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Central East Local Health Integration Network
CEO Report to the Board
February 16th, 2010

The following is a compilation of some of the major activities/events undertaken during the month of January in support of the Central East LHIN's Strategic Directions; a) Transformational Leadership, b) Quality and Safety, c) Service and System Integration, and d) Fiscal Responsibility. Although maintaining the focus of the current 2009/10 Integrated Health Service Plan (IHSP), the Central East LHIN is beginning to work towards the Strategic Aims of the 2010-2013 IHSP; 1. Save a Million Hours of time patients Spend in the Emergency Departments by 2013 and, 2. Reduce the Impact of Vascular Disease by10% by 2013 (2010-2013 IHSP).

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

Mental Health and Addictions Strategy Consumer Partnerships Theme Group: The Consumer Partnerships Theme Group met for the final time on January 20th and finalized the Consumer Partnerships Paper for submission to the Minister's Advisory Group. The CE LHIN Mental Health and Addictions (MHA) Lead was invited to take part in the "MHA System Key Levers for System Change" workshop at the University of Toronto. This is a cross-sectoral group that is working on a mapping process that will document system levers for change as they relate to the new Mental Health and Addictions Strategy. There is one more meeting of this group planned prior to the work going forward to the Minister's Advisory Group. The Central East LHIN is the only LHIN member, amongst representatives from Academics, Education, the Ministry of Community and Social Services, and other MOHLTC sections.

Central LHIN Framework for Community Engagement: Two teams, the Collaborative Transition Team and the Coalition Creation Team, will be established and a meeting held on Friday, February 19th at Ontario Shores Centre for Mental Health Sciences in Whitby followed by a half day webinar/teleconference on the afternoon of Thursday March 4th to complete the necessary work that will allow us to begin the transition to the new Collaboratives model and the Strategic Aims Coalition. The Collaborative Transition Team, for the sessions on the 19th and 4th, will ideally be comprised of representatives from each of the nine existing geographic collaboratives (especially consumer/caregiver representatives), health service providers and the CE LHIN organization.

Key tasks for the Collaborative Transition Team include reviewing and revising the current Collaborative Terms of Reference to reflect the three cluster model (Scarborough, Durham and the North East), maintaining a focus on identifying integration opportunities, responding/facilitating local stakeholder response to funding/integration opportunities and aligning to the CE LHIN Board to Board engagement process, the Triple Aim and the Integrated Health Service Plan. The Transition Team will also focus on recommending the transition process to the new model with a goal of maintaining existing support and a membership renewal process.

The Coalition Creation Team, for the sessions on the 19th and the 4th, will ideally be comprised of representatives from the existing Network Steering Committees and Task Groups, Physician and Nursing

leadership, health service providers and the CE LHIN organization. The key tasks for the Coalition Creation Team include developing new Terms for Reference for the "CE LHIN Emergency Department AIM Coalition" and the "CE LHIN Vascular Disease AIM Coalition" which will reflect new models for clinical leadership and selection, equitable distribution of membership from across the LHIN, Triple Aim and Quality Improvement and integration opportunities. This Team will also focus on recommending the transition process to the new model with a goal of maintaining existing support and recommending a membership renewal process.

The following timeline has been proposed for the Framework for Community Engagement Process.

- March 16, 2010 – CE LHIN Board endorsement of "CE LHIN Framework for Community Engagement"
- Mid March/early April – Call for Expression of Interests (EOI)
- end of April 2010 – confirmation of membership for Collaboratives (3) and Strategic Aim Coalitions (2)
- May 5, 2010 – CE LHIN Symposium – Introduction of CE LHIN engagement structures

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

ED Avoidance Coalition: A final report of the ED Avoidance Coalition IHI Prototyping Project is in progress, following the final IHI teleconference on January 28th. There is a great deal of external interest in this project, particularly from the MOHLTC. Staff are currently working on a Systems Map of the project to be submitted to the MOHLTC.

Lakeridge Health Corporation Emergency Department Safety Project: The Ministry of Health and Long-Term Care has selected The Central East LHIN Hospital Emergency Department Safety project for funding under the Healthy Work Environments Innovation Fund Grant Program and will provide Central East LHIN hospitals with a total of $224,916 in one-time funding in 2009/10 to support this project. The project will promote healthy and safe work environments for Ontario's health care workers and help the Ministry meet the goal of its health human resources strategy – Health Force Ontario - to make Ontario the 'employer of choice' for health care.

