

Waterloo Wellington LHIN

Quarterly Report (Q4)

January 1 to March 31, 2009

Final

March 31, 2009

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1.0 Introduction

As the fiscal year comes to a close, the Board and staff at the Waterloo Wellington LHIN (WWLHIN) are very proud of the year's accomplishments and are looking towards the new fiscal year (2009/10) to continue to make progress on the key provincial strategies and the priorities of the Integrated Health Services Plan (IHSP) 2007/08 to 2009/10. This is the final year of the first IHSP and staff will begin to the work to refresh the IHSP and confirm the priorities for the 2010/11 – 2012/13 IHSP.

Notable accomplishments this quarter include the successful negotiation of 45 service accountability agreements, completion of the WWLHIN's ER/ALC Overarching Plan along with the continued work to implement those plans, and the announcement of the Aging at Home initiatives for the second year of the strategy.

2.0 WWLHIN Local Health System Update

On March 26, 2009, the WWLHIN Board of Directors reviewed and approved a plan for the local health system for 2009/10 - 2011/12. Consistent with the WWLHIN draft Annual Service Plan, the Board's decision to approve the plan was intended to:

- Improve the coordination of and access to mental health services
- Improve access to emergency department services
- Increase ease of use of the health care system
- Improve access to primary care services
- Create a more transparent and accountable health system

The following principles were adopted to guide the decisions of the Board:

- Plan to the known allocation amounts
- Monitor and manage risk
- Ensure resources are spent in alignment with the Integrated Health Service Plan and the MLAA indicators
- Prioritize the use of resources for transformative initiatives, including those that leverage resources to transform the system
- Bind financial resources and performance
- Push service provision to be efficient/low cost/best model
- Create opportunities to buy the preferred future

The Board approved planned funding allocations for all 79 providers for 2009/10, as well as the planned service and performance obligations embodied in service accountability agreements with hospital and community providers.

The WWLHIN awaits confirmation by the Legislative Assembly of Ontario of funding allocations for the provision of health services in Waterloo Wellington in 2009/10.

2.1 Operational Review: Cambridge Memorial Hospital

On February 20th, the WWLHIN appointed an Operational Review Team for Cambridge Memorial Hospital. The Team's purpose is to conduct a comprehensive review leading to the development of a Hospital Improvement Plan that, upon implementation, will enable the hospital to continue to provide quality care and achieve a balanced operating position by March 31, 2010.

The hospital administrative team is currently predicting an in-year \$3.5 million deficit and a further deficit of up to \$3 million for 2009/10. The hospital's budget for 2008/09 is approximately \$103.4 million.

The Team Lead is Vickie Kaminski, Chief Executive Officer, Hôpital régional de Sudbury Regional Hospital (HRSRH). The core team also includes Sue Matthews, Vice President Patient Services and Chief Nursing Executive, Niagara Health System; Paul Temple, Principal of Front End Solutions (Waterloo) and; Ken Tremblay, President and Chief Executive Officer, Chatham-Kent Health Alliance. In accordance with the Terms of Reference for the Operational Review, the WWLHIN selected Kaminski, Temple and Tremblay as team members. The Hospital's nominee was Matthews. Additional expertise, including physician involvement, will be brought in as necessary to support the Review Team. A full report should be available in the first quarter of 2009/10.

2.2 Accountability Agreements: Hospitals

On February 27, 2009, the WWLHIN and Guelph General Hospital (GGH) signed a 2008 - 2010 Hospital Service Accountability Agreement (H-SAA). GGH had identified a projected in-year deficit of \$2.8 million, and a further \$3 million deficit projected for 2009/10.

To bring the Hospital into a balanced budget position by March 31, 2010, GGH worked with a Coaching Team between November 2008 and February 2009. The administrative team at GGH used both the Coaching Team recommendations and hospital staff suggestions to develop a plan to balance the budget, while supporting the continuation of quality care programs and services.

The Coaching Team was led by Andrew Williams, Chief Executive Officer of the Huron Perth Healthcare Alliance (HPHA), and other Team members included, Anne Campbell, Director of Corporate Planning, HPHA and Chris Eivers, Vice-President, Corporate Services, Brant Community Health Care System. The Team's report included recommendations related to governance, the medical staff and the organization as a whole.

WWLHIN and the Coaching Team were appreciative of the fact that the GGH Board members, management and staff were extremely cooperative while the Review was ongoing. The organization was very committed to the process and provided all that was needed to complete a successful Review.

