter. **Future (Q2-Q3 FY2011):** • Time to inpatient bed is the largest share of wait time within the 90th percentile EDLOS for admitted patients. We expect that Pay-for-Results initiatives, including ED-PIP at LHC and RVHS, and LHIN-wide incorporation of Home First business processes will decrease this measure.
Time to Physician Initial Assessment: Triage date/time to date/time of Physician Initial assessment	3.4 Hours	10 % reduction in the 90th Percentile	3.4 Hours		**Past (FY2010):** • The CE LHIN exceeded its FY2010 target of 10% shortening over baseline, achieving 14% shortening in the entire fiscal year. • Although the fiscal year has been over for five months, no suggested recovery methodology for this indicator has been published. Since the funds are already spent, and therefore any recovery will come from hospital base funds, this lack of information makes hospital budgeting difficult. **Current (Q1 FY2011):** • Provincial performance in this indicator for Q1 was 3.5 hours. CE LHIN ranked 7th out of 14 LHINs for this quarter. • In Q1, no designated CE LHIN hospitals have met their time to PIA goals for FY2011, although six have had a further shortening in this time over last year. **Future (Q2-Q3 FY2011):** • The lack of a standard for this measure makes development of reasonable expectations difficult. An indefinite expectation of 10% reduction over baseline is unsustainable.

CENTRAL EAST LHIN

Goal: Increase ER Capacity/Performance

Intervention: ER Pay for Results Year 4 –

Supplementary Measures	Baseline	Target TBD	Current Performance	Quarterly Performance	Key Considerations
Percent positive rating to the patient satisfaction survey question: "Overall, how would you rate the care you received in the Emergency Department"	79% Q4 08/09	TBD	82%		**Past (Q3 09/10-Q2 10/11):** • Absent data for previous performance periods for most hospitals makes performance trends difficult to comment on. **Current (Q3 10/11):** ▪ This quarter is the first since the Stocktake began being published in which we have data for all our hospitals. • The range of scores across all CE LHIN hospitals is from 79 (TSG) to 92 (RMH), and represents an overall 3% improvement over Q4 09/09. • With one exception (NHH), Q3 performance is the best for each hospital of any yet portrayed. **Future (Q3-4 FY2010):** • For this indicator, which is part of the Pay-for-Results program, we believe that a target set by MOHLTC that is consistent across LHIN's would be of more value than for each LHIN to set its own.

CENTRAL EAST LHIN

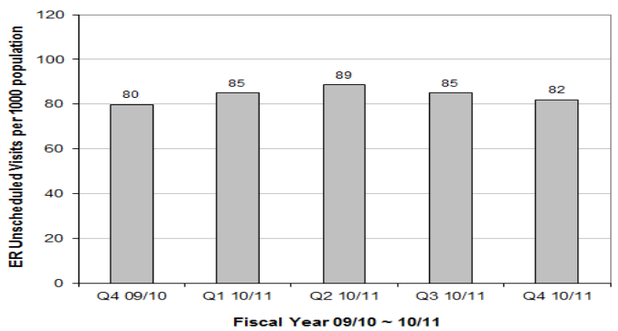
Goal: Reduce ER Demand

Intervention: Aging at Home (AAH) and Urgent Priorities Fund (UPF)

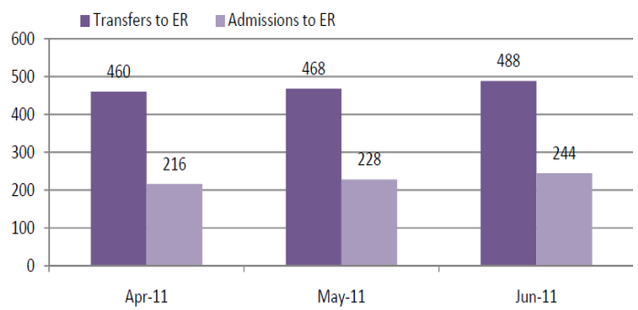
AAH
- First Link Alzheimer Program
- 7 NP's on 3 NPSTAT (2 AAH; 1 funded through MOHLTC)
- Caregiver Support Centre in Scarborough
- Community Support Services (Adult Day Programs, Meals, Transportation)
- Supportive Housing
- Community Based Palliative Care Team in Scarborough

UPF
- Chronic Kidney Disease Early Intervention & Outreach
- Self-Management Training for Consumers & Caregivers
- Comprehensive Vascular Disease Prevention & Management
- Unattached Patient Initiative
- Timely Discharge Information System
- WRAP (Wellness Recovery Action Plan) for patients with Mental Health conditions

Ontario

Supplementary Measures	Baseline TBD	Target TBD	Current Performance	Quarterly Performance	Key Considerations
Number of ER Unscheduled Visits by quarter per 1000 population	NA	NA	82	 Data Source: MoHLTC Provincial Health Planning Database & CIHI-NACRS	**Past (Q4 09/10-Q3 10/11):** • CE LHIN performance in this measure has had little fluctuation in past periods. **Current (Q4 FY2010):** • CE LHIN results in this measure are 5th lowest in the province—number of unscheduled visits per 1000 population is consistently lower than the province, but following the same trend. • CE LHIN decreased by 3 visits from Q3 to Q4, but increased by 2 visits from Q4 09/10. In the same periods, the province decreased by 1 visit and increased by 2 visits, respectively (provincial performance for Q4 10/11 was 97 visits). **Future (Q4 09/10-Q1 10/11):** • CE LHIN will continue to work with community and hospital health service providers to prevent avoidable ED visits.