Fetal Fibronectin Testing: The Ministry of Health and Long-Term Care is providing the Central East LHIN with $72,500 in base funding in 2009/10 for the implementation and continued provision of fetal fibronectin (FFN) testing in hospitals that provide obstetrical services. Providing safe, high quality care, closer to home for Ontario's mothers and their babies is a key commitment for the Ministry of Health and Long-Term Care. The Fetal Fibronectin test for evaluation of women suspected of preterm labour is a reliable predictor of preterm birth. Use of the test results in a reduction in preterm labour admissions, maternal transfer rates, maternal length of stay, and reproductive health care utilization without compromising neonatal outcome.

H1N1 Update: The MOHLTC's Emergency Management Branch initiated a process Dec 21, 2009 to compile a comprehensive "lessons learned" process for early in the New Year (throughout January and early February). The intent is to obtain stakeholder feedback for the improvement of the ministry's plans and procedures for responding to all emergencies, including a potential H1N1 Wave 3. They will hold a series of facilitated discussions with associations and unions, focus groups with front line health workers and distribute short surveys. LHINs have been requested to begin to collect our organization's thoughts and

engage people to reflect on the last several months in order to contribute effectively to the process ahead. The Primary Care Working Group and the Surge System Management Committee are best positioned to respond to this request for input. They will be asked to provide feedback on the areas identified below at their upcoming meetings in February.

Potential areas to consider, where applicable to our organization, include:

- Important Health Notices (IHNs) and guidance documents
- Communications: H1N1 website, media briefings, stakeholder teleconferences
- Use of the Health Provider's Hotline
- Coordination of response: within the ministry, between ministries, between levels of government, between the ministry and the health sector, between health sector organizations
- Response measures, such as:
  - Antiviral stockpile deployment
  - Access to provincial stockpile of supplies and equipment
  - Alternate influenza assessment, treatment and referral strategies
  - Critical care surge capacity and access to ventilators
- H1N1 immunization program
- Use of the Ontario Health Plan for an Influenza Pandemic (OHPIP) as well as our organization/sector's plans and our ability to mount an effective response
- Opportunities for our organization and priorities for overall improvement of organization/sector and provincial plans

Aging at Home Strategy

Year 1 Investments: Efforts continue in understanding how Year 1 projects/services are making an impact on the system. While some of the funding addressed enhanced capacity (e.g. supportive housing) other services were introduced for the first time in some geographic areas (e.g. enhanced caregiver supports). In addition, while some funding was added to an agency's base funding; other funding was one-time reoccurring in nature, until the merits were determined. We are reviewing the one time allocations and, in discussion with the providers/partners, working to make necessary changes in order to assist in achieving quality outcomes.

Year 2 Investments: Most Year 2 funding allocations made it into the service system by fall 2009, with the exception of the $2.4M for the comprehensive geriatric assessment proposal (Scarborough/West Durham) which received approval late 2009. Extensive discussions have taken place with the sponsor agency of the latter program to detail implementation plans. Based on the work of the group developing a geriatric assessment service for the rest of the LHIN, to be submitted under Year 3 Aging at Home, further discussions have been had regarding overall governance of this soon to be $5.4M LHN-wide program. It is important to note the successful relationships that are being built and innovative services that are being proposed to improve the timely identification, assessment, intervention and follow up for the frail elderly in the Central East LHIN.

Year 3 Process: To date, the proposal for geriatric assessment for the rest of Durham and the Northeast cluster has been received by the LHIN. A large community meeting was held prior to submission of this

proposal to elicit feedback on the proposed model. A proposal is also being developed by the CE CCAC pertaining to services that will enable individuals in hospital to return home in a timely fashion post-acute care stay. Finally, a call for interest in restorative care beds is being prepared. That said, work has been undertaken on the restorative care unit at the Village of Taunton Mills in Whitby to bring it into compliance with the legislation. Late 2009 the MOHLTC released a "Transitional Program Framework, November 2009", that outlined what types of services could be provided within what type of bed (e.g. interim long term care beds, convalescent care beds, etc.) Each of the projects across the province that introduced new capacity in "bed" form are being reviewed by the Compliance Branch of the MOHLTC to ensure adherence to appropriate legislation/regulations. CE LHIN staff and local providers are being challenged to meet these new compliance standards that are more reflective of longer-stay convalescent programs than the short-term restorative function these beds are designed for. The new standards will also increase the daily per diem currently being paid to the Village of Taunton Mills. The CE LHIN, MOHLTC and the Village of Taunton Mills have until February 15th to determine the sustainability of this successful program under the new framework.

Year End Reallocations: Extensive efforts undertaken as staff work with agencies to understand their projected year end status and how best to utilize, on a one time basis, any expected surplus.

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

Pay-for Results: The fifth monthly performance report has been received from Year 2 Pay-for-Results designated Hospitals. The year to date savings as of December is 1,664 ED visits, 85,810 ED hours, and 6,341 inpatient days across all Pay-for Results initiatives (exclusive).

