

Waterloo Wellington LHIN

Quarterly Report (Q3)

October 1 to December 31, 2008

December 31, 2008

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1.0 Introduction

Activities of the Waterloo Wellington LHIN (WWLHIN) during the third quarter (Q3) were focused on completion of the draft ASP for 2009/10 – 2011/12 and the ED/ALC Overarching Plan, review of the Aging at Home – Year 2 submissions, the work of the Clinical Optimization project and e-Health initiatives, and the Community Annual Planning Submissions (CAPS) from the CCAC, Community Health Centres (CHC), Community Support Services (CSS) and Mental Health and Addictions (MH&A) service providers. The WWLHIN priorities continue to align with the strategic direction of the Ministry of Health and Long-Term Care (MOHLTC) while at the same time advancing the local priorities of the IHSP.

2.0 WWLHIN Local Health System Update

2.1 Accountability Agreements

Performance of all of the WWLHIN health service providers (HSPs) continues to be monitored and specific action is taken where required. Agreements with all of the hospitals have been reached, with the exception of Guelph General Hospital (GGH). In December, the GGH is developing a plan to bring the hospital into a balanced financial operating position within the existing funding allocation and planning targets to enable the hospital to sign the 2008-10 Hospital Service Accountability Agreement (H-SAA).

An Improvement Plan has been requested from Cambridge Memorial Hospital as this hospital is projecting a higher than planned deficit for 2008/09 and are in breach of their H-SAA. The Improvement Plan is due the beginning of January 2009.

2.2 Draft Annual Service Plan for 2009/10 – 2011/12

The Draft ASP for 2009/10 – 2011/12 submitted the three components in August, September and October 2008.

2.3 CAPS process and plans for M-SAA

The Community Annual Planning Submission (CAPS) process was initiated during the third quarter with submissions by the WWLHIN CSS, CHC, MH&A and the CCAC service providers. All 43 submissions have been received and staff are currently undertaking an analysis phase to finalize the approach to negotiations of the Multi-Sectoral Accountability Agreements (M-SAAs) that will take place in the fourth quarter.

To prepare service providers for the M-SAA negotiations, education sessions were held during November to provide an opportunity for staff and board members from all of our CSS, CHC, MH&A and CCAC to learn and ask questions about the template agreement and the negotiation process.

2.4 Aging at Home - Year 2

The WWLHIN released its \$2 million call for proposals for year two of its Aging at Home Strategy in August 2008. While the WWLHIN reaffirmed its interest from year one in the three focus areas of services for frail and complex seniors, supportive housing services, and seniors' health and wellness, it also took into account the direction of the MOHLTC to focus efforts on emergency department (ED) wait times and alternative level of care (ALC) pressures. For this reason, the WWLHIN made it an explicit requirement of all proponents to show how they would in a sustainable way relieve either ED wait-times or ALC pressures in Waterloo Wellington. The WWLHIN has also extended this requirement to the planning initiatives it is currently funding through year one of its Aging at Home Strategy, for which about \$2.5 million (of the total new increment of \$4.5 million in 2009/10) has been reserved for allocation in March/April 2009.

During October and November, staff assessed the 26 qualified proposals that were received. While the review process is ongoing, the WWLHIN has now begun to focus its attention on proposals that align with the planned destinations for ALC patients in acute care beds. The WWLHIN is currently gathering additional information/seeking clarification from these proponents, or assessing the responses to its queries.

2.5 ED/ALC

The WWLHIN continues to work with our HSPs to improve wait times in our EDs and reduce the number of ALC patients in our acute care hospitals. Specific details are contained in the ED/ALC Overarching Plan which was provided to MOHLTC in mid-December. To accomplish our goals, we will continue to undertake a two pronged approach:

1. **Understanding the Problem** – focused on addressing data and coding issues, ongoing reporting of the disposition of each individual requiring alternative level of care in the community, and ongoing monitoring and analysis of key indicators such as ED wait times and wait times to LTC placement.
2. **Implementing Solutions to Enhance Healthcare System Effectiveness** – focused on identifying and implementing system solutions aimed at improving current services and flow between them as well as identifying and implementing new services which impact ED/ALC.

2.6 Youth Addictions Treatment Services

In September, funding was received from the MOHLTC to improve system capacity for residential youth addictions treatment services in the WWLHIN. The MOHLTC indicated the funding was to be directed towards two specific providers, Ray of Hope and Portage for the creation of approximately 16 new beds. The funding provided was based on an estimated rate of only a per bed cost and did not include the required services needed to support residential beds, such as case management, outreach and aftercare. Through investigation, we determined that without those elements, treatment will not be as successful and our investment will be eroded.

In October, an interim number of residential youth addictions treatment beds were implemented at both Ray of Hope and Portage. Following this decision, both organizations continued to work with the WWLHIN, and other providers and partners, such as local school boards, to create the foundation for an integrated youth addictions treatment program in the WWLHIN.

At the November meeting of the WWLHIN Board of Directors, the decision was made to invest, an additional \$811,000 of Urgent Priorities Funding on an ongoing basis, in the youth addictions treatment program. This was to supplement the \$1.7M in new funding provided by MOHLTC. The additional funds (from the MOHLTC and the WWLHIN Urgent Priorities Funding) were directed to an integrated youth addictions treatment program that will support 16 beds as well as community based programming. The program will provide services and support for 194 youths each year and implementation of the program is underway.

2.7 Clinical Optimization Review

The purpose of the Clinical Optimization Review is to examine the provision of existing acute care services and then to develop and implement an overall direction for the provision of acute care services in the WWLHIN.

The knowledge obtained through this review will enable the WWLHIN, together with its HSPs, to build an integrated acute care service system that will advance the strategic directions of the WWLHIN:

- Improve accessibility to health services
- Improve the health of the population
- Enhance system effectiveness
- Build a community capacity to achieve a sustainable health system

Members of the Clinical Optimization Review Steering Committee have agreed on the following vision for the project:

'The health of the people of Waterloo Wellington will be improved by access to patient centered innovative and sustainable acute care services well linked to a broader health service continuum'

The project is now initiating a process to engage a consultant to support the project and the Steering Committee and work has started on the first deliverable: identifying and describing all clinical programs provided by each hospital and by patient type (in-patient and out-patient).

2.8 Pharmacy Optimization Review

The purpose of the Pharmacy Optimization Review is to explore and develop an integrated model for pharmacy provision within the WWLHIN that enhances patient safety and outcomes, meets or exceeds best practices and standards, and attains efficiencies and economies of scale. The pharmacy review is led by St. Joseph's Health Centre, Guelph General Hospital and Grand River Hospital, Kitchener with support from a Steering Committee. The Committee agreed on its Terms of Reference and the goals and deliverables; it is currently in the process of setting up a work group that will develop an integrated pharmacy provision model. The Steering Committee plans to present a recommended model for pharmacy services to WWLHIN by May 2009.

