DRAFT Project Charter

Central East Priority Project Summary

Project Name: Hospital Clinical Services Plan

Purpose of Board Review	☐ For Information Only ☐ For Approval ☒ For Endorsement to Proceed with Further Planning/Refinement/Review
Project Charter Sponsor(s)	CE LHIN Hospitals, CCAC and relevant CE LHIN Planning Partners
Project Type	☐ Service Enhancement ☐ New Service / Program ☒ Integration Activity ☐ Demonstration Project ☐ Single Phase Project ☒ Multi-Phase Project
Funding Required	
Funding Source	LHIN Priority Fund — Funding Year (s): 07-08 08-09 — Funding Type: One Time
Anticipated Project Owner (Accountability)	☒ CE LHIN ☐ CE LHIN Health Service Provider ☐ Assigned CE LHIN Project Team
Project Deliverables / Goals	▪ See Attached Project Charter "Goals and Objectives"
Project Timelines	Start: Nov 2007 — Completion: Fall 2008
Project Reviewed By:	Networks: *describe* Collaboratives: *describe* Task Groups: *describe* CE LHIN Staff: *Staff in consulation with Board and CE LHIN Service Providers*

Strategic Directions

- ☒ The LHIN Board will lead the transformation of the health care system into a culture of interdependence.
- ☒ Healthcare will be person-centred in safe environments of quality care.
- ☒ Create an integrated system of care that is easily accessed, sustainable and achieves good outcomes.
- ☒ Resource investments in the Central East LHIN will be fiscally responsible and prudent.

Priorities for Change

- ☒ Seamless Care for Seniors
- ☒ Mental Health and Addictions
- ☒ CDPM
- ☒ Wait Times and Critical Care

Enablers

- ☐ Primary Care
- ☒ E-health
- ☒ Health Services Planning
- ☒ Health Human Resources
- ☐ Diversity
- ☐ Back Office Transformation
- ☒ Moving People Through The System

System Outcomes

☒ Accessible	☒ Safe	☒ Appropriately Resourced
☒ Effective	☒ People Centred	☒ Equitable
☒ Efficient	☒ Integrated	☐ Focused on Population Health

Project Name: Hospital Clinical Services Plan		Project Acronym or No.: **HCSP**	
Workstream Lead/Project Sponsor: tbd	Project Coordinator: tbd	Target Project Completion Date: yyyy/mm/dd	
Project Lead/Project Manager: James Meloche		Version No.: 0.1	Version Date: 2007/10/02

Project Background

The Central East LHIN consists of 9 community hospital corporations dispersed across 14 sites (excluding the Uxbridge Cottage Hospital). There are no academic health science centres and limited tertiary-level care within the LHIN. Some specialized services are not performed within the Central East LHIN.

A key mandate of all LHINs is to integrate the local health system with a view to improving access and quality of health care services. As defined in the *Local Health Systems Integration Act*, to integrate is to:

> *(a) co-ordinate services and interactions between different persons and entities; (b) partner with another person or entity in providing services or in operating; (c) transfer, merge or amalgamate services, operations, persons or entities; (d) start or cease providing services; (e)cease to operate or to dissolve or wind up the operations of a person or entity.*

In addition to this legal definition, the CE LHIN has identified integration as a means, not an end, to achieving the following objectives:

- Health system experienced as a coordinated system: People will get the right treatment at the right time by the right provider
- Seamless flow of information that supports patient care
- Create timely access to quality services by aligning people, processes and resources
- Elimination of wasteful and time consuming duplication

A completed clinical services significantly advances the strategic directions of CE LHIN in the following way:

- Promotes improved **quality and safety** of the health care system, including patient outcomes in our hospital system
- Accelerates **system integration** in the hospital system primarily, and its interface with other community services
- Ensures **fiscal responsibility** of our health system, including ensuring that the hospital system is appropriately resources in the future and that quality is in the forefront of LHIN decision making.
- Demonstrates **transformational leadership** and innovation within the entire LHIN

This initiative will prepare and the CE LHIN – as well as prepare for the implementation – for the proposed LHIN funding formula or Health-Based Allocation Model (HBAM.) With the knowledge of the costs associated to clinical programs, this tool will allow the LHIN to fund for services based on the location of the patient population, as well as support patient access to the providers of best quality and efficiency.