Number of resident transfers to ER(s) from a Long-Term Care facility (LTC) broken down by primary reason for transfer	TBD	TBD	LHIN to indicate total number of transfers	Data Source: LHIN Nurse Led Outreach Team program data collected/analyzed through a designated process identified by each NLOT model	**Past (Q2-Q4 FY2010):**
					• 35 out of 68 total LTCHs had signed MOUs with NPSTAT
					• Total number of direct encounters and diversions increased in Q4 to 1606 and 1513, respectively - ED diversion rate of 94.2%
					• Total ED $$ saved was $649,369.80.
					Current (Q1 FY2011):
					The chart reflects data from 59 homes which were fully compliant with reporting over the 3 months. The current quarter demonstrates a nominal monthly increase in the admissions. The Central East LHIN does not track primary reason for transfer for all homes.
					• 38 LTCHs have signed MOUs with NPSTAT out of a total of 68
					  • Q1 Total number of Direct Care encounters: 1337, with an ED diversion rate of 96%
					  • Q1 ED hours saved: 3,010.22, corresponding to a savings of $392,395.90 (based on estimate of $330 per ED visit)
					• Demand for NPSTAT services is growing substantially as a result of increasing workload for existing NP's. Need for provision of evening and weekend NP outreach services has been identified. ALC transition activities are increasing as NPs facilitate earlier discharges and provide clinical support to the LTCH's when residents are repatriated.
					• A standardized tool was developed to align to the CE LHIN and MOHLTC's strategic priorities. The tool continues to evolve and in addition to "Direct Care" encounters, the tool now includes "Indirect Care" encounters, including all supporting aspects of NP practice (ALC transitions and repatriation, consulting, capacity-building, stakeholder education, presentations, family councils and meetings, etc.).
					• Barriers include lack of physician engagement, refusal of LTCHs to allow nursing staff to use basic nursing skills such as hanging IV medications or solutions, and refusal of LTCHs to take complex and more acutely-ill residents from hospital.
					• Additional supports are required for resident repatriation and changed care requirements:
					  • LTCH nurses are expected to learn new skills that have not historically been a part of the LTC environment. It is a challenge for LTCHs to cope with hospitalized residents who are increasingly being discharged earlier; are more acutely ill, and who often have new medical devices and therapies that historically belonged in the hospital.
					  • There is a discrepancy between the urgency and motivation of the system to decrease hospital stays and the urgency and motivation of LTCH staff and administrators to meet that need.
					• The NPSTAT team currently has a complement of 6.8 NPs dedicated to outreach plus a 0.5 FTE Clinical Director.
					Future (Q2-Q4 0/11):
					• Planned activities: Due to the demand for NPSTAT services especially in the north east and Scarborough regions of the LHIN, the CE LHIN is poised to hire up to 7 additional NPs to cover the remaining LTCHs and to provide full-time after-hours coverage, including week-ends, should funding be made available.
					• If funding were to be made available and if we were able to recruit a full complement of NPs and expand outreach services to all of the LHIN's 70 LTCHs, then we most likely would witness a substantial increase in ED diversions and decreased ALC days. Daily service coverage could be available 13hrs from Monday-Friday, and 8hrs on both Saturdays and Sundays when the ED transfer rates from LTCHs are high.

Number of resident transfers to ER(s) resulting in inpatient admissions	TBD	TBD	LHIN to indicate total number of transfers resulting in admission	 Data Source: LHIN Nurse Led Outreach Team program data collected/analyzed through a designated process identified by each NLOT model	

CENTRAL EAST LHIN

Goal: Improved Bed Utilization

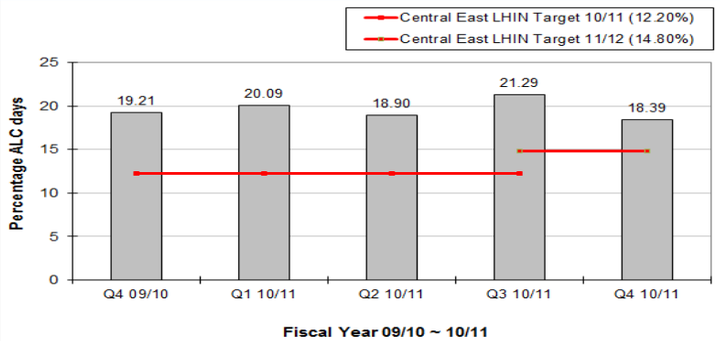
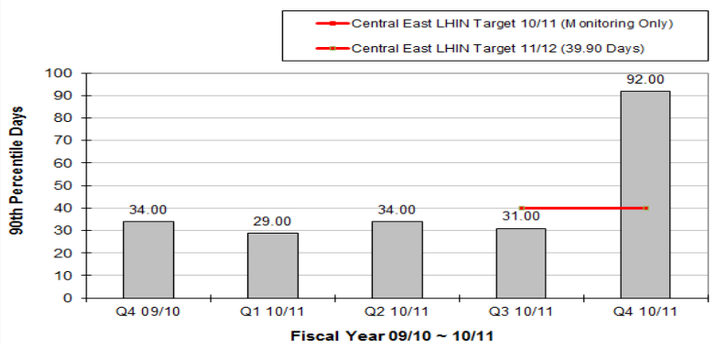
Intervention: Aging at Home (AAH) and Urgent Priorities Fund (UPF) -

AAH Year III
- Home First spread across CE LHIN
- GAIN (Geriatric Assessment Intervention Network) Clinics
- Transitional Care Beds
- Home at Last

UPF
- Nurse Practitioner Outreach to Long-Term Care Homes
- CSS funding (LHIN-wide) for Enhanced Services in support of the Home First philosophy

CCAC Interventions in 2010-11 Q3 Reallocations
Funding was provided to the CE CCAC for targeted reductions in wait lists for specific short term services, including Speech/Language therapies, Recreational and Occupational Therapies. These services were targeted as they were time-limited interventions that would not create new pressures in 2011-12.