2.9 Complex Continuing Care Optimization Review

In May 2008, following review and approval of all HSP proposed 2008/09 operating plans, St. Joseph's Health Centre was asked to co-lead with the WWLHIN a Complex Continuing Care (CCC) Optimization Review. The purpose of the CCC Optimization Review was to align hospital-based CCC services and their associated resources, by means of integration, to better reflect population needs, improve access, enhance patient safety, attain service consistency, and provide better coordinated and planned services in the future. All eight WWLHIN hospitals, the Waterloo Wellington CCAC are involved in this review, which began in June 2008. The WWLHIN is currently reviewing the report and confirming next steps.

2.10 Advancing Integration Initiatives

This quarter there was an opportunity to educate HSPs about the concept of integration at the Chair's Forum, and further information about this event is provided below in the Public Affairs and Community Engagement Section.

This quarter, a voluntary integration that was anticipated, in the form of a transfer of an ambulatory clinic that provides services to adults with Cystic Fibrosis between Grand River Hospital, Kitchener and St. Mary's General Hospital, Kitchener, has been postponed by the participants due difficulties in freeing up resources by one of the hospitals

The WWLHIN received a Health System Improvement Pre-Proposal (HSIP) from the Canadian Mental Health Association, Grand River Branch (CMHA - GRB) to inform about an intended merging between four self-help organizations in the Waterloo Wellington region. Earlier this year, the WWLHIN had liaised with the participants about this intended merger and had already had an initial meeting with the CMHA - GRB about what was put forth on the HSIP. The WWLHIN is now waiting for the approval of the proposed merger by the members of the four self-help organizations before moving forward with the next steps.

Another voluntary integration currently underway is between Joseph's Health Centre (SJHC), Guelph and Grand River Hospital (GRH), Kitchener and will result in GRH providing pharmacy services to SJHC.

The creation of the Emergency Mental Health Unit at Guelph General Hospital (GGH) is a partnership between three health service providers. During this quarter, the participants were in the final stages of the development of a Memorandum of Agreement and the required reconstruction work at GGH progresses well.

2.11 e Health

The MOHLTC continues to move forward with a provincial e-Health strategy in support of chronic disease management and the WWLHIN is actively engaged with this MOHLTC program in preparation for the implementation and adoption of provincial solutions such as the Diabetes Registry. To support the e-Health work of the WWLHIN, a project management office has been established.

To determine the preparedness of hospital and community HSPs, readiness assessments were undertaken during this quarter. Staff involved in this process included not only the e-Health team, but the planning, integration and community engagement staff, who took on a review questionnaires and surveys to provide the initial gap assessments.

The **HEALTHeCONNECTIONS** project has almost completed its Phase 1 planning stage, having completed an environmental scan, current state, future state and gap analysis. The project has made great progress in establishing a strategy for demonstrating enhanced health care services models for chronic disease management enabled by e-Health. Emphasis continues to will be on consumer e-Health solutions and personal health records. This project will be closely linked to the provincial e-Health strategy.

The WWLHIN is also continuing to make significant progress towards the advancement of its foundational e-Health projects:

- Deployment of ONEMail and ONENetwork to community-based health service providers.
 - 115 organizations/sites are registered for ONE Mail and are in various stages of implementation
 - Approximately 4700 new ONE Mail email addresses have been requested from the community
 - 33 sites are now “live”
- Implementation of HiNet electronic-Children’s Health Network (eCHN) across all hospitals for the creation of accessible health records for children.
 - 8 of the planned 8 sites have the eCHN viewer installed
 - 1 of the planned 7 ADT Hospital Interfaces installed
 - Completion of all but 57% the eHR and LAB interfaces is anticipated in the fourth quarter
- Continued Involvement of Guelph Family Health Team in Ontario Telemedicine Network’s telehomecare pilot project.

Architectural building block studies were completed and two reports presented findings about:

- Hospital IT Integration Architecture
- Continuing Care IT Integration Architecture
- Information from these studies is being used in both the MOHLTC and HealthConnections initiatives.

2.12 Public Affairs and Community Engagement

Board of Directors Relations

As noted in the integration section above, the WWLHIN hosted its annual Chair’s Forum during this quarter. Those in attendance included Board members and senior administrators from a strong cross-section of providers such as hospitals, CCAC, long-term care homes and community agencies. The topic of this year’s forum was “What is Integration?” This event was planned in conjunction with governance leaders from HSPs and along with presentations by staff about integration a local HSP that had undertaken a merger of four organizations shared their recent experience with attendees. As part of the event’s activities, we gathered input from our partners on how we can work together to successfully implement integration models that support the organizations in their efforts to provide quality programs and services.

Government Relations Activities

The WWLHIN continues to foster relationships with government officials at both the municipal and provincial levels. During this quarter, one-on-one meetings were held with Guelph Mayor Karen Farbridge and Waterloo Mayor Brenda Halloran.

In addition, we met with newly appointed County of Wellington Warden Joanne Ross–Zuj. This meeting was to educate Warden Ross-Zuj about the capital approval process as it relates to a potential hospital building project in Fergus (Groves Memorial Hospital). There has been some misunderstanding of the approval status of a potential hospital building project for this area. We will continue to work with the hospital's senior leaders and municipal elected officials to clearly articulate the status of the project.

On Friday, December 5, the WWLHIN in partnership with MPPs John Milloy, Leeanna Pendergast and Liz Sandals held news conferences in both Kitchener and Guelph to announce funding for youth addictions treatment programs at Ray of Hope (Kitchener) and Portage (Elora). Both of the news conferences were well attended and received positive coverage in media outlets across the WWLHIN area.

Media Relations

The WWLHIN is pro-active in its efforts to work with media across the area to generate positive news stories and respond in a timely manner to media requests.

On November 14, an Editorial Board Meeting was held with the Cambridge Times.

We are also working closer with our health service providers to promote their activities. Specific joint media activities led by the WWLHIN this past quarter include working with Guelph General Hospital, Ray of Hope, Portage, and the Aging at Home initiatives, including Parish Nursing and Make Yourself at Home.

It has been a busy period working with the local media to bring understanding to the hospital budgeting process. To this end, we also worked with the eight hospitals in the WWLHIN to develop high-level key messages around the budget process.

In November, we introduced a new activity, to further communicate the Board of Directors activities to the media as well as other external partners. A Board Highlights document will be produced after each Board meeting to outline topics discussed and decisions made at the open meetings. The document is sent via e-mail to media, health service providers, MPs, MPPs, and Community Council members. This document is also posted on the WWLHIN's website.

Web site Revitalization

In November, LHIN communication staff undertook the development of a plan to revitalize the WWLHIN Web site (www.wwlhin.on.ca).

The revitalized site will work within the visual identity guidelines that were approved by MOHLTC/MGCS and developed in conjunctions with the LHIN Provincial Communicators' Network. The improvements will focus primarily on content and structural matters. The key objective of this project is improved information sharing with two key target audiences – the general public and local health service providers. Additionally, it will involve the more effective use of available Web technology, an improved system of site navigation and content structure and adhere to industry “best practice” standards for electronic communications. The launch of the revitalized site is planned for Q4.