2.3 Accountability Agreements: Community based services

The WWLHIN successfully negotiated 45 accountability agreements with its community providers, including the Community Care Access Centre, and all its Community Support Services agencies, Mental Health and Addictions providers, and Community Health Centres. The WWLHIN worked with health service providers to complete the required documentation to achieve an executable Multi-sectoral Service Accountability Agreement (M-SAA), but encountered delays from both providers and the Ministry in the Web Enabled Reporting System.

2.4 ED/ALC: Commitment to Action

The WWLHIN continues to make progress implementing initiatives identified in our ER/Alternative Level of Care (ALC) Overarching Strategy. Advancements in this work during the fourth quarter included:

- Hiring a ER/ALC Performance Lead to focus on implementing the ED/ALC Strategy with the goal of reaching performance targets
- Launch of ER Process Improvement Program (PIP) with WWLHIN hospitals
- Review of ER Pay for Results Year 1 (2008/09) and planning for Year 2 (2009/10)
- Expansion of Transition Beds from 32 in 2008/09 to 58 in 2009/10
- Approval of 3 Aging at Home initiatives for Year 2 (2009/10) were specifically selected to have a direct impact on ER/ALC pressures
- Ongoing efforts to “understand the ER/ALC challenge” by working with a Working Group focused on indicators and coding
- The inclusion of ER/ALC challenge as part of M-SAA negotiations
- The inclusion of ER/ALC indicators in M-SAA for the Waterloo Wellington CCAC

2.5 Aging at Home Year Two (2009/10)

The WWLHIN has completed the process of reviewing submissions received in response to its Call for Proposals, which was released in August 2008. At that time, \$2.0 million in new funding was reserved for proposals meant to address Emergency Department (ER) and/or Alternative Level of Care (ALC) pressures in Waterloo Wellington.

Proposals were accepted for three focus areas: (1) services for frail and complex seniors, (2) seniors supportive housing services, and (3) seniors health and wellness initiatives. The deadline for submission was September 30, 2008, and total of 30 eligible proposals were received by the deadline. The evaluation process took place between October 2008 and early January 2009. The process comprised the application of a series of evaluative screens, which were designed to assess proposals relative to WWLHIN Decision-making Criteria, proponent's organizational capacity, and cost/benefit, among other considerations. Finalist proposals were then assessed in a strategic context relative to their contribution to support integrated solutions to addressing ALC pressures in Waterloo Wellington. WWLHIN staff conducted the evaluation process and their recommendations were assessed by subject matter experts prior to presentation to the Board of Directors for review and approval.

Aging at Home - Approved Proposals:

The following proposals were advanced for recommendation and approved for funding in 2009/10 by the Board of Directors at the January 2009 meeting:

1. Specialized Long-Term Care Psychogeriatric Services: Pinehaven Nursing Home
Funding: 2009/10 \$458,195; 2010/11: \$425,615.
2. Waterloo Wellington Community Palliative Care Teams: Waterloo Wellington CCAC
Funding: 2009/10: \$699,341; 2010/11: \$765,463.
3. Overnight Weekday Respite Care: Sunnyside Home
Funding: 2009/10: \$355,734; 2010/11: \$367,704.

Aging at Home - Next Steps:

The WWLHIN has retained \$3.1 million in new funding for allocation purposes for Year Two (2009/10) of its Aging at Home Strategy. The WWLHIN is currently awaiting the results of planning initiatives it approved through Year 1 (2008/09) decisions for seniors supportive housing services, integrated seniors services, and a behavioural health program. Results from these initiatives are expected by March 31, 2009. Allocation decisions for the balance of Aging at Home Year Two (2009/10) are expected to be released in April 2009.

2.6 Notice of Voluntary Integration: Self Help Alliance-Canadian Mental Health Association

The WWLHIN received a notice of intended integration from the Canadian Mental Health Association Grand River Branch (CMHA-GRB) on February 17, 2009. In accordance with the *Local Health System Integration Act, 2006* (LHSIA), the WWLHIN recognized the need to respond within 60 days as to whether its Board intended to oppose or modify the proposed voluntary integration (as per Section 27 (4) of LHSIA). On March 26, 2009, the WWLHIN Board of Directors approved the voluntary integration of the Self-Help Alliance and the CMHA-GRB.

Background:

Four organizations provide self help and peer mental health services in the WWLHIN. These are the Waterloo Region Self Help for Psychiatric Consumer/Survivors (WRSH), the Cambridge Active Self Help Organization (CASH), the Mutual Aid with Psychiatric Survivors of Wellington and Dufferin incorporated (WDSH), and the Mood Disorders Association of Waterloo Region (MDA).

The four self help organizations have been working in partnership under an umbrella organization called the "Self Help Alliance" (SHA), and the four organizations have maintained their independent boards.