Project Scope

The key objectives of the clinical services planning initiative are:

- Improving quality and safety by grouping together clinical or surgical specialists, their teams and appropriate physical resources

- Expanding or creating new programs that would not be viable or sustainable at multiple sites
- Creating operational and clinical efficiencies that would allow hospitals to focus on, and improve, their core programs. This would allow the hospital to meet community need to core acute care programs within budget
- Paradoxically, create new “centres of excellence” that create confidence of CE LHIN residents to receive services within the LHIN and as close-to-home as possible, thereby capturing or repatriating CE LHIN “market share.”

A large part of community hospital programming consists of core services such as emergency services, general surgery, obstetric services, and general medical and geriatric services. Discussions regarding clinical service planning and horizontal integration for these core services will focus on:

- Categorization of level of services provided
- Better coordination of regional fiscal and human resources, including credentialing
- Development of regional referral networks, implementation of best practices, and standardization of clinical pathways and performance goals (e.g., wait time targets).
- *Would not be the focus of any service consolidations within the region.*

With regard to some of the surgical and medical subspecialties provided in CE LHIN community hospitals, more study is required on what service delivery model and solutions would best serve the region, including equity of access, provision of quality services, health human resources & physician retention, and service and fiscal sustainability. Solutions may be found through regional networking of existing providers, but consolidation of programs should be considered as an option. Study may also reveal opportunities for establishing new surgical/medical programs or other hospital services not currently provided in the CE LHIN.

Relationship to Clinical Services Planning to the Central East LHIN IHSP

The first Integrated Health Service Plan did not explicitly identify the differences between horizontal and vertical integration, nor was there specific reference to hospital clinical service planning. The focus of the first IHSP was on improving the continuum of care so as to improve integrated access to health services (i.e., vertical integration).

Nonetheless, horizontal and vertical integration are interdependent processes. Any thinking that we could achieve vertical integration without making (perhaps difficult) decisions and gains on horizontal integration is based on an erroneous understanding of integration itself.

From the outset of physician engagement, the Senior Director of Planning, Integration and Community Engagement has openly communicated to physicians, Medical Advisory Committees, and Medical Societies that there is a need for a LHIN-wide clinical plan. There was common acceptance by these stakeholders for this need as most were confronted with establishing their own hospital specific health service plan in absence of a "system perspective."

This type of reflection is precisely what the CE LHIN task groups are undertaking by examining and what the IHSP anticipated. Specifically, we have committed to service planning for:

- rehabilitation services (to support senior's care and chronic disease prevention and management)
- wait times initiatives (hip and knee total joint replacement, cardiac surgery, cancer surgery, MRI/CT, and cataract surgery)
- critical care
- emergency department services
- Alternate level of care (ALC)
- specialized geriatric services
- chronic disease programs (cardiovascular, respiratory, renal and arthritis programs)
- specialized mental health services

While the CE LHIN has already indirectly and in a limited way begun the processes of horizontal integration, much more needs to be done.

Project Benefits

Specific performance measures will be determined as part of the clinical service plan. It is expected that measures will include:

- Decrease in hospital mortality ratios
- Improved wait times for targeted areas
- Decrease in ambulatory-care sensitive hospital admission rates
- Appropriate increase in rates of service provided to CE LHIN residents by CE LHIN Hospitals
- Appropriate shift from inpatient to ambulatory programs

Goals, Objectives & Performance Measures

Goals	Objectives/Deliverables	Performance Measures
1. Obtain Effective Stakeholder Commitment	A. Hold an initial Clinical Services Planning Think-Tank (November 9, 2007) B. Develop an effective communications strategy that includes vision, objectives, values	• Completed background fact-finding / environmental scan of Canadian experiences in regional hospital planning. • An initial kick-off session held on Nov 9 attended by desired