2.13 Health System Performance Summary

WWLHIN Performance Dashboard Third Quarter 2008/09

Performance Indicator	Indicator Type	Provincial Target	LHIN Starting Point	LHIN Performance Target - 2008/09	Projected Performance Target	Performance Corridor - Higher Value	Performance Corridor - Lower Value	Actual Performance	WWLHIN Risk Assessment
90th Percentile Wait Times for Cancer Surgery ¹	Access	84 Days	57.00	50.00	53.50	58.85	48.15	72.00	Monitor
90th Percentile Wait Times for Cardiac By-Pass Procedures ¹	Access	182 Days	40.00	40.00	40.00	44.00	36.00	24.00	Doing Well
90th Percentile Wait Times for Cataract Surgery ¹	Access	182 Days	95.00	95.00	95.00	104.50	85.50	77.00	Doing Well
90th Percentile Wait Times for Hip Replacement ¹	Access	182 Days	189.00	182.00	185.50	204.05	166.95	98.00	Doing Well
90th Percentile Wait Times for Knee Replacement ¹	Access	182 Days	205.00	182.00	193.50	212.85	174.15	100.00	Doing Well
90th Percentile Wait Times for Diagnostic MRI Scan ¹	Access	28 Days	140.00	60.00	100.00	125.00	75.00	69.00	Attention Required
90th Percentile Wait Times for Diagnostic CT Scan ¹	Access	28 Days	48.00	28.00	38.00	47.50	28.50	22.00	Doing Well
Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC) ²	Integration	290.76 per 100,000	276.00	276.00	276.00	303.60	248.40	-	-
Median Wait Time to Long-Term Care Home Placement -All Placements ³	Integration	50 Days	87.00	74.00	80.50	100.63	60.38	102.00	Attention Required
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution ²	Integration	9.46%	13.00	11.20	12.10	13.31	10.89	-	-
Rate of Emergency Department Visits that could be Managed Elsewhere ²	Integration	11.79 per 1,000	17.99	15.00	16.49	18.14	14.84	-	-
Readmission Rates for Acute Myocardial Infarction (AMI) ²	Quality	3.80%	3.11	3.10	3.11	3.88	2.33	-	-

¹ = Actual Performance Value is from Q2 2008/09 (Jul, Aug, & Sep 2008)

² = No data to facilitate analysis & reporting for this Quarter (Q2 2008/09)

³ = Actual Performance Value is from Q1 2008/09 (Apr, May, & Jun 2008)

Actual Performance colour assigned based on comparing:

Doing Well - Below Corridor & LHIN Starting Point

Improving - In Corridor & below LHIN Starting Point

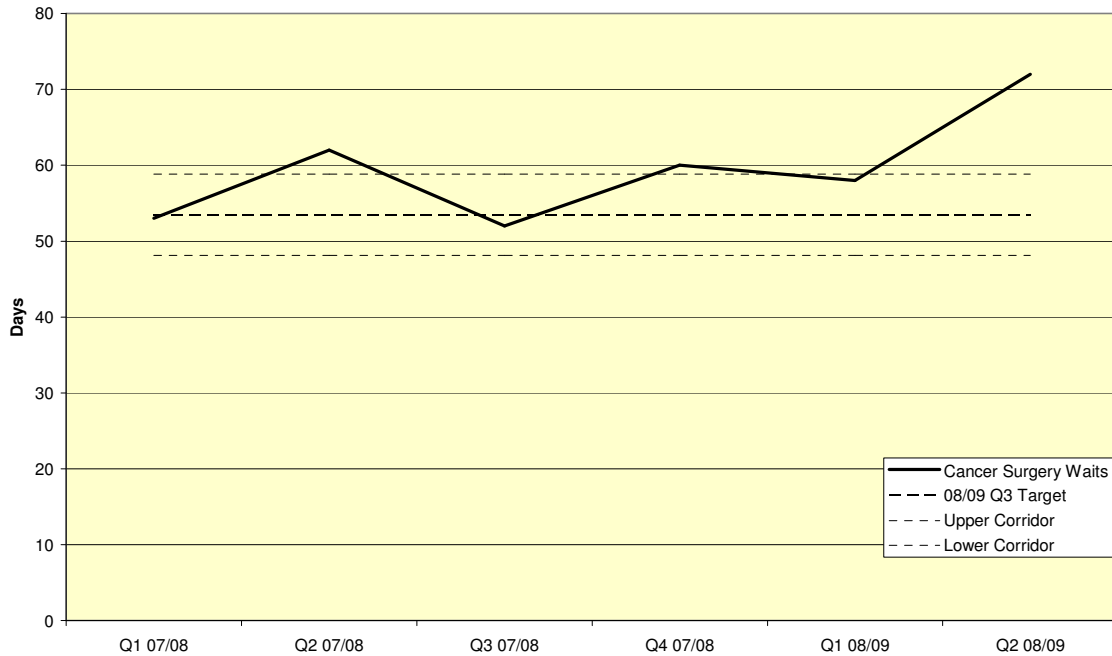
Monitor - In Corridor & above LHIN Starting Point

Attention - Above Corridor & above LHIN Starting Point

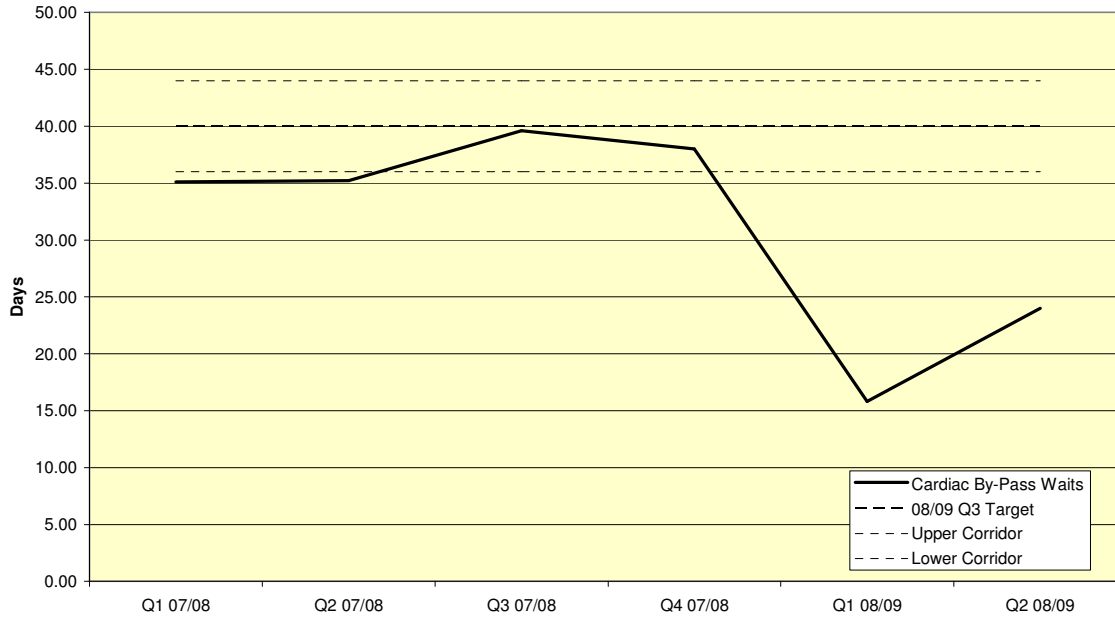
Improving Access

Performance Indicator	Indicator Type	Provincial Target	LHIN Starting Point	LHIN Performance Target - 2008/09	Projected Performance Target	Performance Corridor - Higher Value	Performance Corridor - Lower Value	Actual Performance	WWLHIN Risk Assessment
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90th Percentile Wait Times for Diagnostic MRI Scan ¹	Access	28 Days	140.00	60.00	100.00	125.00	75.00	69.00	Attention Required
90th Percentile Wait Times for Diagnostic CT Scan ¹	Access	28 Days	48.00	28.00	38.00	47.50	28.50	22.00	Doing Well