Over time, the four organizations have built a strong relationship with the CMHA-GRB. CASH, WDSH and MDA receive dedicated funding through CMHA, but only WRSH has signed an M-SAA with the WWLHIN for 2009/10-2010/11.

Currently, CMHA-GRB is responsible for the human resources (all of the staff of the Self Help Alliance are employed by CMHA-GRB), finance, and administration for all four organizations; the Self Help Alliance is responsible for planning and programs.

In 2007, the SHA decided to voluntarily amalgamate and during 2008, a joint work group was established to define an organizational model for a merged entity and to reconsider their partnership with CMHA-GRB. The outcome of the work group was a proposal to:

- merge the four self help organizations and create one consumer Board responsible for representing consumer issues to local planning tables and service organizations,
- retain the SHA staff employed by the CMHA-GRB,
- designate the CMHA-GRB Executive Director with the duties of the Executive Director for the SHA,
- hold CMHA-GRB accountable to the WWLHIN with regard to the funding for all four organizations.

At their Annual General Meeting in Fall 2008, the members of the self help groups agreed to proceed with their merger into the Self Help Alliance and, to that end, they drafted and approved a Memorandum of Understanding and a By Law. Taking these steps led to the issue of a notice of voluntary integration to the WWLHIN.

Next Steps:

The WWLHIN assessed the notice of intended integration against key criteria. These included alignment with and support to the WWLHIN's Integrated Health Service Plan, engagement of relevant communities in the process and in the proposed outcomes of the integration, contribution to strengthening mental health and addiction peer support in the WWLHIN, reduction in service or administrative duplication, service sustainability, risk management, including health human resources, and alternatives to integration.

2.6 Proposed Integration Initiatives: Cystic Fibrosis, Pharmacy Services

The WWLHIN continues to support the advancement of ideas and proposals that lead to a more coordinated, integrated, and sustainable system. St. Mary's General Hospital and Grand River Hospital continue to have discussions about the proposed transfer of a small Cystic Fibrosis program, but it is not expected that further development will occur on this integration until the second quarter of 2009/10.

The WWLHIN Regional Medication System project, which is lead by two hospital CEOs, is currently identifying integration opportunities in the overall provision of medication management. This project team has made significant progress in determining a WWLHIN-wide model. The next step will be to develop a business case for the preferred model to clearly articulate the benefits and the risks of the preferred model. The project Steering Committee is working closely with Ontario Buys/Ministry of Finance to obtain financial support for this initiative. The Steering Committee's recommendations are expected in the first quarter of 2009/10.

2.7 Planning and Capital Redevelopment

The WWLHIN continues to work with the Ministry and Health Service providers to align planning and service design activities with current and future infrastructure decisions.

A key project requiring ongoing attention is the Tier II divestment of mental health beds from London Health Sciences to Grand River Hospital. Risks include construction delays and health human resource challenges to support the operation of 50 Long-Term mental health beds.

It is expected that in the first quarter of 2009/10, Guelph General Hospital will open its Emergency Mental Health Unit. However, immediate clarity is required from the Ministry regarding the legal status for this project as Schedule One between Homewood and Guelph General Hospital.

In the fourth quarter, WWLHIN staff developed the conceptual framework for the implementation of the Integrated Health Service Plan for 2010-2013. Environmental scanning activities including the design of community engagement events are expected to begin in early Q1, 2009/10. The WWLHIN plans to actively engage specific populations, including, but not limited to Aboriginal and Francophone communities.

A new planning staff member joined the WWLHIN, and she is working to support access to, and analyze data, to inform design and transformation activities. In February, two WWLHIN staff participated in the Triple Aim Seminar in Scottsdale Arizona. As a result of this event, the WWLHIN is now part of a plan to collaborate with other LHINs and the Change Foundation; this activity will continue into 2009/10.

2.8 Clinical Optimization Review

The Clinical Optimization Review has entered its second phase after the creation of the vision for this 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”

In the second phase, the task groups will identify problems and barriers in the current provision of acute (clinical) care services and recommend integration opportunities and new service models.

WWLHIN-wide data collection and analysis is underway. All acute care facilities are actively involved with senior staff participating in this process. The Clinical Optimization Steering Committee has a planning session scheduled for April 24, 2009. At this meeting, the group will determine and agree upon priorities for WWLHIN-wide service planning. It is expected that the subgroup recommendations for the direction of acute care services will be completed in the third quarter of 2009/10. An early sub group has already been established based on the uniqueness of rural health.