Ontario

System Measures	Baseline	MLPA Target	Current Performance	Quarterly Performance	Key Considerations
Percentage ALC Days	20.22 % (Q1, Q2, Q3 10/11)	14.80% (FY 11/12)	18.39%	 Data Source: CIHI-DAD	**Past (Q4 09/10-Q3 10/11):** • % ALC has not changed substantially in the last year, and varies only with discharge rates. **Current (Q4 FY2010):** • In Q4 10/11, there were a total of 1,451 Acute ALC discharges, an increase of 291 discharges from Q3. A higher number of discharged patients and a lower %ALC indicates that the discharged patients spent less time in the ALC designation. • For all acute ALC discharges in Q4 10/11, the number of days between ALC designation and discharge decreased to 48 days from 50 days in Q3 10/11, and the number of days between ALC designation and discharge to Long Term Care decreased from 260 days in Q3 to 97 days in Q4. **Future (Q1-Q2 11/12):** • Because %ALC is calculated only on discharge, it is not an indicator that helps HSP's and LHIN's plan for future interventions. Additionally, LHIN's have been informed that %ALC is not an indicator that will be available from the WTIS tool. Thus, monitoring this indicator will continue to be difficult and of limited value. We would recommend any of the following three indicators currently being tracked by hospitals and LHIN's as an alternative: ALC designation rate; volume of ALC patients on the wait list; ratio of ALC designation rate to discharge rate • As part of the Home First implementation across the LHIN, the Central East CCAC is monitoring both the overall ALC designation rate and the proportion of ALC patients designated within 2 days of admission at each hospital on a weekly basis. Additionally, HSAA's have been amended to require a decrease in the total volume of ALC-LTC designated patients over baseline. We have seen improvement in this measure at most sites throughout the LHIN, and anticipate improvement at LHO as a result of their improvement plan. To date, 5,249 patients have been discharged from hospital on CCAC and CSS enhanced services in support of Home First, and 648 remain on these enhanced services.
90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)	42.00 Days Q4 09/10 & Q1, Q2, Q3 10/11	39.90 Days (FY 11/12)	92.00 Days	 Data Source: Home Care Database (HCD), OACCAC, Health Data Branch SAS EG Server	**Past (Q4 09/10-Q3 10/11):** • Wait times are within the target but due to budget issues and CECCAC commitment to support Home First this indicator may increase as our community clients have to wait for services. While this indicator continues to be within the target we will continue to strive to continue to reduce wait times. However this indicator is primarily influenced by resources that are available. The wait times for services will remain artificially low until the CECCAC can service the clients. This is because the wait time is not counted until service is provided; therefore the wait time will always escalate when the service is initiated. **Current (Q4 10/11):** • CECCAC initiated Home First in 4 of our partner hospitals in this quarter. Included in the rollout was the initiation of Extended Hours Case Management at some of these hospitals. Therefore, assessment initiation is now completed by the Hospital Case Manager and not by our Community intake Team. All of these types of referrals have short wait times (ie. IV Therapy) for service and as a result, all of these assessments have been removed from our Community Intake. Consequently, there was a growth in our wait times for Community clients. • As well, in this quarter we received dedicated funds from the CELHIN to support taking high priority therapy clients and a number of ALC type clients(RAI aggregate score greater than 16) off the waitlist. Therefore the waiting days for these clients which are only accounted for when the service begins would have been added to the total waiting time when they were removed from the list which increased the total wait ime number to 92 days. . **Future (Q1-Q2 11/12):** • Wait time will decrease in Q2 but should settle at the target by Q3. The settling time is required as we complete the implementation of Home First across CELHIN geography and fully staff our Extended Hour team in all of the larger hospital sites. When this is completed there will be less hospital referrals processed through the Community Intake.. • The plan is to strive to reduce the wait time days back to the target of 39.90 . However, it is important to note that the target may need to be adjusted as the wait time will grow when only community referrals are processed through our Community Intake. These clients wait a significant time for service and only when they receive service will their long wait time be counted. These clients wait for service as a result of our budget shortfall where our waitlist guidelines directs Case Managers to waitlist all of ourl Personal Support clients(excluding Palliative Care clients) and many of the clients requiring professional services with high to low needs.

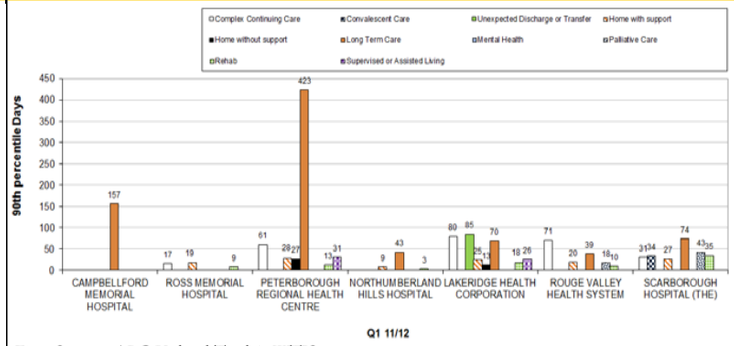
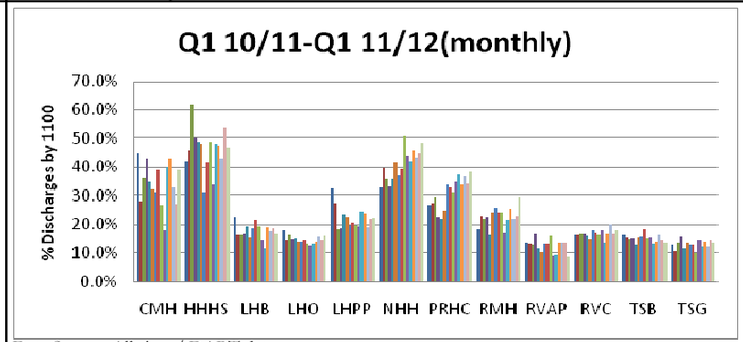
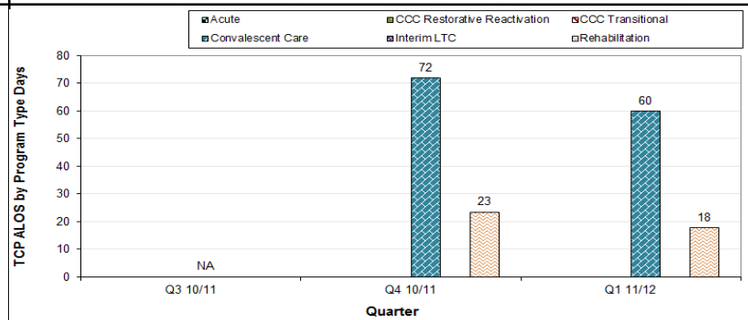
CENTRAL EAST LHIN

Goal: Improved Bed Utilization

Intervention: Aging at Home (AAH) and Urgent Priorities Fund (UPF)

AAH Year III
- Home First spread across CE LHIN
- GAIN (Geriatric Assessment Intervention Network) Clinics
- Transitional Care Beds