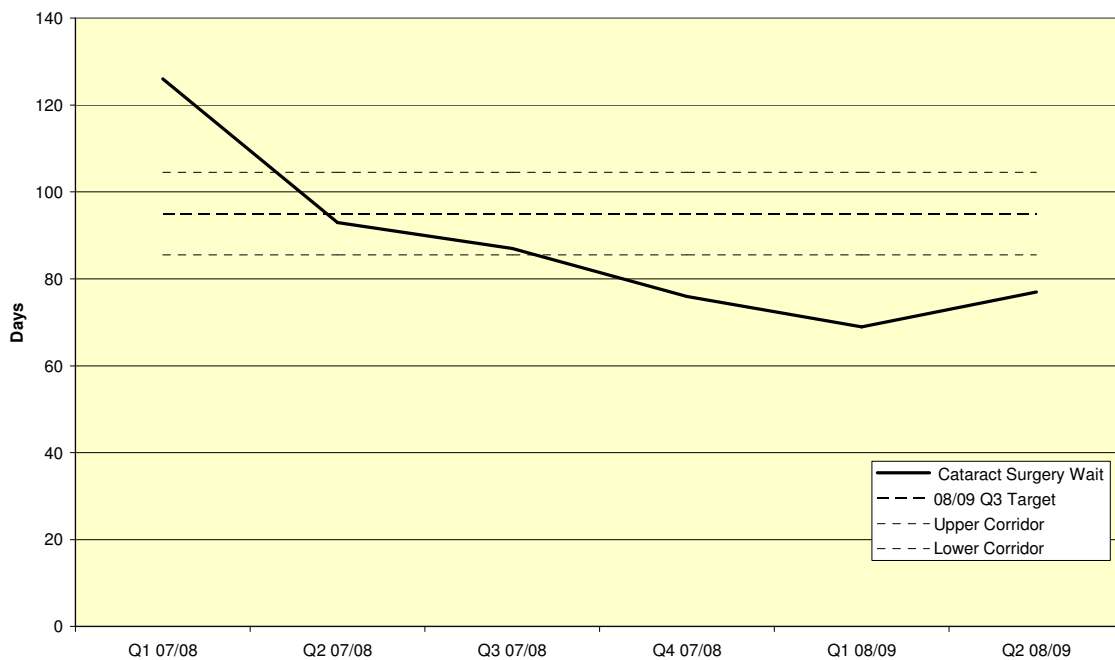
WWLHIN 90th Percentile Wait For Cancer Surgery



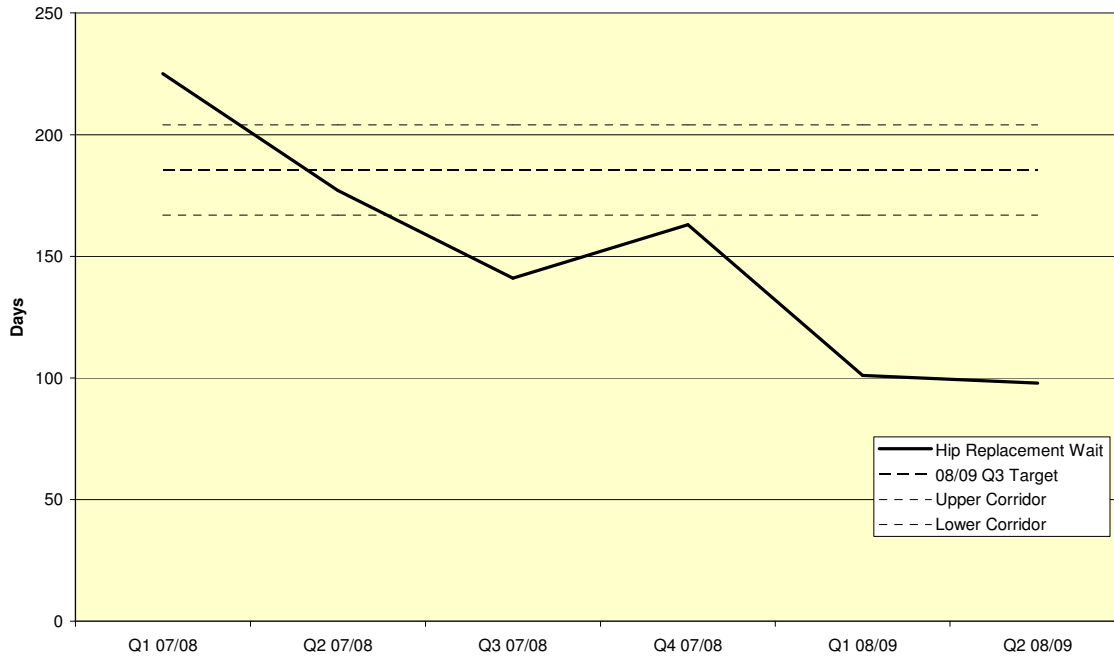
WWLHIN 90th Percentile Wait For Cardiac By-Pass Procedures



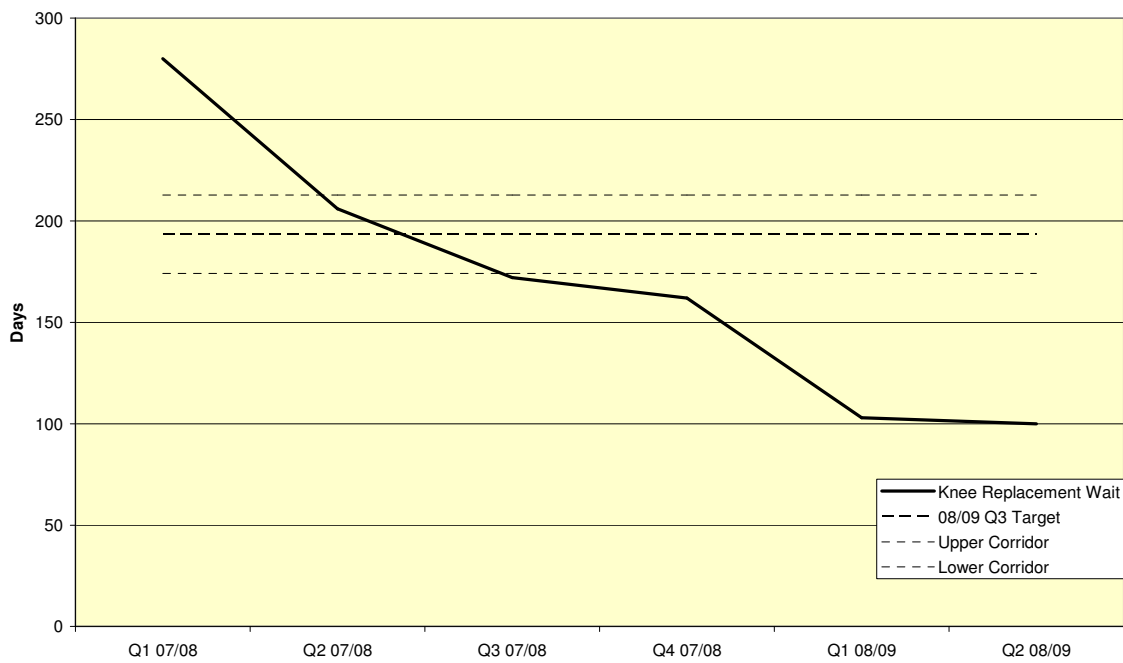
WWLHIN 90th Percentile Wait for Cataract Surgery