Rural Health Working Group

In January 2009 a Rural Health Working group was established through the Clinical Optimization Review. The steering committee endorsed the recommendation to examine rural health models as a whole, including access to acute care services linked with the provision of primary care in a rural setting. The working group is chaired by Dr. Chris Rowley, Chief of Staff, North Wellington Health Alliance, and is comprised of local rural health experts from across the continuum of care (e.g., CCAC, Family Health Teams, acute care hospitals, long-term care and community services). To date four of five scheduled community consultations have taken place, and data collection and analysis is underway. On April 8, 2009, a half-day strategic planning session was scheduled to review the preliminary findings and commence the development of a vision. It is expected that this group will submit its report to the Clinical Optimization Steering Committee in June 2009.

2.9 Public Affairs and Community Engagement

Website Development

As reported in the third quarter report, the WWLHIN has refreshed its main website to provide an improved visitor experience. The website will continue to be a key vehicle for our LHIN to share current information in keeping with our commitment to transparency and public education on health care related issues and decisions taken by the WWLHIN Board of Directors.

In addition, the WWLHIN launched a new website titled Waterloo Wellington Partners in Health (www.wwpartersinhealth.ca) that highlights important partnership initiatives focused on developing an integrated and sustainable health care system for local residents. The website will be used to outline collaborative efforts to support a patient-focused health care system for all WWLHIN area residents.

Public Consultation

Active participation at community events, LHIN-initiated presentation opportunities and consultations are ongoing. The WWLHIN purposely seeks opportunities to connect with the various communities and decision-makers within our geographic boundaries.

The WWLHIN is currently seeking public input in identifying issues and opportunities related to the provision of health care to our rural population. This consultation process will provide important feedback in relation to the larger Clinical Optimization Review.

Public sessions were held in Harriston, Elora, Elmira and Ayr, with a 5th session planned for April 2009 in Rockwood. Sessions include both an educational component with presentations by the WWLHIN and local health service providers leading to an interactive session where participants provide their perspectives on the issues and opportunities that most affect or might provide benefit to them as rural residents.

Presentations

In our continuing efforts to involve and inform key officials within the WWLHIN, Kathy Durst, Board Chair, and Sandra Hanmer, CEO, conducted a series of presentations to municipal councils providing an update on activities and accomplishments in 2008/09. In addition, presentations to community-based organizations provide an opportunity to educate students and community-members on the LHIN model of health care, as well as current projects and accomplishments.

Presentations**January**

Municipal Council, Township of Centre Wellington (Elora),
Municipal Council, County of Wellington (Guelph)

February

Municipal Council, Township of North Dumfries (Cambridge)
Municipal Council, Township of Woolwich (Elmira)
Municipal Council, Waterloo Regional Council (Kitchener)
Municipal Council, City of Cambridge (Cambridge)
Municipal Council, City of Kitchener (Kitchener)
Kiwanis Club, Guelph
Ontario Long-Term Care Association (Winter Forum)

March

Municipal Council, Township of Wilmot (Baden)
Municipal Council, City of Waterloo (Waterloo)
University of Waterloo (Pharmacy 2nd year class)
Physician Recruitment Committee
St. Joseph's Health System (Hamilton)

Community-Based Events

Visibility at key local events provides an opportunity to reach community members who may not currently interact with the health care system, as well as to continually improve relationships with service providers operating within the WWLHIN.

Community-Organized Activities**February**

Passport Day – organized by the Wellington Geriatric Services Network: this inaugural event brought CSS providers together to identify opportunities for improved system navigation for the senior population of the WWLHIN. This provided an excellent opportunity to share information on Year 1 and 2 Aging at Home-funded initiatives.

March

Health & Wellness Expo – RIM Park, Waterloo: the largest consumer-oriented health and wellness event held in Waterloo Wellington each year, this show provides an opportunity for the WWLHIN to connect with “health-aware” members of the general public. It is an excellent

opportunity to provide information on the LHIN model of health care and current activities and accomplishments to a community that is wellness-oriented.

WWLHIN-Organized Activities

February

Presentation by Dr. Ben Chan, Ontario Health Quality Council: Members of the WWLHIN Long-Term Care provider community were invited to attend an information session at Parkwood Mennonite Home in Waterloo. The focus of Dr. Chan's presentation was the proposed Long-Term Care Quality Initiative and its relevance to local providers.

Government Relations

The WWLHIN continues to work with both municipal and provincial government leaders to advance the transformation of the local health care system. As mentioned previously, presentations to the 20 municipalities located within the WWLHIN area are underway. Regular updates are provided to all members of the Provincial Government regarding health care issues and items.

Media Relations

Media relations continues to be a major focus for the organization. Over the last quarter, regular meetings were held with both print and radio news organizations. The major items covered in the past quarter include the rural health public information sessions, completion of the Coaching Team report for Guelph General Hospital, and the appointment of an Operational Review Team for Cambridge Memorial Hospital.