Nurse Practitioner (NP) Outreach Teams: Nurse Practitioners (NPs) in the Central East region are welcoming the news that Linda Dacres has accepted the position of CE LHIN Nurse Practitioner Clinical Director. Based out of the Port Hope branch of the Central East Community Care Access Centre (CCAC), Linda will work with NPs from across the region to lead current Central East LHIN NP initiatives and establish a CE LHIN-wide Nurse Practitioner Community of Practice. As Clinical Director, reporting to the CCAC, Linda will provide clinical leadership, strategic visioning and promote consistency of Nurse Practitioner (NP) practices with an initial focus on the Long-Term Care Homes (LTCH), NP Outreach teams and the Geriatric Emergency Management (GEM) Nurses. In addition to providing leadership and creating learning opportunities for NPs, Linda will also deliver clinical care to the Long Term Care Homes in the Port Hope and Cobourg areas.

Reducing the Impact of Vascular Disease by 10% (2010-2013 IHSP):
Focus on Population Health…

CE LHIN Self Management Initiative: On Dec 22nd, the CE LHIN Self Management Project Leadership team submitted a Business Case to transition the Self Management Training for Consumers and Caregivers priority project to an on-going Self Management program within the CE LHIN. The Business Case was reviewed by staff. Based on this review, it was recommended that Option #1 as proposed, be pursued. This Option would see a single organization with accountability for the Central East Self Management Program. On January 21, 2010 a request was made to the Central East Community Care Access Centre (CECCAC) to be the lead agency. This reflects a continuation and success to date of the role of the CE CCAC as

health service provider sponsor for the three year project. On January 29th the Central East CCAC accepted our request.

The Self Management Project Leadership Team, CE LHIN staff and the CE CCAC Senior Management recognize that the single agency accountability model has both strengths and weaknesses and inherent risks which must be considered in the implementation of this program. Those identified during the development and review of the Business Case were shared with the CE CCAC. Recruitment of the staff as outlined commenced on February 1, 2010 to allow for a smooth transition on April 1, 2010. The Self Management Program will effectively be a standalone program (single cost centre) within the Performance, Accountability and Strategic Planning portfolio of the CE CCAC. Base funding provided for this program will be dedicated to the program and will increase proportionately at the same rate as any overall CECCAC base funding increases that may be approved by the CE LHIN, or if specific additional funding is provided.

The current project team has done an excellent job in addressing the issues of community and volunteer partnerships and there are great practices embedded in the current design of the project which will be carried over into the on-going CCAC program. A CE LHIN Self Management Advisory Council, reporting to the CECCAC, will be formed and will create a formal structure and foundation to further address the critical element of community partnerships. An Advisory Council will put in place a structure which will engender shared leadership and support continuous improvement of the program elements.

On February 18th a joint meeting between LHIN and CCAC will take place to receive an update on the status, review and further strategize on the development of a clear plan to guide the transition from priority project to CECCAC-led program. Central to this discussion will be identification of ways the LHIN will be able to support the vision of a single, consistent and coordinated CE LHIN Self Management program and support the transition of organizations currently delivering programs and initiating Stanford-related programming outside of a LHIN-wide program. Outcomes of this process and endorsement of the final agreement will be brought forward to the CECCAC and CE LHIN Boards accordingly.

Ontario Diabetes Strategy: Building on the November 2009 provincial announcements, the province is proceeding with implementation of the Phase 1 Diabetes Education Teams. Details about the Phase 2 diabetes team (service expansion) are expected from MOHLTC shortly. Provincially, the MOHLTC has initiated a targeted application/engagement process to discuss the development of regional/LHIN-based diabetes coordination centres. Updates will be provided as they become available.

Chronic Kidney Disease: Representatives of the CE Renal Network met with Dr. Judith Miller, Medical Director, Ontario Renal Network. Discussion focused on the achievements to date within CE LHIN related to Renal Chronic Disease Prevention and Management and the expectations during the development of the Ontario Renal Network. The process to hire fourteen Administrative Leads across the province is underway, with the LHIN staff being involved in the local interview process.

The three Renal Programs have received detailed Service Agreements from the Ontario Renal Network. These Agreements outline expectations for service planning, delivery and reporting. In future, the LHIN will receive volume and funding information and advice from the ORN directly, this is a new and evolving role/relationship.

The Scarborough Kidney Care Initiative (CE LHIN Priority Project) was selected to be show-cased at the upcoming provincial MOHLTC, LHIN and HSP Integration Consensus Conference taking place on February 11th in Toronto. James Meloche and project leadership were one of four projects invited to develop a video showcasing the strategies used to advance effective integration across various healthcare sectors.