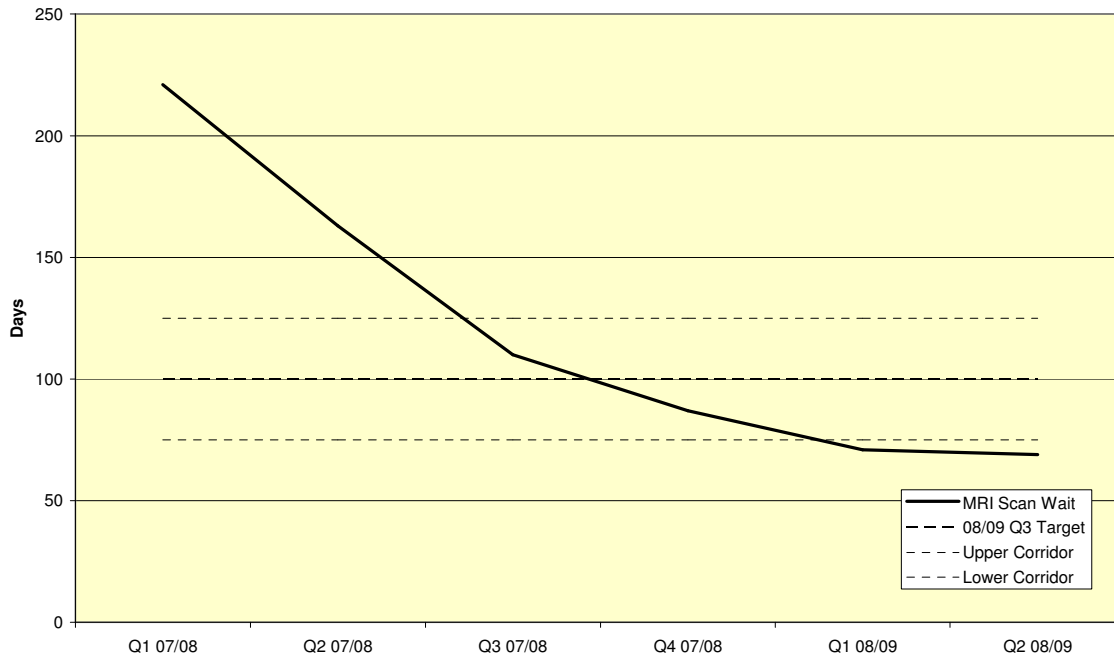
WWLHIN 90th Percentile Wait for Hip Replacement



WWLHIN 90th Percentile Wait for Knee Replacements



WWLHIN 90th Percentile Wait for MRI Scans



Performance results with respect to access to priority services continue to track well this quarter. The results meet or exceed year-end performance targets in each area with the exception of cancer wait times, for which a Variance Report is attached as Appendix 1. The escalation in the cancer wait time in this quarter has been determined to be a data capture error with a specific group of physicians not accurately coding the decision affecting readiness to treat (DARTs) for their patients. Protocols are in place through the Wait Times Data Group to distinguish between those patients who are truly waiting for a long time and those who patients who were coded in error. This work will ensure that a feedback mechanism is in place to advise physicians about data errors and correct the problem going forward.

Particular success was achieved with MRI wait times, and work continues to ensure that we are building upon this success by coordinating access to MRI services in our LHIN. We continue to assess this as an area of high risk for our community as the existing tools at our disposal can not add sufficient capacity to the system.

See Appendix 1: Risk Management Plan for Performance Indicators Where Variance Has Been Identified: Cancer Surgery Wait Times.

Improving Quality

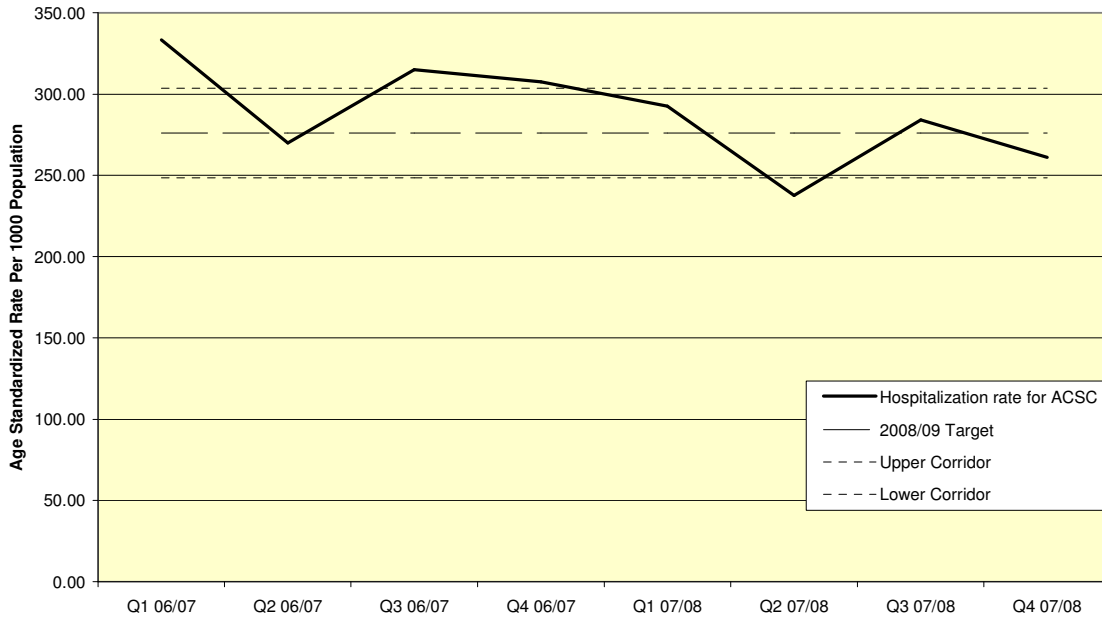
Performance Indicator	Indicator Type	Provincial Target	LHIN Starting Point	LHIN		Performance Corridor - Higher Value	Performance Corridor - Lower Value	Actual Performance	WWLHIN Risk Assessment
				Performance Target - 2008/09	Projected Performance Target				
Readmission Rates for Acute Myocardial Infarction (AMI) ²	Quality	3.80%	3.11	3.10	3.11	3.88	2.33	-	-

Refreshed data for this quarter are not available to support analysis of performance with respect to Readmission Rates for Acute Myocardial Infarction. Performance reported in the second quarter was tracking well at 3.11%.