Goals	Objectives/Deliverables	Performance Measures
	and shared interests. C. Develop engagement strategy to keep relevant stakeholders informed about progress and results.	stakeholders • Communications strategy that communicates vision, principles, goals and process
2. Vendor Selection and Project Oversight	A. Prepare and conduct a competitive Request for Proposal to select a core vendor for the project B. Develop multi-tiered governance structure for oversight of the activity, including provider governance, physicians and health human resources. C. Align planning activities and human resources within the CE LHIN organization and health service providers to ensure the project is completed on time	• Successful completion of RFP and selection of vendor • Funding Agreement in place with CE LHIN health service provider to manage the projects activities • Development of governance and project management structure
3. Hospital Services Planning and Scenario Modeling	A. Review of Current Patterns of Service Delivery • Categorization (level of service) and inventory of current services B. Projection of Future Demand (5 and 10 year horizons) C. Projection of Service Delivery v. Demand (assuming status quo) D. Scenario Modeling (Projection of demand against changes in the delivery model – see Goal 4) E. Analysis of Cross-LHIN patient flow (current and future).	• Analysis of specialty-specific patterns of utilization to determine where patients receive services compared to where they live, and a population based review of expected compared to actual admission rates. • Specialty-specific demand for CE LHIN residents and surrounding areas are projected taking into account population growth and ageing as well as specialty-specific trends in admission rates, length of stay and same day admissions. Projections indicate the nature and volume of work, not where patients will be treated. • Given the referral patterns identified in step A, the projected demand from step B is distributed to give the likely patient mix and volume at selected hospitals. This provides a base case scenario to demonstrate how future hospital work will be distributed if referral patterns and policy remain the same. • Model various scenarios to deal with future hospital work.

Goals	Objectives/Deliverables	Performance Measures
		Detailed changes at clinical, age, region of residence and hospital level that can be modeled include changes in demand, average length of stay and referral patterns. This would include potential changes to the existing delivery system.
4. Identify Integration Opportunities and New Models of Service Delivery	(See Goal 3) A. Identify integration opportunities for clinical services based on quality, access and service volumes B. Explore legal and practical feasibility of LHIN wide hospital physician credentialing C. Developing a workforce plan; D. Developing an ambulatory care plan E. Developing a demand management plan to reduce in-patient bed demand F. Develop a model for LHIN-wide surgical / OR and on-call scheduling system	• # of integration opportunities • Expected improvements in quality and safety of hospital care • Improved access to urgent and non-urgent clinical services across the LHIN • Expected efficiences and better utilization of hospital resources (human, intellectual, physical, financial and capital). Example, improved throughput; increased OR productivity.
A. Change Management	A. Recommend Action Plan for Implementation of Integration Opportunities B. Developing an infrastructure plan related to the above (Goals 3 & 4) C. Undertaking a costing exercise to financially cost the Clinical Services Plan and/or integration opportunities D. Work with Ministry, local stakeholders and non-CE LHIN providers to implement plan and/or obtain necessary approvals.	

Project "IN" & "OUT" of Scope Items

"IN" Scope	"OUT" of Scope
• Obtain Effective Stakeholder Commitment • Vendor Selection and Project Oversight • Hospital Services Planning and Scenario Modeling • Identify Integration Opportunities and New Models of Service Delivery • Change Management Strategies	• Implementation of the clinical service plan, and/or change management strategies prior to required approvals. This would include formal notice of integration opportunities that would require due notice to community stakeholders and CE LHIN board approval • Vertical integration initiatives (e.g., across health care sectors) except where a particular service delivery model calls for the decanting of programs to suitable/capable community-based providers (i.e., outpatient clinics, health education) • Changes in physician remuneration schedules or agreements • Changes to agreed upon Hospital Service Accountability Agreement without due notice from the service provider and/or LHIN.

