

**LEGEND**

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Key	Action Items	Linkages	Partnerships	Data Collection	Strategy Development	Educate and Inform	Service Integration	Navigation Case Mgmt	Resource Alignment	Build New Capacity	Quality Improvement	Aligns to	Who
<b>Central East LHIN Core</b>													
<b>Primary Care</b>													
29	Facilitate, as needed, the timely approvals and implementation of the Community Health Centres currently under development in the area.											ALL	LHIN / MOHLTC
97	Establish <b>Primary Care Working Group</b> : FHTS, CHC, docs, Allied Health											NEW	LHIN
66	Identify strategies to provide "Primary Care" to those with no doctor											ALL	Primary Care WG
28	<b>Interdisciplinary Teams</b> . Explore opportunities to augment or partner with Primary Care Providers (e.g. Family Health Teams, CHCs, OTHERS) in the provision of preventative, maintenance and restorative services/programs											ALL	Primary Care WG
56	Develop and <b>pilot "Green Script"</b> for behavioural modifications. [A statement of commitment by consumer/caregiver and service provider(s) which outlines the behavioural modifications/activities that are recommended.]	52										CDPM	Primary Care WG CDPM HPAC
101 36	Provide Nurse Coordinator, Nurse Practitioner, Case Manager in DR's offices											ALL	LHIN Primary Care WG
<b>Public Health / Health Promotion</b>													
88	Build working relationship with Public Health Units											ALL	CE LHIN
89 23	Health Promotion and Illness prevention - broader health determinants. (MHA) - promotion of senior's healthy living - identification of inter-sectoral actions for health											ALL	Partnership of CE LHIN, Networks, HSPs and PHUs
55	Education/Awareness of impact of broader determinants of health											ALL	Partnership of CE LHIN, Networks, HSPs and PHUs
<b>Cultural Competency</b>													
90	Establish Cultural Competency - Diversity Group											NEW	LHIN
91 93	Inventory of - culturally competent services - services/resources for the uninsured											Cultural Comp	LHIN & WG
92	Cultural Competency Strategy											Cultural Comp	WG - MHA NETWORK
<b>French Language Services</b>													
94	Establish FLS Collaborative or alternative advisory body											FLS	LHIN / GTA LHIN / MOHLTC
95	Designating FLS Service provision											FLS	Partnership
96	Establish a FLS Primary Care Hub											FLS	Partnership
<b>Transportation</b>													
112	Establish Moving People Through the System: Transportation Task Group											NEW	LHIN
61 5	Background Report: existing options; issues; challenges.											CDPM	LHIN Transportation TG
18	Host a Transportation Summit that will bring together consumers, caregivers and providers to identify actions for improving transportation services, thus improving access to services.	61,5										SCFS	LHIN Transportation TG
<b>Telemedicine</b>													
6	Obtain current information on where telemedicine equipment currently resides, its capacities and the network of human resources that are providing services through this medium.											ALL	E-health
111	Explore coordinate regional training schedule for the use of telemedicine/video-conferencing											SCFS	HHR WG E-health