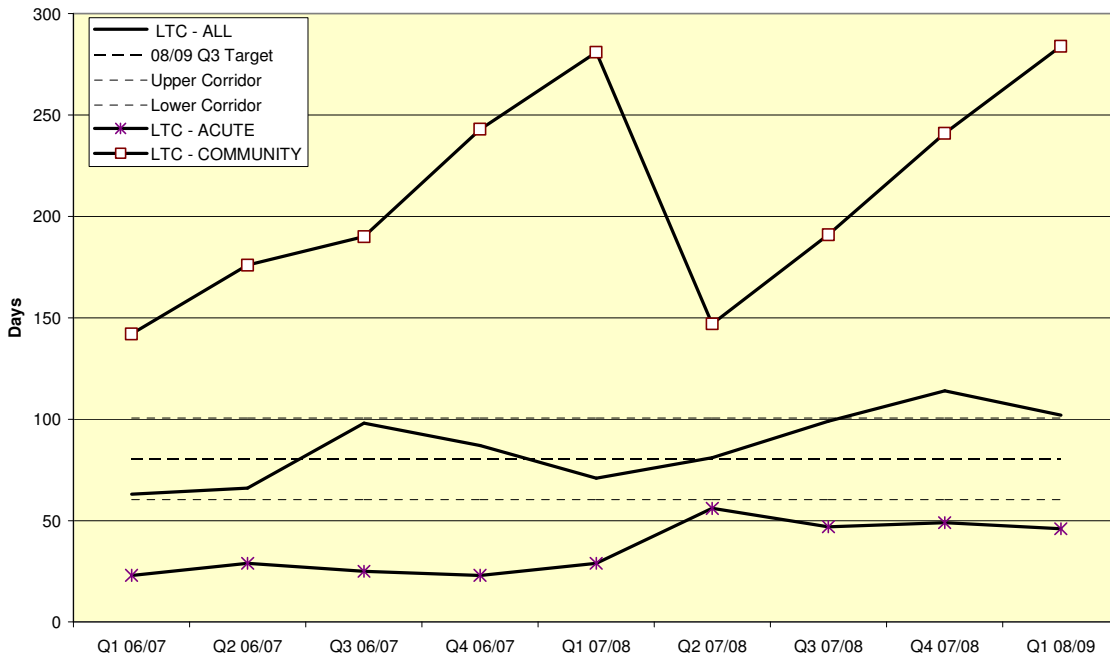
Improving Integration

Performance Indicator	Indicator Type	Provincial Target	LHIN Starting Point	LHIN		Performance Corridor - Higher Value	Performance Corridor - Lower Value	Actual Performance	WWLHIN Risk Assessment
				Performance Target - 2008/09	Projected Performance Target				
Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC) ²	Integration	290.76 per 100,000	276.00	276.00	276.00	303.60	248.40	-	-
Median Wait Time to Long-Term Care Home Placement -All Placements ³	Integration	50 Days	87.00	74.00	80.50	100.63	60.38	102.00	Attention Required
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution ²	Integration	9.46%	13.00	11.20	12.10	13.31	10.89	-	-
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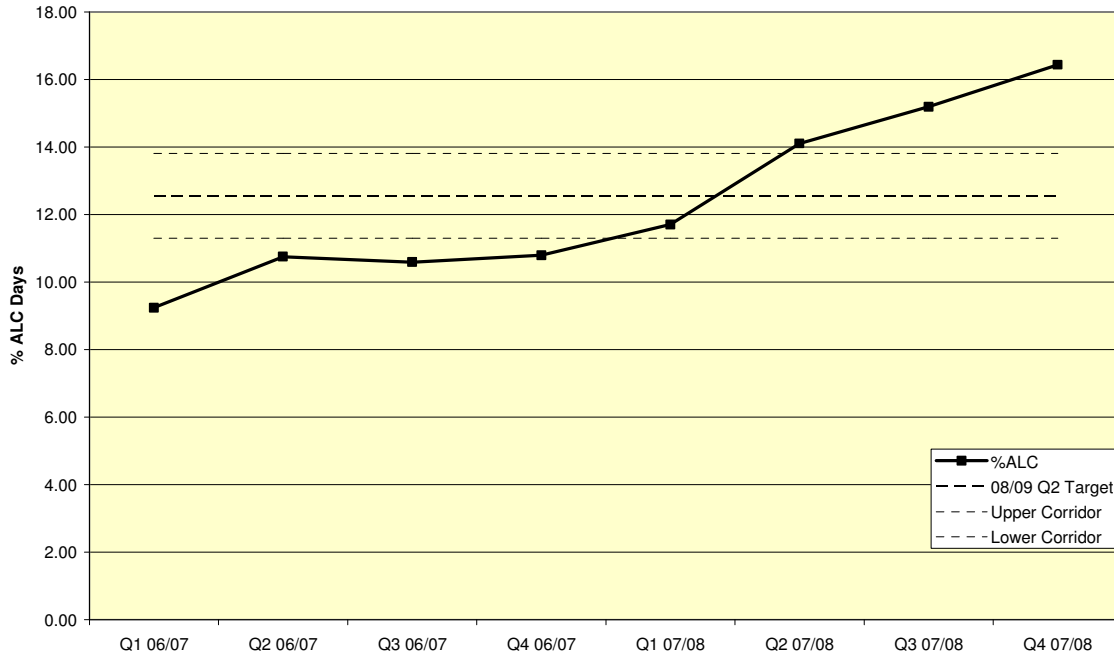
WWLHIN Hospitalization Rate for Ambulatory Care Sensitive Conditions Results as of Q2



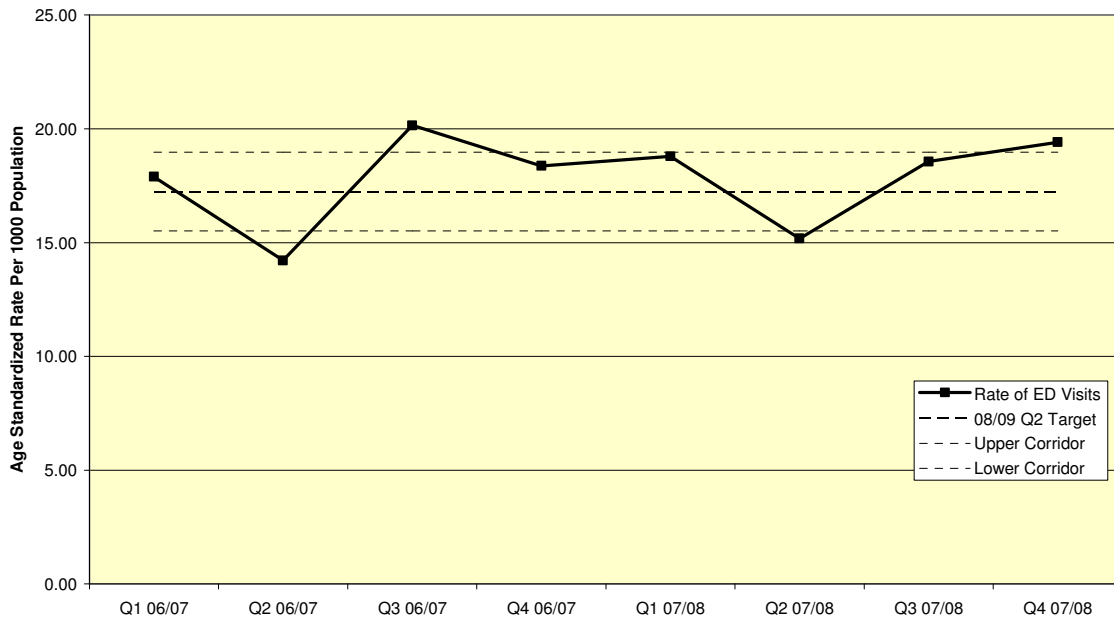
WWLHIN Median Wait For Long Term Care



WWLHIN Percentage Alternate Level of Care Days
Results as of Q2



WWLHIN Rate of Emergency Department Visits That Could Be Managed Elsewhere
Results as of Q2