Ontario

System Measures	Baseline	Target	Current Performance	Quarterly Performance	Key Considerations
Number of days from ALC designation to discharge by discharge destination	TBD	TBD	41 Days	 Data Source: ALC Upload Tool & WTIS	**Past (Q4 10/11):** • For the 255 acute ALC discharges to LTC in Q4 10/11, the number of days between ALC designation and discharge decreased to 97 days from 260 days in Q3 10/11. **Current (Q1 11/12)**: • For the 198 acute ALC discharges to LTC in Q1 11/12, the number of days between ALC designation and discharge to Long Term Care decreased from 97 days in Q4 to 90 days in Q1. The total number of ALC discharges in Q1 was 1.080. • The unusually high number of days between ALC designation and discharge to LTC at PRHC represents success in transferring a long wait patient. The 90th percentile ALC days for all destinations at PRHC in Q1 was 64. **Future (Q4 10/11-Q1 11/12):** • CE CCAC implementation of Home First across the LHIN is expected to reduce the incidence of ALC designations, and particularly of ALC-LTC designations, and free up substantial bed capacity at all hospitals. However, because the number of days is calculated on discharge of ALC designated patients, a decrease in the total number of ALC patients will not have an impact on this measure.
Percentage of hospital inpatient discharges before 11:00 am	TBD	TBD	LHIN to complete	 Data Source: All sites / DART data	**Past (Q2-Q4 10/11):** • All CE LHIN hospitals participated in Wave 3 of ED-PIP, either fully or "light touch," and all have implemented DART **Current (Q1 10/11):** • Hospitals continue to work on improving discharge planning processes to maximize bed efficiency. **Future:** • LHB, LHO, LHPP, RVAP, and RVC are full participants in Wave 4 of ED-PIP. One target indicator for this program is an increase in discharges by 1100.
Transitional Care Program (TCP) Average Length of Stay (ALOS) by Program Type	NA	NA	48 Days	 Note: NA: Does not have any beds that meet the TCP Criteria Data Source: Transitional Care Program Reporting System (TCPRS)	**Past (Q3-Q4 10/11):** • The TCP program was implemented in the final stages of Q3 2010, with 15 CCC beds and 20 Rehab beds (RVAP). • For Q4, ALOS for all TCP beds fell well below the target maximums for the bed types. There were 12 CCC discharges and 39 Rehab discharges during this period, with only one discharge exceeding the 90-day limit for CCC. • The CCAC had great success at maintaining occupancy rates near 100% despite having to manage an outbreak. • In addition to the discharges shown in the graph, there were a total of 8 discharges from the 7 interim Long-Term Care beds at PRHC (near 100% occupancy) and the 8 CCC - Restorative Reactivation beds at NHH, with an ALOS of 17 days. • Of the 59 clients discharged from the four TCP sites, fewer than 2% had an unscheduled visit to the ED during their stay in Q4 2010-11. **Current (Q1 11/12):** • For Q4, ALOS for all TCP beds fell within the target maximums for the bed types. There were 16 CCC discharges and 39 Rehab discharges during this period, with 25% of the CCC clients exceeding the 90 day target LOS. **Future (Q2-Q3 11/12):** • Beds currently funded under the TCP are not being considered for closure. Interim long-term care beds at two hospitals are being reviewed with respect to their alignment with other in-hospital, post-acute services.

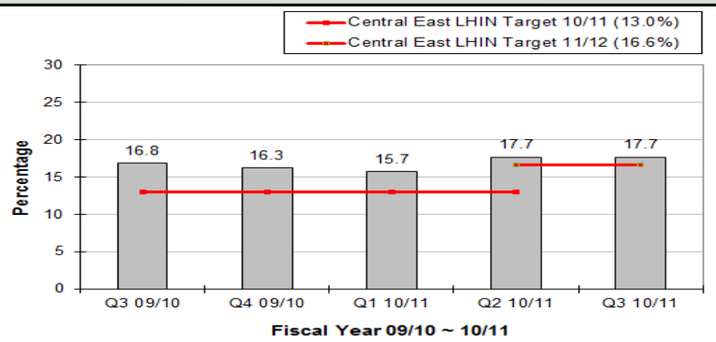
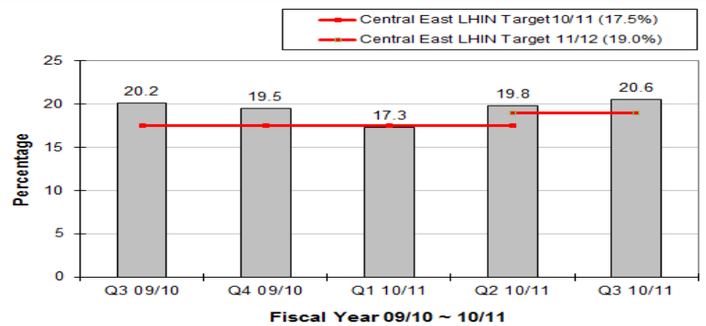
Mental Health & Addiction

CENTRAL EAST LHIN

Goal: Reduce number of repeat unplanned Emergency visits within 30 days for Mental Health and Substance Abuse

Intervention: Aging at Home (AAH) and Urgent Priorities Fund (UPF) -

No new interventions were introduced during this quarter. The work of the ED Avoidance Coalition continued where possible. These included the six Community Crisis Beds, co-loation of the Community Crisis Team at Rouge Valley Health System Emergency Department, and enhancements to the Mental Health Support Unit. CSI integration work was in the process of completion. During Q4 10/11, these services were more widely available throughout the Central East LHIN than they had been previously. The Central East LHIN staff maintained close contact with Health Service providers in order to monitor unscheduled return visits within thirty days for Mental Health.
The Central East LHIN has worked closely with CMHA Peterborough and CMHA Kawartha Lakes on integration of services. The Central East LHIN has worked with several iterations of a regional Mental Health and Addictions Network since 2006. For several reasons (cultural, capacity, resources), the Network has been an iterative process. Most recently a broad-based provider-driven Network has been formed, although now it needs further refinement to better align with LHIN/MOH objectives as identified in the LHINc Mental Health and Addictions report. That work is underway.

System Measure	Baseline	MLPA Target	Current Performance	Quarterly Performance	Key Considerations
Repeat unplanned emergency visits within 30 days for mental health conditions	17.5% Q3, Q4 09/10 & Q1, Q2 10/11	16.6% (FY 11/12)	17.7%	 Data Source: CIHI NACRS	**Past (Q3 09/10-Q2 10/11):** ▪ Initiatives have performed as expected. This is attributable to the increased integration of the System and the improved working relationships amongst Health Service Providers that have been created as a result of Integration Activities. **Current (Q3 10/11):** • CSI Integration will make Peer Support more accssible throughout the Central East LHIN area, particularly in the Durham and Northeast Clusters. Integration planning activities continued with Health Service Providers. • The Central East performance rate is about average in terms of the return rate. In considering the GTA as a unit, Central East has a much lower return rate than Toronto Central, and is approximately 2 points lower than Central, which has a similar urban/rural mix. **Future (Q4 10/11-Q1 11/11):** • Community Crisis beds are used to prevent In-Patient admissions where appropraite. They also ensure that clients are engaged with community providers who can intervene earlier, thus preventing the client's presentation at the local emergency department. Increased access to Community/Peer/CSI supports provides for improved client supports in the community, thus preventing ED use. Increased resources to the MHSU will provide for increased response time and additional follow up services, thus preventing ED use.
Repeat unplanned emergency visits within 30 days for substance abuse conditions	19.6% Q3, Q4 09/10 & Q1, Q2 10/11	19.0% (FY 11/12)	20.6%	 Data Source: CIHI NACRS	**Past (Q3 09/10-Q2 10/11):** ▪ Initiatives have performed as expected. Substance Abuse Resources are limited in the Central East LHIN and Health Service Providers are performing to capacity. ▪ The Central East LHIN has conducted an Addictions Environmental Scan that highlighted system access gaps and that the system is currently at maximal capacity. **Current (Q3 10/11):** • In considering the GTA as a whole, the Central East LHIN has the lowest unscheduled return visit rate in the GTA. The Central East return rate was 2.2 pts below that of the Central LHIN. • The Substance Abuse Health Service Provider system is extremely well integrated both on a LHIN and on a Provincial level. **Future (Q4 10/11-Q1 11/11):** • The implementation of the new additions to Supportive Housing beds in all three quarters of the LHIN is anticipated to have an impact on the rate of unscheduled return visits for substance abuse within the Central East LHIN. Currently, there are sixteen beds each for the Scarborough and Durham Clusters, and 8 for the Northeast Cluster. A process to more effectively integrate the Addictions Health Service Providers in the Central East LHIN was begun during this period, and is still .