Focus on Accessible Health Care…

Aboriginal Strategy/French Language Services: The Greater Toronto Area Aboriginal Strategy Leads Teleconference was held on January 25, 2010 to plan a Community Engagement event targeting Urban Aboriginal Peoples in March 2010. Meetings of both the Aboriginal Health Circle and the Planning Group are planned for February.

Aboriginal Health Transition Fund (AHTF): The Ministry of Health and Long Term Care announced that an amended Contribution Agreement was recently signed between Health Canada and the Ontario Ministry of Health and Long-Term Care to extend the Aboriginal Health Transition Fund (AHTF) Adaptation Plan for an additional year, until March 31, 2011. Ontario has also received an additional $497,925 to support the wrap up of current project activities, knowledge translation activities and evaluation. The additional funding is not intended to support new activities or projects. Eleven of Ontario's AHTF projects submitted requests for additional funding in 2010-11 last September. If LHINs need to carry-over funds to be used by September 30th, 2010, the Ministry is advising LHINs to complete a detailed revised workplan and budget.

Provincial Lead Aboriginal Planning: In 2008, the Hamilton Niagara Haldimand Brant LHIN was provided $7,500 per year to support the cross-LHIN Aboriginal community engagement coordination role until such time as it wishes to hand over its responsibilities in this regard to another LHIN. With the new fiscal year, the CEO HNHB LHIN is willing to advise the ministry to reallocate the money to the Toronto Central LHIN where Vanessa Ambtman has been providing this leadership recently and is willing to continue.

Unattached Patients Initiative (UPA): The Peterborough and expanded Scarborough sites are in operation. An increase in referrals has been generated through direct mail-out to individuals who are on the Health Care Connects waiting list. Dialogue with the MOHLTC on the success of the project and the ability to sustain the project beyond May 2010 are underway.

Enablers

HIS Consolidation Standards Project: The eHealth team is finalizing a process that will sustain and maintain standards that were developed for Phase I MEDITECH modules. The Information Management/Information Technology (IM/IT) Advisory Committee approved the process with a couple of minor changes. After the changes are made, the revised process will be re-submitted to the IM/IT Advisory Committee and the Health Information System (HIS) Advisory Group.

To support the Ontario Shores MEDITECH 6.0 implementation, a formal process was put in place to deal with Standards issues and discrepancies. The Integration Committee (made up of representatives from all hospitals or proxy) will resolve matters as they arise or convene the appropriate Standards Committee to assist with making the required Standards decisions. Although the Phase II HIS Consolidation Standards project is on hold, the IT/IM Committee decided to keep the Sandbox active. The Sandbox, which was built

to provide an environment in which to review and validate Standards, has an assigned administrator from each hospital.

LHIN-Wide Credentialing: The Medical Leadership Group (MLG) has asked the eHealth Office to set up a web meeting which will facilitate the next steps and review the current environment for potential project integration and savings in February. If a decision to move forward with the credentialing proposal is delayed past February, information that was gathered through the Request for Information (May, 2009) will be outdated. At their next meeting, the MLG will discuss and approve the Business Case, which can then be brought forward for approval.

Timely Discharge Information Systems (TDIS): The TDIS project is working through the various agreements, and testing towards implementation of the pilots. Contracts for application vendors (Jonoke, Nightingale) are now signed, so they can begin work on the interfaces to those Client Management Systems (CMS). The Service Level Agreement (SLA) has been delayed as it is being reviewed by Lakeridge lawyers for approvals in order to proceed with the project implementation. The CE LHIN Privacy and Security committee has been involved in reviewing both the Master Hosting agreement and the Service Level Agreement.

Informatics and Subcommittees (CIAG) – now Clinical Advisory Group (CAG): The Clinical Informatics Advisory Group met with the CE LHIN Chief Nurse Executive/Vice President (CNE/VP) Nursing Committee, to whom they report. In their meeting, they discussed the CIAG's role now that Phase II of the HIS Consolidation Standards Project has been discontinued. The CNE / VP Nursing committee agreed upon recommendations that the Group change its name to the Clinical Advisory Committee (CAG).