Refreshed data are not available this quarter for most of the integration measures. Performance with respect to Hospitalization Rate for Ambulatory Care Sensitive Conditions has been historically consistent and was tracking well last quarter at 261.16 per 100,000 population. We continue to monitor through the EDRS our Rate of Emergency Department Visits that could be Managed Elsewhere, and to work with our providers to determine to what extent this reflects a true system pressure rather than a data challenge associated with Family Health Teams operating out of rural Emergency Departments.

The percentage of Alternate Level of Care Days and the Median Wait for Long-Term Care remain key priorities for the WWLHIN. Based on the last available data for Q2, the percentage of Alternate Level of Care Days in WWLHIN was continuing to rise at 16.43%. Information that has been collected directly from WWLHIN hospitals indicates ALC days continue to rise. The Q2 statistic captures data from March of 2008, which is too early of a data period to reflect the impact of many WWLHIN initiatives targeting performance in this area, including the Aging At Home investments, the 40 bed transition bed program, and the ED diversion initiatives underway.

The overall ALC strategy for WWLHIN is a two-pronged approach which addresses the data and coding challenges as well as implementation of system solutions, both of which are necessary in order to see change in this indicator. Through close collaboration between our hospitals and with the help of the Waterloo Wellington CCAC we have been able to build a complete picture of the true scope of the ALC challenge in our LHIN. This work provides the evidence base to support our investment and planning decisions. System solutions, existing, planned and proposed, can therefore be assessed in terms of their impact on this picture. Many of these solutions are already being implemented, including:

- 32 transition beds
- 8 over beds
- GEM nurses in Emergency Departments
- Complex Continuing Care Review
- Review of CCAC placement strategies
- Enhancing CCAC PSW funding targeting ALC patients
- 10 Hospice-level transition beds provided by Grand River Hospital
- Efforts to advance the operating dollars for a portion of the 288 LTC beds coming to Guelph in 2010, allowing for the operation of a portion of the beds at an existing interim location
- Enhancements to mental health services including mental health beds for rural patients and a partnership between Guelph General Hospital and Homewood Health Centre for emergency mental health service delivery
- Transition beds for palliative patients initiating a Community Service Lead position at the WWLHIN to ensure an effective community services system is in place to enable safe discharge of clients from hospital

Within the overall ALC strategy are specific initiatives targeting reduction in the Median Wait for Long Term Care. Key elements of these initiatives include identifying and supportive solutions that optimize the use of existing LTC beds, understanding the barriers to placement in LTC, and the implementation of preventative measures which delay the requirement for this level of care. Current performance for this indicator is at 102 days for all placements. A Variance Report is provided in Appendix 2 for this indicator.

See Appendix 2: Risk management Plan for Performance Indicators Where Variance Has Been Identified: **Median Wait for Long-Term Care.**

3.0 WWLHIN Quarterly Forecast by Sector

*See excel **Spreadsheet 1 - Attachment 2a** – WWLHIN (Q3) - 2008/09 – WWLHIN Quarterly Forecast by Sector Summary.*

4.0 WWLHIN Quarterly Balance Sheet Forecast

See excel *Spreadsheet 2 - WWLHIN (Q3) - 2008/09 – WWLHIN Quarterly Balance Sheet Forecast*.

5.0 WWLHIN Forecast Reallocation Table

*See excel **Spreadsheet 3 - Attachment 3a - WWLHIN (Q3) - 2008/09 –Forecast Reallocation Table – Reallocation between Sectors.***

6.0 WWLHIN Risk Summary

*See excel **Spreadsheet 4 - Attachment 5 - WWLHIN (Q3) - 2008/09 – Risk Summary Template.***

7.0 Report on WWLHIN Operations

*See excel **Spreadsheet 5 - WWLHIN (Q3) - 2008/09** –Report on LHIN Operations.*

8.0 Appendices

Appendix 1: Risk Management Plan for Performance Indicators Where Variance Has Been Identified: **Cancer Surgery Wait Times.**

Appendix 2: Risk Management Plan for Performance Indicators Where Variance Has Been Identified: **Median Wait for Long-Term Care.**

Appendix 1: Risk management Plan for Performance Indicators Where Variance Has Been Identified - Cancer Surgery Wait Times

The following template is to support the reporting of mitigation strategies and performance improvement plans for performance indicators in Tables A to D as set out in the MLAA Schedule 10: Local Health System Performance, where variance has been identified and until the variance is resolved.

For performance indicators where a variance has been identified, please provide the information in the Risk Summary Template (RST). Please use the following template to describe the Risk Management Plan portion of the RST (i.e. Column Y) associated with the performance indicators where a variance has been identified.

1: Performance Indicator; Insert reference number & risk title below (if more than one performance indicator is being reported on, please use a separate attachment for each).

Cancer Surgery Wait Time

2: Description of the Issue (please provide a brief background and/or context and/or particular challenges related to why a variance has been identified with this performance indicator)

Current Performance (Q2): 72 days

Q2 Target: 53.5

Upper Corridor: 58.85

08/09 YE Target: 50

Provincial Target: 84 days

Trend:

Q1 07/08 53

Q2 07/08 62

Q3 07/08 52

Q4 07/08 60

Q1 08/09 58

Q2 08/09 72

3: What are the mitigation strategies and performance improvement plans associated with the performance indicator where a variance has been identified (*Please provide a summary of the steps the LHIN is taking in managing this issue. In addition, please provide a summary of the steps that the health service providers are doing or could be doing to manage this issue. These should include a brief discussion of any resource implications, proposed resource reallocations as well as any operational and/or process changes that could address and resolve the variance*).

The Wait Time Working Group Lead, Dr Craig McFadyen, actively manages the open cases that are getting close to going over the provincial 84 day target through monthly data reviews and communications to all surgeons who have patients getting close to the target.

With most long waits, the general problem continues to be specialist physician offices not using the DARTs dates that patients were unavailable. Dr. McFadyen communicated this past month with a group of surgeons doing urological cancers who were not using the system to capture dates patients are not available. They anticipate this will improve the wait time results going forward.