Excellent Care for All

CENTRAL EAST LHIN

Goal: Reduce Avoidable Hospital Readmission

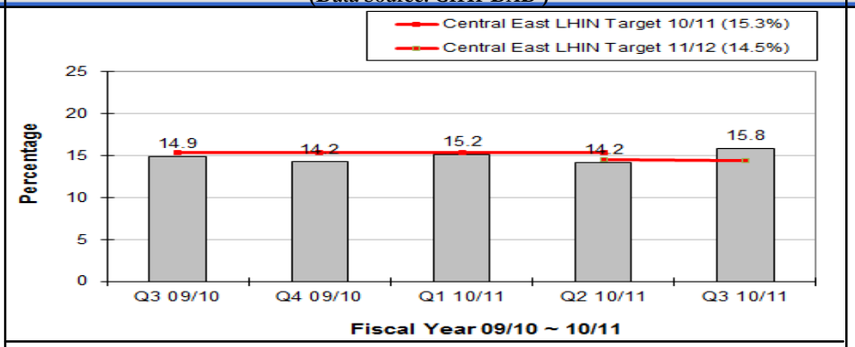
Intervention:

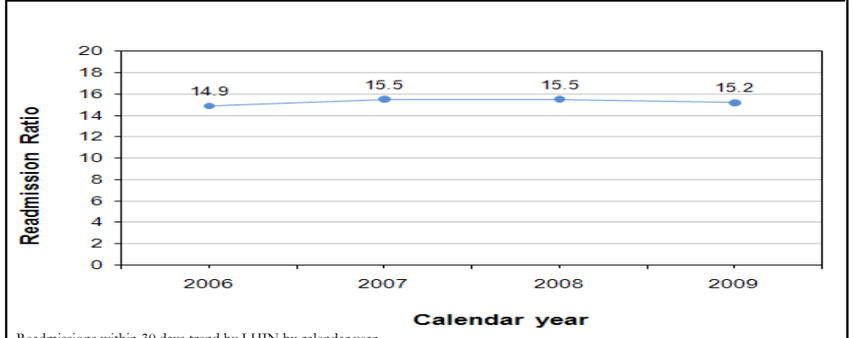
Primary Prevention
- Comprehensive Vascular Disease Prevention and Management Initiative (CVDPMI)
- Chronic Kidney Disease Prevention and Management - Promising Practices and Practicioners Field Guide
- Self Management for Consumers/Caregivers and Self Management support to enable clinicians
- Unattached Patient Assessment and Triage (UPA) - uptake of promising practices by primary care
- Metabolic Syndrome Clinics for people with mental health and addictions needs
- Hospital and Community/Primary Care Smoking Cessation initiative

Acute Care
- Primary PCI and Code STEMI protocol
- Information management system standardizations within renal programs
- Emergency Stroke Care
- Vascular Surgery integration of programs in Scarborough/ West Durham and Northeast/East Durham service clusters

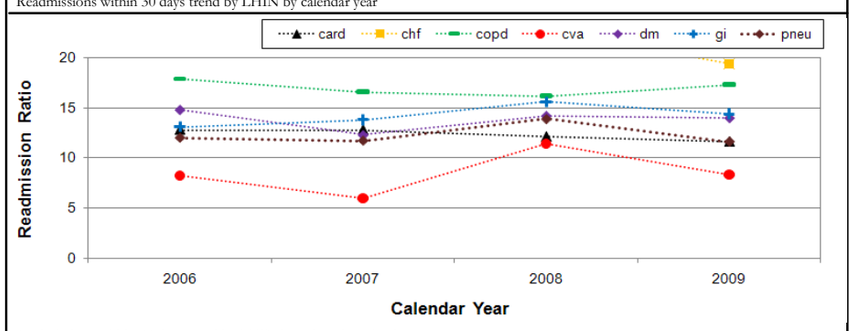
Secondary Prevention of Disease and Adverse Events
- Coordinated intake and triage of diabetics in Scarborough service cluster
- Expansion of Diabetes Service teams
- Primary care CMEs related to vascular, kidney and diabetes management
- Vascular disease management protocols resulting from CVDPMI project
- Comprehensive Geriatric Assessment (GAIN clinics)
- Cardiopulmonary Rehabilitiation System for CE LHIN – Integration of programs in Durham/Scarborough
- Home Dialysis program expansion;
- Vascular Access for dialysis patients
- Kidney transplant preparation and follow-up clinics