Microsoft Enterprise Agreement (MVLS) – Hospitals: The Information Technology (IT) Technical Group and Information Management/IT Advisory Committee reviewed a "proof of concept" plan put forward by the software reseller CCSI. It outlines a standardized deployment method for all hospitals of new software, patches etc., and the project would include the development of Windows 7 image(s) for the CE LHIN hospitals over the next 18 months. CCSI is developing the proposal that will be submitted to Microsoft to take advantage of Microsoft's current funding initiatives. CCSI is proposing that they would project manage and do the development work (with the Microsoft funding) for the CE LHIN. Currently, information on hospital infrastructure and connectivity is being completed, and questions and details are being answered by CCSI (the Hospital reseller). Determination to proceed will be taken at the next IM/IT meeting in February.

eHealth Community Consultation: The CE LHIN eHealth Community Consultation Task Group, who is developing a comprehensive list of eHealth needs for non-hospital community agencies organized by sector, has completed 50% of its work. The Group has now created a draft list of issues and is reviewing potential solutions and associated costs. The Group is also working to determine the priority of their needs and the alignment with one or more of the following: the CE LHIN eHealth Strategic Plan, the eHealth Ontario Strategy, and/or the Integrated Health Service Plan. The Community Consultation Group will complete its work in April 2010 and present their recommendations to the eHealth Steering committee.

Data Centre Consolidation – 5 LHINs Partnership: On January 15th, a CEO Town Hall for Chief Executive Officers (CEOs), Chief Information Officers (CIOs) and other hospital executive team members, was held at Ontario Shores. The purpose of the Town Hall was to review the Joint Business Case

approach and process, review the project status update and discuss next steps. Hospital participants will be asked to sign a 'letter of intent' to continue being involved in the next DCC project phase which is the IT Due Diligence Phase. During this phase, the two remaining vendors will work to finalize their pricing. The LHIN CIOs were asked to continue to source external funding.

Resource Matching & Referrals (RM&R): The CE LHIN, as part of a 7-LHIN partnership, has received funding for the RM&R project and begun work on Phase 1 of the project which occurs from December 2009 to March 31, 2010. The CE LHIN RM&R Working Group, which includes a representative from each hospital, the CCAC, and Long Term Care is working to complete standardized questionnaires on process maps, bed referrals, bed volumes, and forms and e-tools that are used in the referral and transfer process of adult patients from medical and surgical beds to Long Term Care (via CCAC), Community Care Access Centre (CCAC) In-Home Care Services, Rehabilitation and Complex Continuing Care (CCC). SIMS, the University Health Network Information Management group is coordinating project management for the 7 LHINS and is supporting the CE LHIN coordinator and participating organizations in completing the work. Data that is gathered and project information is available to the working group on an RM&R SharePoint site developed by the CE LHIN eHealth Team. The RM&R data collection timelines are being adjusted to accommodate participating organizations where possible, but eHealth Ontario deliverables require the project to be completed by March 31, 2010.

Quick Address Lookup (QAS): The eHealth Team is working to secure a vendor that will supply quick address lookup services. A.LHIN-wide pricing was provided by QAS and presented to the IM/IT Advisory Committee for direction and a demonstration of the product is being organized for interested hospital registration personnel. Hospitals who choose to participate in the QAS project will work with the eHealth Team to negotiate a contract which will likely be completed by the end of the fiscal year.

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

L-SAA/H-SAA/M-SAA

L-SAA: The LAPS process has formally been extended. This was communicated in a memo from the MOH, received December 24th, 2009. This letter extended the agreement and process until the new Long Term Care Home Act (LTCA) is proclaimed. The MOH will give the LHINS notification (min. 90 days) from when the LTCA will be proclaimed, and all L-SAAs must be signed by this date of proclamation. The tentative date has been set as mid July.

All CE LHIN Extendicare homes have completed their LAPS. All LAPS submissions have been received.

LHIN Collaborative (LHINC) will be taking over the responsibility of for all indicators (including those for LAPS) from a provincial level.

H-SAA: The 'Management Planning and Risk Reporting' (MPRR) documents have been reviewed and analyzed by the team. Subsequent reports (multi-level) have been generated, completed and sent (MPRR binders) to all internal CE LHIN staff involved in order to comprehensively support the MPRR process and scheduled LHIN-Hospital meetings. The analysis included impacts to the following:

1. Current H-SAA corridors/targets,

2. Staffing (FTE's including RN's & others) impacts,
3. Order or magnitude estimates for all proposed changes on a LHIN and hospital level (re-alignment strategies within and/or outside corridor).

To date, five of ten hospitals have met with CE LHIN to discuss, clarify and negotiate their MPRR submissions. The completed meetings have been productive and produced positive outcomes. The template for the Amending Agreements was to be released January 15th, but it has been delayed. A webcast is planned for February 10th (with communications and template packages to be sent to all LHINs February 7th, 2010).