2.10 e-Health

In the fourth quarter the Ministry announced the formation of a new provincial agency, **eHealth Ontario**. The new agency will play the leading role in harnessing information technology and innovation to improve patient care, safety and access in support of the government's health strategy.

eHealth Ontario's goal is to provide a single, harmonized, coherent province-wide eHealth Strategy and align it through a single point of accountability, and their work will enable and fulfill the government's strategic healthcare priorities.

In February, eHealth Ontario released Ontario's eHealth Strategy for consultation. The strategy focuses eHealth on three clinical priorities: Diabetes Management, Medication Management, and Wait Times.

The WWLHIN is well positioned to support these priorities. The **HEALTHeCONNECTIONS** project supports Diabetes Management. The project has progressed through Phase 1 Planning, and is about to move on to Phase 2 Implementation. Arrangements are being finalized with Canada Health Infoway, the province and the WWLHIN Board of Directors in the coming weeks. The project team has worked closely with Family Health Teams, Diabetes Education Centres, and area hospitals to complete Phase 1.

The WWLHIN continues to work with local health service providers to adopt eHealth solutions:

- To enable the transmission of personal health information the ONEMail implementation has connected health service providers with secure email
- The provincial Drug Profile Viewer is deployed to our hospitals
- The electronic-Children's Health Network (eCHN) integration with the hospitals is 90% complete
- The use of Telemedicine within the WWLHIN is gaining ground, resulting in the formation of a Telemedicine advancement working group
- The Guelph Family Health Team successfully completed a pilot project in support of telehomecare

The WWLHIN is committed to improving patient care, safety and access to services through the use of information technology and innovation.

2.12 Health System Performance Summary

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	51.75	56.93	46.58	47.00	2008-09 Target Exceeded
90th Percentile Wait Times for Cardiac Bypass Procedures ¹	Access	182 Days	40.00	40.00	40.00	44.00	36.00	35.00	2008-09 Target Exceeded
90th Percentile Wait Times for Cataract Surgery ¹	Access	182 Days	95.00	95.00	95.00	104.50	85.50	69.00	2008-09 Target Exceeded
90th Percentile Wait Times for Hip Replacement ¹	Access	182 Days	189.00	182.00	183.75	202.13	165.38	92.00	2008-09 Target Exceeded
90th Percentile Wait Times for Knee Replacement ¹	Access	182 Days	205.00	182.00	187.75	206.53	168.98	105.00	2008-09 Target Exceeded
90th Percentile Wait Times for Diagnostic MRI Scan ¹	Access	28 Days	140.00	60.00	80.00	100.00	60.00	61.00	Improving
90th Percentile Wait Times for Diagnostic CT Scan ¹	Access	28 Days	48.00	28.00	33.00	41.25	24.75	22.00	2008-09 Target Exceeded
Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC) ^{2,3}	Integration	290.76 per 100,000	276.00	276.00	276.00	303.60	248.40	232.55	2008-09 Target Exceeded
Median Wait Time to Long-Term Care Home Placement - All Placements ²	Integration	50 Days	87.00	74.00	77.25	96.56	57.94	114.00	Attention Required
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution ²	Integration	9.46%	13.00	11.20	11.65	12.82	10.49	16.40	Attention Required
Rate of Emergency Department Visits that could be Managed Elsewhere ^{2,3}	Integration	11.79 per 1,000	17.99	15.00	15.75	17.32	14.17	16.55	Improving
Readmission Rates for Acute Myocardial Infarction (AMI) ²	Quality	3.80%	3.11	3.10	3.10	3.88	2.33	2.95	Improving

Notes

- 1 = Actual Performance Value is from Q3 2008/09 (Oct, Nov, & Dec 2008)
 2 = Actual Performance Value is from Q2 2008/09 (Jul, Aug, & Sep 2008)
 3 = Actual Performance Value = (Actual Reported X 4)

Colour assigned based on comparing:

Doing Well - Below Corridor & LHIN Starting Point

Improving - In Corridor & Below LHIN Starting Point

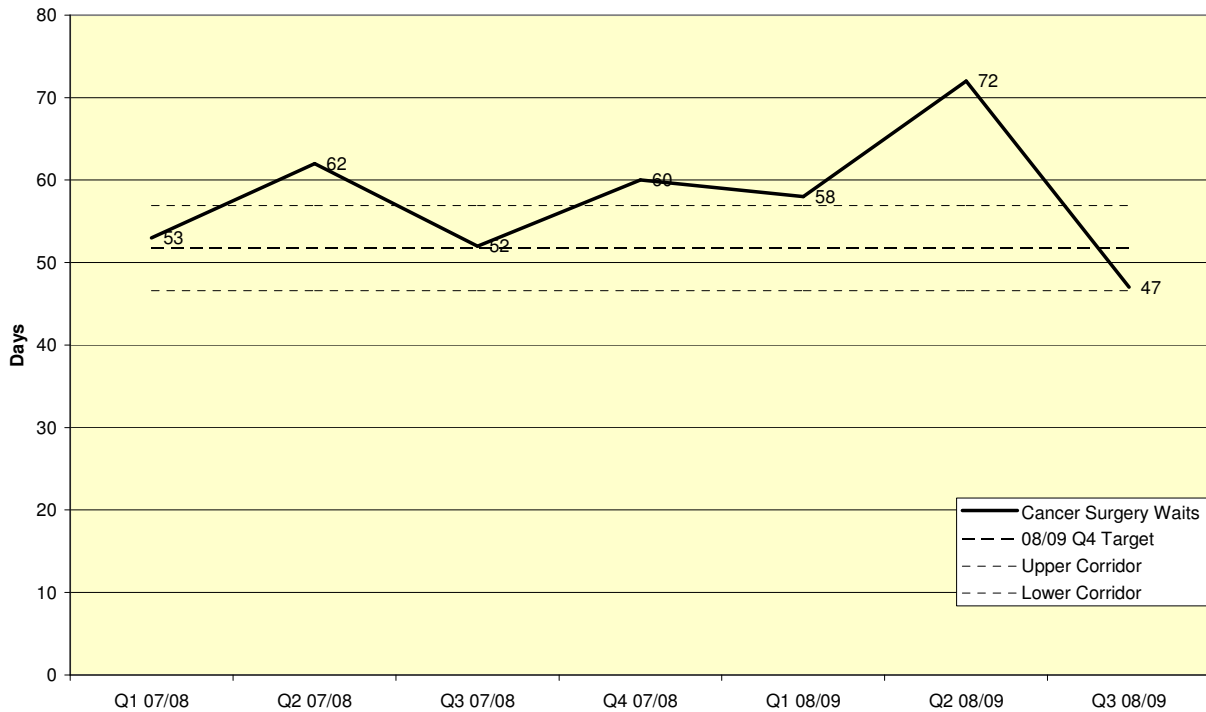
Monitor - In Corridor & above LHIN Starting Point