Ontario

System Measures	Baseline	MLPA Target	Current Performance	Quarterly Performance (Data Source: CIHI-DAD)	Key Considerations
30 day readmission rates for selected CMGs (Case Mix Groups)	14.8 % Q1, Q2 10/11	14.5 % (FY 11/12)	15.8%		**Past (Q3 09/10-Q2 10/11):** ▪ CE LHIN Readmission Rate performance improved throughout 2009-10 in Q2 10-11 seeing the lowest rate achieved to date (14.2%). ▪ For the past three years, the CE LHIN has dedicated significant energy to chronic disease primary and secondary prevention and management. These efforts have engaged providers in the implementation of initiatives designed to prevent ED visits, admissions, re-admissions and shorten length of stay. CE LHIN has set a Strategic Aim to reduce the impact of Vascular Disease by 10%. ▪ In 2009 – Northumberland Hills Hospital's overall 30 Day Readmission rate was 11.9% which was well below their anticipated evidence based readmission rate of 14.3%. Northumberland is one of two sites within the LHIN who have achieved 0% Alternate Level of Care days. Rouge Valley Health System also performed better than anticipated at 13% - this centre has an active Cardiovascular Rehabilitation program which supports clients post cardiac event. ▪ Through VP/Chief Nursing Officer group across the CE LHIN hospitals identified next steps for advancing performance improvement initiatives in their selected areas of focus (Congestive Heart Failure, COPD, Diabetes and Pneumonia). ▪ As a condition of 2011-12 HSAAs hospitals were asked to select two CMGs, from within the seven included within the provincial indicator and develop Quality Improvement CMG Plans to achieve a minimum 10% improvement. **Current (Q3 10/11):** • An increase in Q3 10-11 has occurred - this increase is beyond that experienced previously between quarters. Q3 represents the beginning of the annual system surge (Oct-March). Given that CHF and COPD/Bronchitis/Asthma, Pneumonia are significant drivers in our LHIN and influenced by seasonal challenges (i.e. air quality, flu, temperature variations) - an increase during Q3 could be anticipated. Slight increases in Q3 and Q4 have been experienced in past. • Despite experiencing an increase during Q3 2010-11 our performance is still below provincial performance. The CE LHIN has consistently been one of the top three performing LHINs with respect to this indicator In the most recent Stocktake (May 2011) – CE LHIN demonstrated the largest overall improvement of all LHINs at 1.37% • The LHIN review of hospital submissions identified that their activities will focus on implementing best practice care and strengthening partnerships across the continuum of care within the hospital and community to address one or more of the following key components of care: a) Admission Assessment b) Standard Order Sets c) Care Paths d) Patient Disease Education and Literature e) Medication Reconciliation /Counseling f) Written Discharge Instructions g) Follow up appointment with Primary Care • Active QIP processes are in place for CHF and COPD. **Future (Q4 10/11-Q1 11/11):** • If every hospital meets their 10% improvement target – overall LHIN rate would be 14.7%. 2010-11 is the initial year for CMG improvement plans, thus progress will be made in the assessment and review of each CMG with improvements by year end. Every hospital in the LHIN has patient / client / caregiver and employee satisfaction surveys, patients relations processes, critical incident reporting, quality improvement plans, patient declarations of values in place.



Readmissions within 30 days trend by LHIN by calendar year



Readmissions within 30 days trend by LHIN by cohort by calendar year

CENTRAL EAST LHIN

Goal: Reduce Avoidable Hospital Readmission

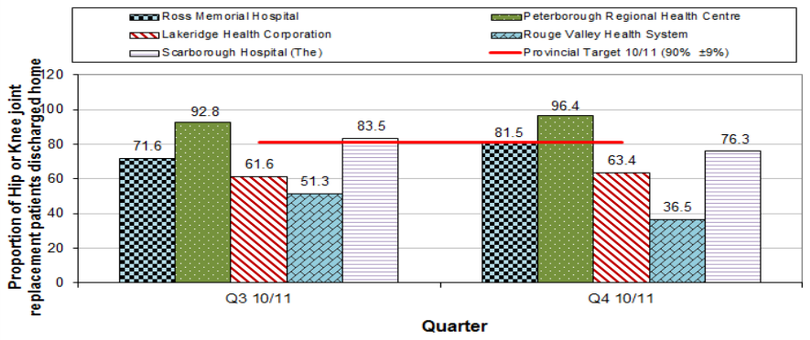
Intervention:

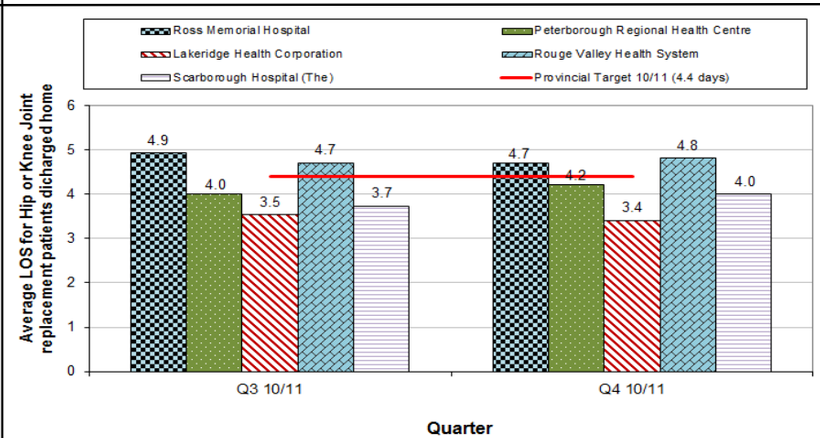
With engaging the support of the Orthopaedic Expert Panel, CE LHIN initiated meetings with three hospitals to understand/identify the hospitals' challenges and issues related to the key performance indicators listed in the Orthopaedic Quality Scorecard, and explore strategies and work plans to improve the hospitals' performance.

Next steps include expanding the discussion to the August Wait Times Strategy Working Group meeting to talk to all Central East LHIN hospitals on this topic, as well as seeking related process standardization and improvement.

Ontario

System Measures	Baseline	Target	Current Performance	Quarterly Performance (Data Source: DAD)	Key Considerations

Proportion of primary unilateral Hip or Knee Joint Replacement patients discharged home	TBD	90% ± 9%	71.8%		**Performance**:
					• Proportion of Patients Discharged Home: In Q4 2010/11, CE LHIN is below the provincial target at 90% ± 9%. 3 out of 5 listed hospitals are below the 80% lower corridor, including LHC, RVHS and TSH. Both of RMH and PRHC improved during Q4 and met the provincial target.
					• Average Length of Stay: In Q4 2010/11, CE LHIN met the provincial target at 4.4 days. 3 hospitals have lower Average Length of Stay, including PRHC, LHC and TSH, comparing to the provincial target. RMH and RVHS experienced higher Average Length of Stay instead in the range of 4.7-4.9 days in both of Q3 and Q4.
					
					Main factors:
					Lower Proportion of Patients Discharged Home is a result of high utilization of rehab beds, inconsistent education materials, aging population and limited capacity of CCAC.
					
					Initiatives:
					• Three meetings were initiated with 3 CE LHIN hospitals including RMH, LHC and RVHS, for following purposes, with the support of the Orthopaedic Expert Panel.
					  • To understand their issues/challenges related to the key performance indicators in the areas of efficiency, effectiveness / safety and accessibility.
					  • To explore possible remedy strategies and work plans.
					• Hospitals will be invited to discuss above issues with the representative of the Orthopaedic Expert Panel in the upcoming August CE LHIN Wait Times Strategy Working Group.
					
					Forecast:
					CE LHIN will continue to monitor hospitals performance on related indicators and work with hospitals throughout 2011/12 towards achieving the provincial targets. We expect to see improvements starting from Q3 2011/12.