A provincial roll up is being compiled by the H-SAA Steering Committee to provide a potential impact assessment to the Ministry as well as other LHINS (e.g. overall revenues/expenses, projected financial year end position for 2010/11, sum of annualized savings for operational efficiencies, one-time implementation costs, re-alignment strategies within/outside corridor, FTE impacts for RN's & others and inter-LHIN transfers). In addition to the overall provincial roll-ups, the 5 GTA LHINs have been in consultation with each other to share high-level ideas for operational efficiencies as well as cross-reference impacts of our Hospitals' proposed re-alignment strategies (within/outside corridor) on surrounding LHINS.

M-SAA: Although the Multi-Sectoral Service Accountability Agreements (M-SAA) for the community sector have been executed, the accountability process to date has been informal and includes regular monitoring of the agreements through the quarterly reports. There have been several on-site hands-on training sessions with individual Health Service Providers (HSP's) including Alderville Health Services and Curve Lake, etc. that have been conducted to assist them in correctly working through the new reporting tool (i.e. Community Accountability Tool).

2009/10 Q2 submissions were not all submitted within the requested timeline. However staff investigation revealed various legitimate reasons:
1. Utilization of the new CAT tool to report quarterly information (learning curve);
2. IT technical challenges (e.g. firewalls, incompatibility, WERS technical issues, etc.);
3. Reporting standards conversion;

Several of our HSP's did not correctly complete the report and had data quality issues (some significantly more so than others). Another problem that further exacerbated the data quality issue is the lack of understanding for many of our HSP's who are in the process of converting their information in accordance with the Ontario Healthcare Reporting Standards (OHRS) that is mandated by the province.

System Finance & Performance Management (SFPM) staff's focus will move to reviewing performance expectations and submissions for Q3 where applicable, as well as reviewing forecasts for year end. All M-SAA's have now have been uploaded to the website, as per the requirement within the M-SAA agreement.

The CE LHIN Decision Support Team is finalizing a M-SAA monitoring dashboard and expect to have it completed for March 2010.

Allocations: Funding letters and/or payments were processed for: a) the last of the Pay for Results; b) District Stroke funding; c) final UPF - DART, OSC Metabolic & Weight management, CCAC Advanced

Wound Management, Wrap Around, STEMI, Additional CT Scans; d) LHC funding increase; e) Growth funding; f) PRHC Paediatrics Program, g) Health Infrastructure Renewal Funds (HIRF).

Funding letters and related payments are planned for processing in February for: a) additional CT scans; b) TSH base dialysis funding increase; c) ABI base funding increase; d) finalization of PRHC and LHC stroke funding; e) Opening Cash Allocations & APTS roll over for fiscal 2010/11.

Year-end Surpluses: The health service providers have provided forecasts of expected year-end surpluses. A summary for the 2009/10 fiscal year was compiled to include base funding as well as AAH and UPF project surplus estimates. The P4R funding and forecast surpluses have been completed and processed. The reallocation of surplus funds is underway in January & February for projects and base allocations from the community agencies, LTCH and hospitals. All surplus reallocations between and within sectors will be completed in February.

Annual Reconciliation Report (ARR): The 2008/09 ARR (Annual Reconciliation Reports) for the CSS and CMH community agencies are being reviewed by staff as they come in. The CE LHIN is the only LHIN to have completed the 2007/08 fiscal year ARR process.

Reallocations: The Q3 reallocations have started to flow. The sector reallocation between Hospitals and LTCHs has been submitted and we are still awaiting process completion by MOHLTC. The final reallocations will be completed in February. A full report on 2009/10 reallocations will be provided to the Board.

Central East Community Care Access Centre (CECCAC): The cost containment initiatives implemented early in 2009 have begun to take hold. While the average monthly deficit from April 2009 to October 2009 continued to track at about ($1.1M), the November monthly deficit was ($0.7M) and the December monthly deficit was ($0.5M). This is good news and demonstrates the first wave of cost containment strategies are having the intended impact. The additional 16 cost containment projects initiated in late 2009 will build on these early results and will help them realize savings through February and March, 2010. The CECCAC is implementing all cost containment projects on an aggressive schedule in order to eliminate their accumulated deficit by March 31, 2011.

Family Health Teams: The Ministry of Health and Long Term Care recently announced that a 2.25 per cent increase has been approved for the funding of the salary benchmarks for interdisciplinary health provider and administrative staff in Family Health Teams for the fiscal year 2009-10, retroactive to April 1, 2009.

Community Health Centre (CHC): Some CHCs are facing a challenge with the WERS and CAT reporting for Q3. PCA staff is working with them to assist with reporting requirements.

2009/10 Q2 H-SAA Performance Assessment Dashboard : The Hospital Service Accountability Agreement Dashboard will be completed by the end of January 2010 and will be assessed in accordance with each Hospital's 2008-10 Hospital Service Accountability Agreement.