Cardiac													
64	Develop Cardiac Care Strategic Plan - full continuum (incl. cardiac rehab, prevention)											CDPM	CDPM
CKD/Renal													
70	Consensus on CE LHIN ESRD/Dialysis issues, next steps.											CDPM	CDPM / Providers
Self Management													
54	Inventory of Education and Self-Management Programs/ Initiatives for (i.e. current initiatives and providers and the gaps/challenges): 1. cardiovascular disease and stroke; 2. chronic kidney disease; 3. diabetes; 4. Arthritis and related conditions 5. Respiratory disease (COPD, bronchitis, asthma)	2, 49, 4, 54, 73										CDPM	LHIN CDPM
52	Identify a consistent self management model for CE LHIN	54, 56										CDPM	CDPM Primary Care WG
69	Assess access to and strategize on respite (relief of caregiving duties) options and other caregiver support needs.											CDPM	CDPM
71	Expand access to self management programs											CDPM	LHIN / CDPM
Coordination													
39	Implement coordinated/cross-disease prevention programs for people who have various chronic diseases: Primary (pre disease) and Secondary Prevention (e.g. healthy lifestyles with disease) and Tertiary (Disease Management)	34										CDPM	LHIN CDPM Providers
43	Improve consistency of screening and assessment tools. (Identify and share best practices)											CDPM	CDPM Providers
58	Identify opportunity for coordinated visits and scheduling	58, 42, 60										CDPM	CDPM Providers
42	Consistent guideline for specialist referral (pre-consult preparation)	58, 42, 60, 97										CDPM	CDPM Primary Care WG HPAC
60	Identify opportunity for coordinated/central intake (b/w programs)	58, 42, 60										CDPM	CDPM Providers
	Osteoarthritis Assessment / Joint Replacement											NEW	LHIN Providers
57	Link people with CD to mental health (depression) supports	97										CDPM	CDPM MHA / Primary Care
38	Client information travels with them to various chronic disease providers											CDPM	E-health
Health Human Resources													
65	Stroke: Develop more accurate understanding of HHR limitations/pressures	103										CDPM	CDPM Stroke Strategy HHR WG
37	Identify barriers and opportunities to form interdisciplinary care teams for people with chronic disease	97, 103, 28										CDPM	CDPM HHR WG Primary Care WG
50	Develop safe, evidence-based alliances and linkages with complementary health practitioners/practices..											CDPM	CDPM HPAC
67	Access to adequate numbers of appropriately trained chronic disease professionals	65										CDPM	LHIN HHR WG
Mental Health and Addictions													
Service Delivery													
74	Regional Networking Groups for specific populations. Utilize a systems approach to service and promote regional networking groups for specific populations											MH&A	MHA
73	Up to date inventory of programs and services. To maintain an up-to-date, publicly accessible inventory of agencies, programs and services											MH&A	MHA LHIN
80	Youth Early Intervention Strategy Broad Initiative. Develop an Youth Early Intervention strategy including prevention education, early intervention and mechanisms to move from children's to adult system											MH&A	LHIN Partnership
82	Consistent Data Collection Methodology and Outcome Measures. Develop consistent data collection methodology and outcome measures for success to inform planning processes and funding decisions											MH&A	MHA MOHLTC project
83	Common intake and assessment. Develop and expand on existing common intake processes and common assessment tools											MH&A	MHA Providers
84	Shared resources and service coordination. Community mental health and addictions agencies to find ways to share resources and coordinate services											MH&A	Providers MHA
Knowledge Exchange													



22	Hospitals and Long-Term Care Homes will be expected to demonstrate effective, evidence-based falls prevention and medication reconciliation / management practices/programs.												SCFS	LHIN Quality and Safety WG HPAC Partners
24	Medication Management. Once completed, the Central East LHIN will review the evaluation of the Medication Management project through the former Scarborough Community Care Access Centre to determine future opportunities for this model.												SCFS	LHIN HPAC?
<b>Wait Times &amp; Critical Care</b>														
114	Wait time task group to facilitate inter-facility working partnerships that will improve access to provincial targets												WT/CC	LHIN Providers
115	Establish and ED Task Group												WT/CC	LHIN Providers
116	Produce regular progress reports on the wait times in the Central East LHIN												WT/CC	WT WG
117	Hospitals in the CE LHIN will participate in the Provincial Wait Time Information System and other quality improvements												WT/CC	Providers
118	Conduct a critical care health human resources needs assessment and explore coordinated recruitment												WT/CC	Critical Care Lead HHR WG
119	Explore an "always available" critical care bed concept for ICU referrals between CE LHIN hospitals. Institute compulsory use of Critical to better track patient referrals and system performance												WT/CC	Critical Care Lead Providers
120	At a minimum, the Scarborough Hospital, Rouge Valley Health System, Lakeridge Health System (Oshawa) and the Peterborough Regional Health Centre will have instituted an intensivist led management model for their critical care units 24/7 by 2008.												WT/CC	LHIN Critical Care Lead Providers

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