Average length of Stay of primary unilateral Hip or Knee Joint Replacement patients discharged home	TBD	4.4 Days	4.1 Days		

Surgical and Diagnostic Imaging Wait Times

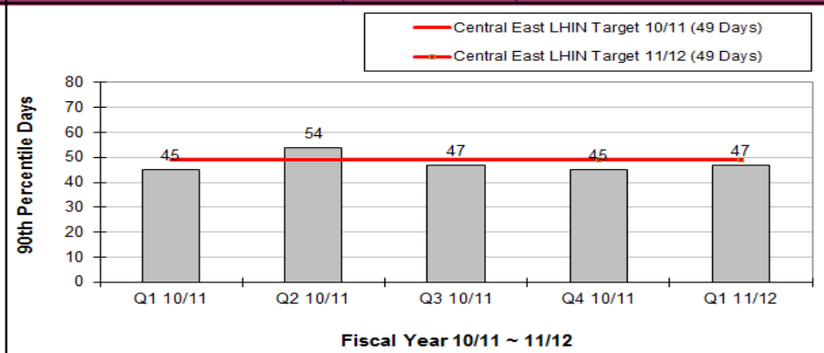
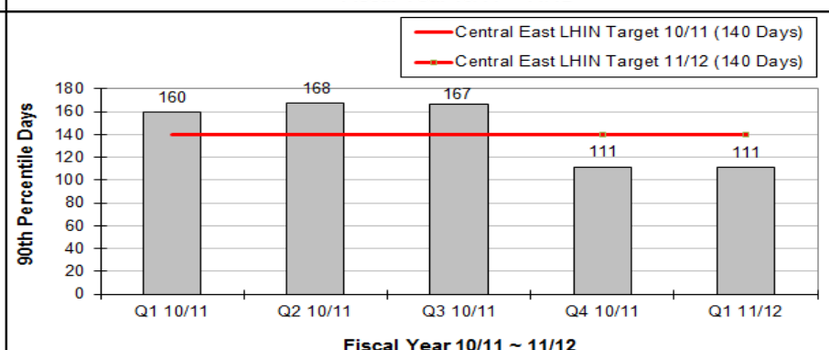
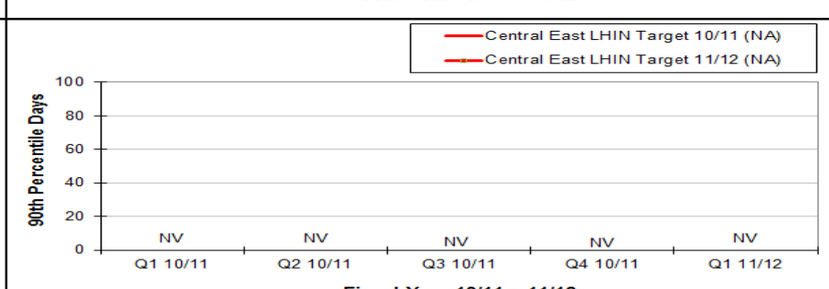
CENTRAL EAST LHIN

Goal: Reduce Surgical and Diagnostic Imaging Wait Times

Intervention:

CE LHIN implemented a Wait Times Strategy Working Group in the beginning of 2009/10 with participation from all hospitals delivering wait time services. Monthly meetings are held to discuss, identify and resolve pressures/ risks as well as to share best practices, using detailed real time information. If hospitals are unable to complete funded volumes, in-year savings will be re-allocated to hospitals that have capacity to perform additional volumes. Re-allocation of funded volumes is an ongoing process (not limited to just Q2/Q3). Other working groups are also in place and/or in the planning phase (Diagnostic Imaging Working Group; Decision Support Working Group; Physician Engagement Sub-Working Group). Wait Time Performance Indicators are incorporated into the 2011/12 Hospital Service Accountability Agreement with Hospital-specific Negotiated Targets to ensure achievement of the CE LHIN targets, in accordance with 2010/11 MLPA. All CE LHIN approved Data Quality and Wait Time Improvement initiatives have been implemented and are on-going.

Ontario

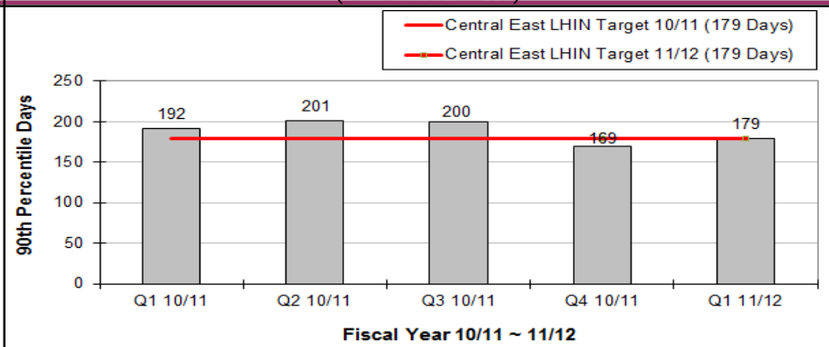
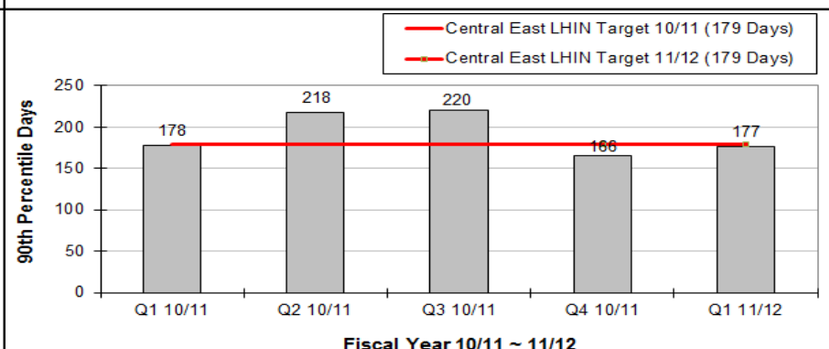
System Measures	Baseline FY 10/11	MLPA Target	Current Performance	Quarterly Performance (Data Source: WTIS)	Key Considerations
90th Percentile Wait Times for Cancer Surgery	48 Days	49 Days (FY 11/12)	47 Days		CE LHIN met the performance target in Q1 2011.
90th Percentile Wait Times for Cataract Surgery	153 Days	140 Days (FY 11/12)	111 Days		CE LHIN met the performance target in Q1 2011.
90th Percentile Wait Times for Cardiac By-Pass Procedures	NA	NA (FY 11/12)	NV	 (Data Source: Cardiac Care Network) **Note:** No, or low volume (NV) - A hospital that is required to report, either reported that they did not perform this service during the reporting period, or the reported number of cases did not meet the indicator threshold (the number of reported cases was less than 10 for quarterly data and less than 6 for monthly data).	N/A