Attention - Above Corridor & above LHIN starting point

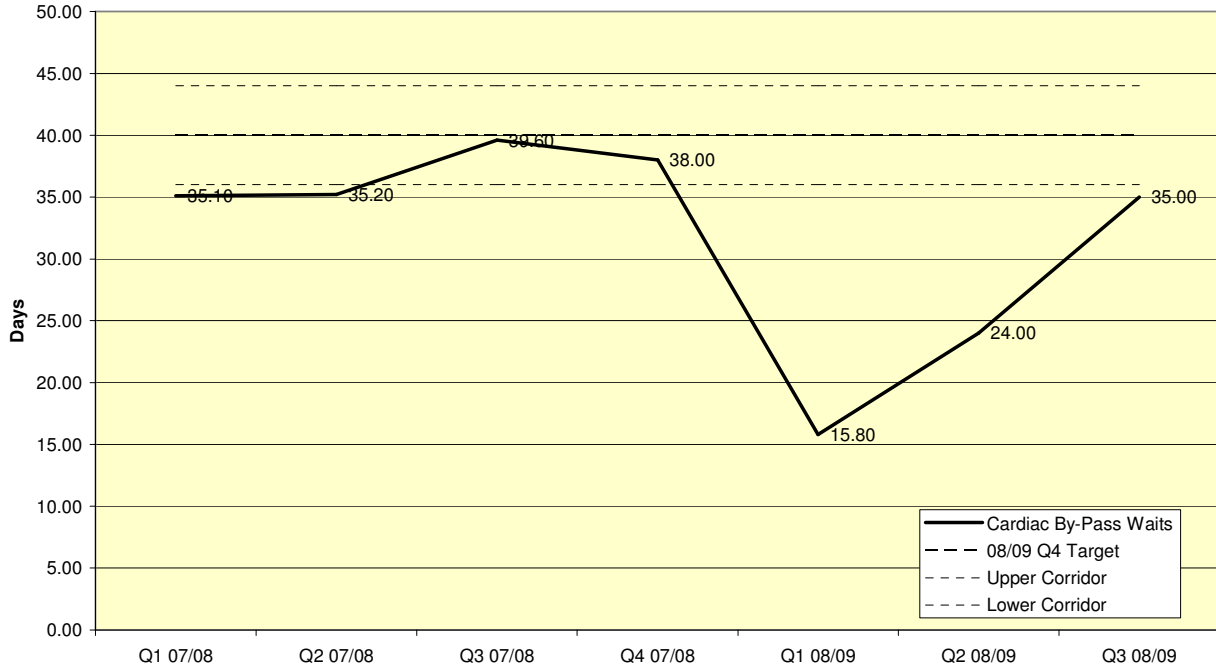
Improving Access

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	80.00	100.00	60.00	61.00	Improving
90th Percentile Wait Times for Diagnostic CT Scan ¹	Access	28 Days	48.00	28.00	33.00	41.25	24.75	22.00	2008-09 Target Exceeded

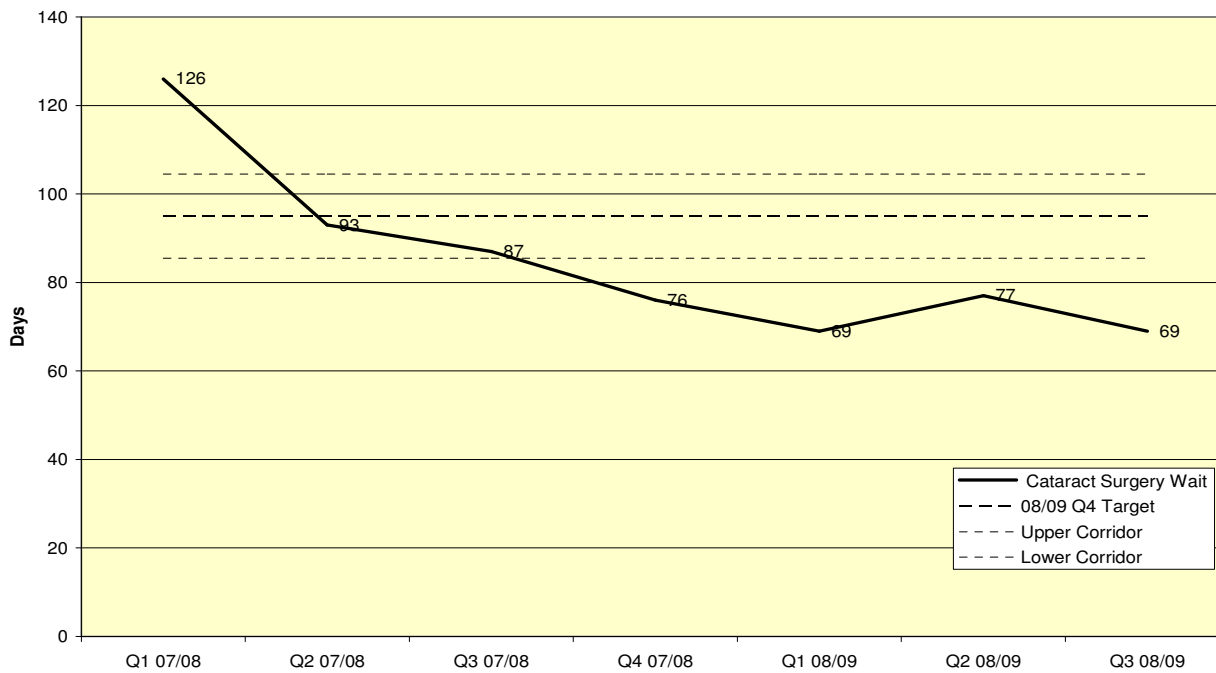
WWLHIN 90th Percentile Wait For Cancer Surgery