CE LHIN Wait Time Strategy Working Group (WTSWG): Central East LHIN's Wait Time Strategy Working Group (WTSWG) has recently met to discuss the current status of each hospital's performance and funding as of January 2010 (funded volumes & wait times) forecasted for year end.

CE LHIN hospitals have updated their 2009/10 year end forecast using January 2010 information. Current survey results indicate that the following key service areas are on track to deliver their 2009/10 funded volumes: 1) Magnetic Resonance Imaging (MRI), 2) Computed Tomography (CT), and 3) Paediatric Surgery.

All Central East Hospitals are forecasting to deliver funded volumes (base + one-time incrementals) by year end, including the in-year additional volumes of 1,288 MRI hours & 2,707 CT hours. Additionally, hospitals have identified that there is the capacity and patient demand to deliver more MRI & CT hours & Paediatric cases.

For other key service areas such as Cataract Surgery, Hip/Knee Replacements and General Surgery (only reporting on LHIN-managed areas), various hospitals have currently experienced some difficulties and some funded volumes will not be met by year end for a number of reasons:

1. Cataract Surgery: Loss of an Ophthalmologist for an extended period of time;
2. Hip/Knee Replacements: An unexpected OR closure along with changes in referral patterns and case mix preference, loss of an Orthopaedic Surgeon mid-year (successfully recruited another who started in October/November 2009), flood in on a surgical floor which reduced sterilization capability and staffing issues (e.g. surgeon, anaesthesia, etc.).
3. General Surgery: Lack of patient demand (WTS/HBAM funding methodology allocated more funded volumes than current demand for these services) for certain types of general surgery (e.g. Cholecystemctomy), loss of a general surgeon, OR closures, changes in reporting, changes to internal processes (e.g. inpatient to outpatient surgery)

Central East LHIN staff, working in collaboration with each of the Hospitals is actively working to re-allocate the unmet volumes intra-LHIN before giving back to the Wait Time Strategy office. Utilization of the CE LHIN Wait Time Strategy Working Group (WTSWG) Re-Allocation methodology is underway and will be determined within the next week.

In conjunction with this mid-year re-allocation, WTSWG members have also just completed the Ministry/Wait Time Strategy survey for requested 2010/11 initial one-time incremental volumes. The LHIN's are expected to receive preliminary allocations by February 12th, 2010.

To ensure that all CE LHIN hospitals who are offering Wait Time services are allocated 2010/11 one-time incremental volumes equitably, a revised version of the CE LHIN WTSWG allocation methodology will be calculated by CE LHIN staff and evaluated by WTSWG members before final confirmation to the Ministry/Wait Time Strategy office is sent. As per the request of WTSWG members, the CE LHIN WTSWG allocation methodology going-forward will consider; 1) Capacity/Need, 2) Wait Time Performance and 3) Wait Lists (new). Funding will be available provincially in 2010/11 as was allocated in 2009/10 with the exception of Cataract Surgery (reduction in 2010/11 from 2009/10 by approximately $1.85M on a provincial level).

The Ministry/Wait Time Strategy office has requested a hospital-by-hospital breakdown of CE LHIN allocations to be submitted by February 24, 2010 with subsequent teleconferences to be held to clarify their

allocation methodology and adjustments. A presentation was conducted by the Wait Time Strategy office to WTSWG members for the January 2010 meeting to discuss their guidelines for preliminary allocation methodology:

1. Service areas of greatest need will be prioritized;
2. Demand-based allocation;
3. Volumes are determined based on maintenance or improvement of wait time performance in relation to provincial targets;
4. Requests to be considered that are based on historical performance.

The Base Volume Methodology for each of the key service areas is currently being reviewed for potential revision by Wait Time Strategy office.

Once all teleconferences/face-to-face meetings and various next steps are concluded, Wait Time Strategy office funding letters will be sent to the LHIN's by March 31st, 2010.

Other Issues: 1) Final re-allocations of UPF and AAH funding are being completed in Q4 2) The capital issues (relating to both own source funding and MOH requested grant funding) that are arising will take up additional resources from the LHIN. The capital branch and the CE LHIN will be meeting on February 1st for an update of projects and next steps. **3)** The SFPM team are currently working on a Risk Management framework that will have a draft available for senior management before the end of this fiscal year.

Health Provider News

Focus on Patient Experience…

Code STEMI at Rouge Valley: In a recent news release, Rouge Valley Health System announced that the Rouge Valley Health System (RVHS) has received approval to continue implementation of its "gold standard" pilot program in life-saving cardiac care intervention. Natalie Bubela, Vice President of Programs, RVHS is quoted as follows: "We thank the Central East Local Health Integration Network (CE LHIN) Board of Directors for making this decision, which means the hospital will now continue and expand a program we piloted during the last year to bring unstable cardiac patients the specialized care they need within a crucial 90-minute window."