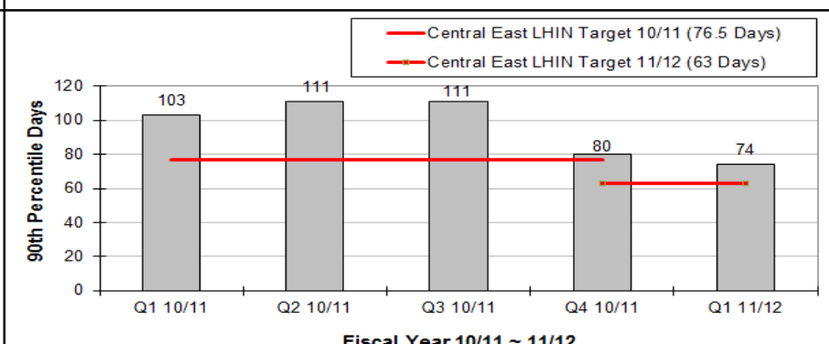
CENTRAL EAST LHIN

Goal: Reduce Surgical and Diagnostic Imaging Wait Times

Intervention:

CE LHIN implemented a Wait Times Strategy Working Group in the beginning of 2009/10 with participation from all hospitals delivering wait time services. Monthly meetings are held to discuss, identify and resolve pressures/ risks as well as to share best practices, using detailed real time information. If hospitals are unable to complete funded volumes, in-year savings will be re-allocated to hospitals that have capacity to perform additional volumes. Re-allocation of funded volumes is an ongoing process (not limited to just Q2/Q3). Other working groups are also in place and/or in the planning phase (Diagnostic Imaging Working Group; Decision Support Working Group; Physician Engagement Sub-Working Group). Wait Time Performance Indicators are incorporated into the 2011/12 Hospital Service Accountability Agreement with Hospital-specific Negotiated Targets to ensure achievement of the CE LHIN targets, in accordance with 2010/11 MLPA. All CE LHIN approved Data Quality and Wait Time Improvement initiatives have been implemented and are on-going.

System Measures	Baseline FY 10/11	MLPA Target	Current Performance	Quarterly Performance (Data Source: WTIS)	Key Considerations
90th Percentile Wait Time for Hip Replacement	190 Days	179 Days (FY 11/12)	179 Days		CE LHIN met the performance target in Q1 2011.
90th Percentile wait Times for Knee Replacement	187 Days	179 Days (FY 11/12)	177 Days		CE LHIN met the performance target in Q1 2011.

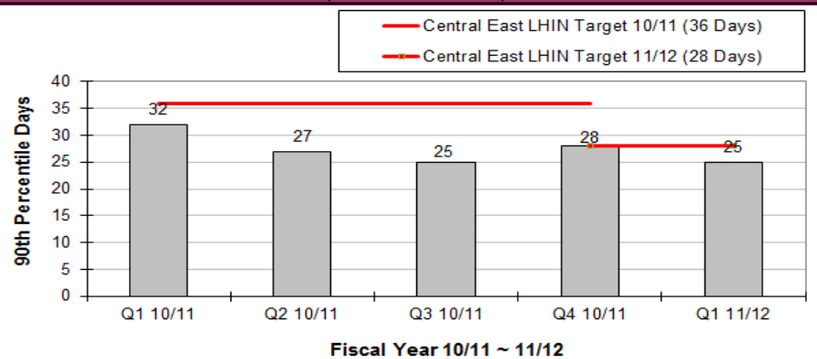
90th Percentile Wait Time for Diagnostic MRI Scan	102 Days	63 Days (FY 11/12)	74 Days		• In Q1 2011/12, the MRI wait time was above the CE LHIN target by 11 days. The MLPA target of 63 days is not attainable in 2011-12 because the LHIN is facing increasingly high demand due mainly to repatriation.
					• Q1 results continued the success of 2010/11 Q4 due to on-going wait time improvement initiatives regarding data quality and in-house education at all hospitals, as well as the following:
					  • RMH's new MRI machine became operational in January 2011;
					  • MRI PIP completed at TSH & RVHS to assist in the reduction of MRI wait times & managing wait lists in 2010/11.
					• Modest improvements to the current performance of 74 days are possible as a result of the following:
					  • The LHC MRI machine will be replaced in Sept 2011;
					  • Two new MRI machines (TSH and RVHS) are expected to become operational in the summer of 2011. Because of the late start date of TSH & RVHS, any unspent annualized base funded volume will be allocated to other hospitals, as proposed to the Wait Times Strategy;
					  • Continued improvement measures regarding data quality and in-house education as noted above;
					  • Engagement sessions with Hospital Physicians/Surgeons are in development (e.g. Medical Advisory Councils, Chief of Staff/Surgery);
					  • Wait Time Performance Indicators have been incorporated into Hospital Service Accountability Agreements with Hospital-specific negotiated targets.
					  • Note that these improvements are likely to be offset by additional volumes related to implementation of the OBSP program and repatriation challenges.

CENTRAL EAST LHIN

Goal: Reduce Surgical and Diagnostic Imaging Wait Times

Intervention:

CE LHIN implemented a Wait Times Strategy Working Group in the beginning of 2009/10 with participation from all hospitals delivering wait time services. Monthly meetings are held to discuss, identify and resolve pressures/ risks as well as to share best practices, using detailed real time information. If hospitals are unable to complete funded volumes, in-year savings will be re-allocated to hospitals that have capacity to perform additional volumes. Re-allocation of funded volumes is an ongoing process (not limited to just Q2/Q3). Other working groups are also in place and/or in the planning phase (Diagnostic Imaging Working Group; Decision Support Working Group; Physician Engagement Sub-Working Group). Wait Time Performance Indicators are incorporated into the 2011/12 Hospital Service Accountability Agreement with Hospital-specific Negotiated Targets to ensure achievement of the CE LHIN targets, in accordance with 2010/11 MLPA. All CE LHIN approved Data Quality and Wait Time Improvement initiatives have been implemented and are on-going.

System Measures	Baseline FY 10/11	MLPA Target	Current Performance	Quarterly Performance (Data Source: WTIS)	Key Considerations
90th Percentile wait Times for Diagnostic CT Scan	28 Days	28 Days (FY 11/12)	25 Days		CE LHIN met the performance target in Q1 2011.