Project Timelines

High-Level Milestones	Target Completion Dates
♦ Initial Clinical Services Plan Think Tank	♦ Nov 9, 2007
♦ Completed RFP	♦ Nov 2007
♦ RFP Issues and Reviewed	♦ Jan 2008
♦ Vendor Selected	♦ Feb 2008
♦ Plan Conducted and Completed	♦ July 2008
♦ Board Review	♦ Aug 2008
♦ Health Services Plan Release	♦ Sep 2008
♦ Initial Implementation for consideration in Hospital Annual Planning Submissions and Hospital Services Accountability Agreement	♦ Fall 2008

Project Costs

Category	**2007-08**	**2008-09**		
Salaries and Wages				
Benefits (22% of S&W)				
ODOE (15% of S&W)				
Materials/Equipment				
Office Space/Facilities				
Training/Development				
Consultants				
TOTALS				

Funding Source

LHIN Priority Funding, including an new allocations to be provided through the 2008 Annual Service Plan.

In-kind contributions, including costs associated to travel and meetings will be the responsibility of participating health service providers. Health service provider staff will providing support to the project, but not be remunerated by the CE LHIN.

Project Team

Team Member, Organization	Role on the Project	Required Involvement	
		Estimated Duration	Level of Effort
• CE LHIN Clinical Services Project Manager	• Serve as an interface between the vendor and the senior team of the CE LHIN, specifically the Sr. Director of Clinical Services Plan	• 12 months	• 100%
• Project Vendor Team	• Conduct analysis, modeling and options as per deliverables above.	• Approx 9 months	• 100%
• CE LHIN Senior Integration Consultants	• Provide advice/direction on related IHSP priorities	• Duration of Project	• 10%
• CE LHIN Decision Support	• Assist in the collection and analysis of data and related performance metrics	• Duration of Project	• 10%
• CE LHIN Communications	• Primary responsible for all project internal and external communications, including news releases & website development.	• Duration of Project	• 10%

Project Partners

Partners	Common Interests & Priorities	Roles & Responsibilities
• Central East CCAC • CE LHIN Hospitals (Administration and Governance) • Ministry of Health and Long-Term Care (Priority Programs) • Academic Health Sciences Centres in Toronto • Provinical Stakeholders such		• To serve as project coordinator/banker.

Partners	Common Interests & Priorities	Roles & Responsibilities
as OHA, CCO, CCN • CE LHIN Planning Partners including Critical Care, ED, ALC, Rehab, MHA, Seniors, and ED		

Project Stakeholders

Stakeholders	Interests & Needs	Management Strategies
• Community Residents / Patients • CE LHIN health care professionals and their associations (e.g., OMA, RNAO) • Unions / Collective Bargaining Units • CE LHIN community based health care providers • Local and Provincial Governments • Ministry of Health and Long-Term Care (Priority Programs) • Academic Health Sciences Centres in Toronto • Provinical Stakeholders such as OHA, CCO, CCN, OSS		

Other Related Projects & Initiatives

Project/Initiative	Interdependency & Impact
•	•

People & Organization Change Impacts

Description of Impact	Impact Management Strategies

Project Communications

Audience	Information Needs	Format & Timing	Responsible
•	•	•	•

Project Risks

Risk	Likelihood	Impact	Risk Response
•	•	•	•
	•	•	•
	•	•	•

Critical Success Factors

•

Assumptions & Constraints

Assumptions	Constraints
•	•

Sign-Off

Workstream Lead/Project Sponsor

Name & Organization	Signature	Date

Project Lead/Project Manager

Name & Organization	Signature	Date

Project Partners

Name(s) & Organization(s)	Signature(s)	Date(s)

Project Team Members

Name(s) & Organization(s)	Signature(s)	Date(s)

Charter Revision History

Version Numbering:
- 0.x - internal draft - under development *(Working copy for Project Coordinators)*
- 1.x - document under review / internal draft *(Begin 1.0 numbering when sent to Workstream Lead for comment)*
- 2.x - document submitted for approval *(Begin 2.0 numbering when sent to Oversight for approval)*
- 3.x - document approved *(Renumber to 3.0 after Oversight Approval)*

Revision No.	Description	Modified By	Date
0.1	Development of first draft	James Meloche	Oct 3, 2007