PRHC Surgical Constant Care: In order to comply with the MOHLTC requirements, PRHC reported the opening of the Surgical Constant Care Unit. This unit was approved and will be classified as a level 2, with a total of 8 non-ventilated critical care beds.

Ministry Announcements:

B&C Bed Long Term Care Renewal Strategy: The MOHLTC recently advised the Fairview Lodge LTCH and Bon Air Residence that their applications to redevelop have been reviewed by the ministry and the LHIN and have been approved to participate in Phase 1 of the Long-Term Care Home Renewal Strategy. The Government is committed to redeveloping 35,000 B, C and Upgraded D long-term care beds in

communities across Ontario. This initiative will provide residents with an improved quality of life in updated, home-like living environments.

Shepherd Lodge and Craiglee Nursing Home recently received an increase in base funding for the Structural Compliance Premium (SCP). The SCP has increased from $3.00 to $5.00 per day per bed for the beds that have been redeveloped according to the *Long-Term Care Facility Design Manual, May 1999.* In the case of Shepherd Lodge, 60 beds, previously classified as B beds, will now be reclassified as "new" and will receive the $5 SCP in ongoing base funding retroactive to April 1, 2009. Craiglee Nursing Home has had 20 C beds reclassified as “new”.

Behavioural Support Systems (BSS): The Ministry of Health and Long Term Care recently announced the start of an important initiative called the Behavioural Support Systems (BSS) project which will be led by the North Simcoe Muskoka LHIN in partnership with the Alzheimer Knowledge Exchange and supported by the Ontario Health Quality Council. The purpose of the project is to create environments where residents can be cared for appropriately and with dignity and respect. These environments must also be a place where staff can feel safe as they work to the best of their ability to deliver quality care. There will also be benefits for the system as whole through reduced waits for appropriate long-term care beds, a reduction in unnecessary hospital visits and decreased ALC days in acute care. At this time it is contemplated that the project will proceed in three phases. Funding has been provided for the first phase of the project which begins immediately and will occur over the following approximately nine months. The first phase will focus on defining the population to be served, proposing a system model based on best practices, and establishing an appropriate measurement and evaluation framework. Subsequent phases will test the potential of specific interventions to improve outcomes and will examine how best to scale these up more broadly throughout the system. Project planning has begun and in the next few weeks there will be announcements about opportunities to participate as well as regular and ongoing project updates. A formal project “kick off” is being planned for February 2010.

Long Term Care (LTC) Home Registered Practical Nurses (RPN): The Ministry of Health announced that a 1.87% stabilization increase will be provided to support the 1200 newly created RPN positions in the LTC sector.

Other:

Home Care Nursing Web Resource: The Ontario Home Care Association (OHCA) and the Ontario Community Support Association (OCSA) are pleased to announce the launch of an exciting new web resource for home health care, which will support new graduate nurses in their practice of home care nursing. The web site can be accessed at www.mynurseeducation.ca. It is available to all registered nurses (RN) and registered practical nurses (RPN) interested in learning more about nursing in the home care sector.

Ontario Medical Association: The Ontario Medical Association announced mid January that the organization will be recruiting for the recently vacant position of Regional Manager to support the OMA district that is aligned with our LHIN.

Core Business Requirements – LHIN Operations

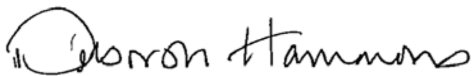
CRM/Share Point Project: The CE LHIN was chosen as one of the pilot sites for the deployment of the CRM and the project charter has been finalized and has been approved by all parties. The final stages of data gathering and cleansing are underway and is being prepped for the data load. Training is expected to take place Feb. 18th, 2010.

Human Resources Update: John Lohrenz, Lead Performance and Accountability, left the Central East LHIN as of Friday, January 22, 2010 to pursue other opportunities. John was one of the Central East LHIN's original employees and his contribution to the CE LHIN has been greatly appreciated. We wish him well on his new ventures!!

Charli Law was the successful candidate who will be filling the position of Corporate Business Support Financial Analyst. The System Finance & Performance Management Unit is currently recruiting a replacement financial analyst to fill Charli's vacancy.

All Staff Training Session: All Central East LHIN staff participated in an on-line training session on The Accessibility for Ontarians with Disabilities Act, 2005 which mandates all public sector offices to develop, implement and enforce mandatory accessibility standards to identify, remove and prevent barriers to accessibility.

Respectfully submitted,



Deborah Hammons
Chief Executive Officer