Presently the open case management protocol is, for those cases going over 84 days, a letter is sent to the physician's office. The letter suggests different reasons for the long wait, related to the data, and asks for a response within 2 weeks. If it is a data issue, it is resolved usually in a couple days, if it is a clinical management issue Dr. McFadyen meets and deals with the physician directly.

With the focus on managing the open cases who are nearing the access target, closed cases with long waits that are subsequently discovered to be a data issue, are not at this time fixed. The data lead is assessing the impact these updates may make to the wait time rates overall and will be reporting next steps the WWLHIN shortly.

4: What will the LHIN monitor over the next three months to assess improvements to the performance indicator?

The focus of the program will have to shift to managing cases nearing the 50 day target. In addition, the problem surgical cases this past quarter were for cancer surgeries that were not part of the open case management initiative, they have been added.

The Wait Times Steering Committee is reviewing the monthly statistics.

Analysis

Current Performance (Q2): 72 days

Q2 Target: 53.5

Upper Corridor: 58.85

08/09 YE Target: 50

Provincial Target: 84 days

Trend:

Q1 07/08 53

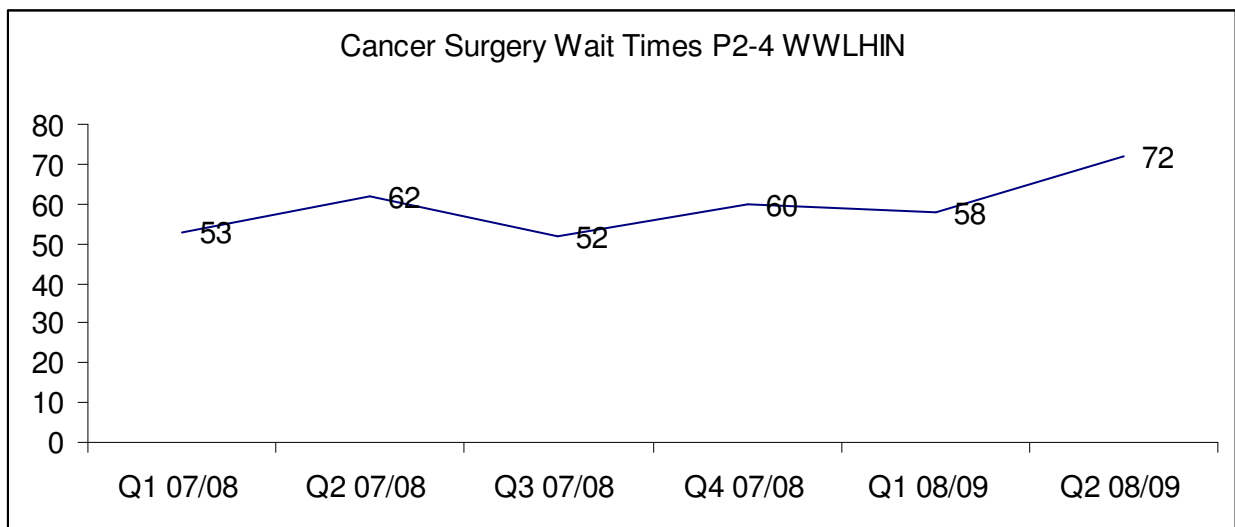
Q2 07/08 62

Q3 07/08 52

Q4 07/08 60

Q1 08/09 58

Q2 08/09 72



Cancer Surgery Volumes July 2007 – September 2008

July 07	155	July 08	156
Aug 07	153	Aug 08	122
Sept 07	178	Sept 08	169

Appendix 2: Risk management Plan for Performance Indicators Where Variance Has Been Identified - Median Wait for Long-Term Care

The following template is to support the reporting of mitigation strategies and performance improvement plans for performance indicators in Tables A to D as set out in the MLAA Schedule 10: Local Health System Performance, where variance has been identified and until the variance is resolved.

For performance indicators where a variance has been identified, please provide the information in the Risk Summary Template (RST). Please use the following template to describe the Risk Management Plan portion of the RST (i.e. Column Y) associated with the performance indicators where a variance has been identified.

1: Performance Indicator; Insert reference number & risk title below (if more than one performance indicator is being reported on, please use a separate attachment for each).

Median Wait to Long Term Care

2: Description of the Issue (please provide a brief background and/or context and/or particular challenges related to why a variance has been identified with this performance indicator)

The median wait for long term care for all placements has been steadily increasing over the past 4 quarters. The median wait for individuals waiting in an acute setting has stabilized over this time as a result of initiatives in WWLHIN to address the system wide pressures created by high ALC. The wait for individuals in the community has seen high variation over the same time period. There is a three-fold challenge in WWLHIN in that there is a shortage of LTC beds available (288 being added in 2009), the distribution by geography and type of bed does not match population need, and a shortage of services such as supportive housing has resulted in the available long term care beds being occupied in some cases by clients with long length of stay who would be better served elsewhere.

3: What are the mitigation strategies and performance improvement plans associated with the performance indicator where a variance has been identified (Please provide a summary of the steps the LHIN is taking in managing this issue. In addition, please provide a summary of the steps that the health service providers are doing or could be doing to manage this issue. These should include a brief discussion of any resource implications, proposed resource reallocations as well as any operational and/or process changes that could address and resolve the variance).

In response to the overall capacity challenge in WWLHIN, 288 beds will be opening in 2009. Current efforts remain focused on making the best use of a scarce resource, by mitigating demand side pressures and ensure that all resources in the system are appropriately utilized.

Several initiatives under Aging At Home are designed to help seniors age safely in the community and relieve demand for LTC. These include:

- Assisted Living for at Risk Frail Elderly
- Access to Care and Housing for Homeless
- Parish Nursing
- Connections for Health Aging
- Telehome Monitoring for Seniors
- In Home Primary Care Prevention and Monitoring for Seniors at Risk
- Sunnyside Supportive Housing
- Geriatric Emergency Medicine Nurses
- Hospice Waterloo Day Respite

Several initiatives with the WWCCAC are also underway. Discharge planning review between the WWCCAC and WWLHIN hospitals took place in Q2. Increased PSW hours and increased therapy hours in the community will begin in October.

Discussion with the MOHLTC and our long term care homes to explore options to put beds into abeyance and shift resources to areas of highest need is ongoing. We have also asked MOHLTC if operating dollars set aside for the LTC beds in Guelph can be advanced, as planned, for 2009/10 to support beds in an interim location. This request is important as implementation of the LTC beds has been delayed due to announcement and construction delays.

Transition beds (see ALC variance report) are providing more appropriate care than the acute setting while clients wait for LTC placement, and early results demonstrate that in some cases clients who had been destined for LTC have been able to return home.

4: What will the LHIN monitor over the next three months to assess improvements to the performance indicator?

WWLHIN is working with the WWCCAC to focus efforts and investment where the need is highest. We are tracking, as discrete measures, patients waiting in hospital beds (med/surg as well as rehab, palliative, complex continuing care), and in the community by priority level on a monthly basis. We will know we are successful with our current initiatives when the priority 1A1, 1A and 1B waits decline. Transition bed occupancy and outcomes are being assessed monthly by WWLHIN, WWCCAC and our hospitals, as are our ALC monthly reports.