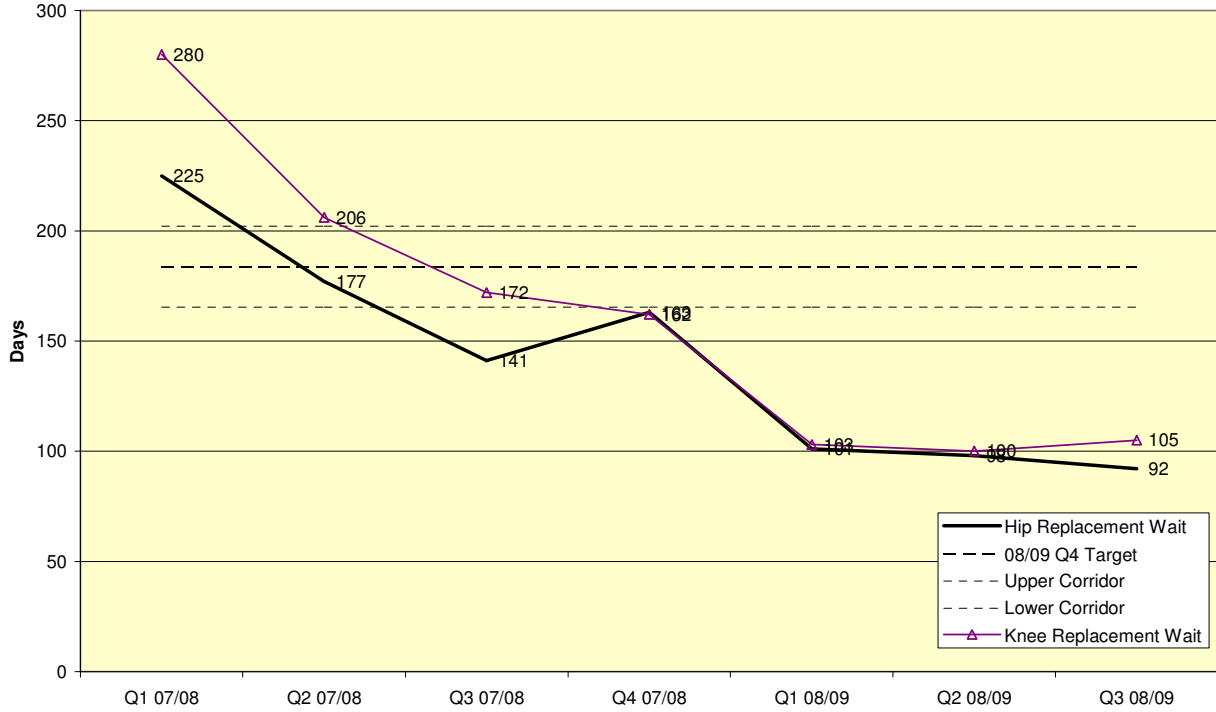
WWLHIN 90th Percentile Wait For Cardiac By-Pass Procedures



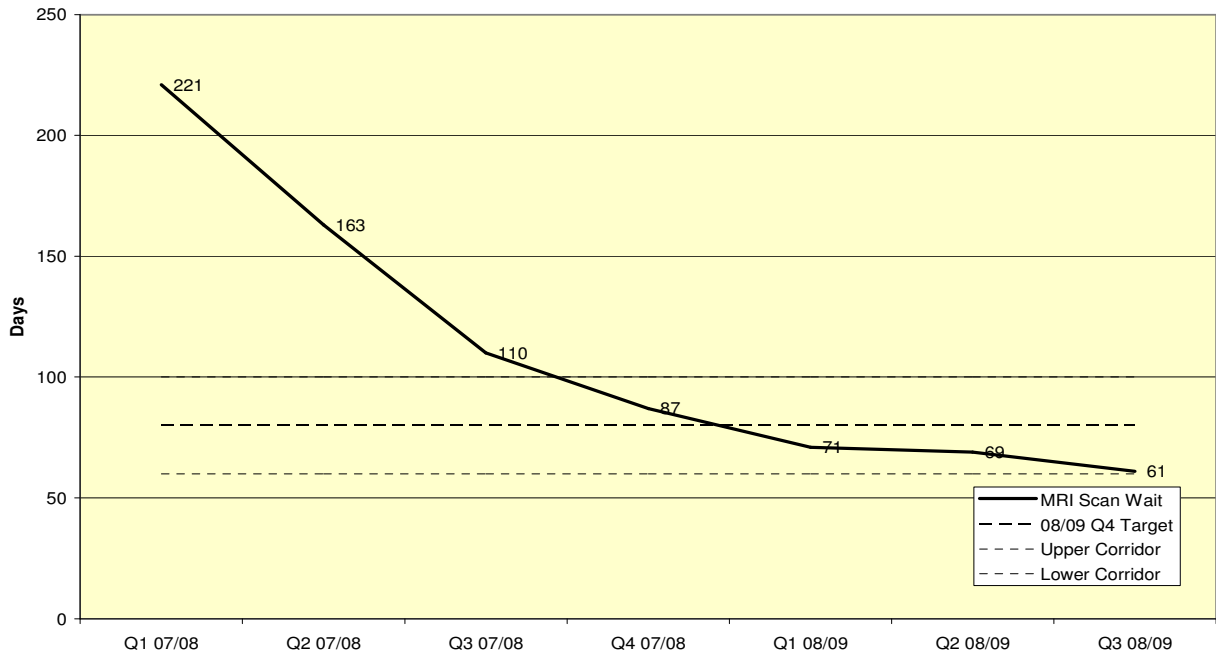
WWLHIN 90th Percentile Wait for Cataract Surgery



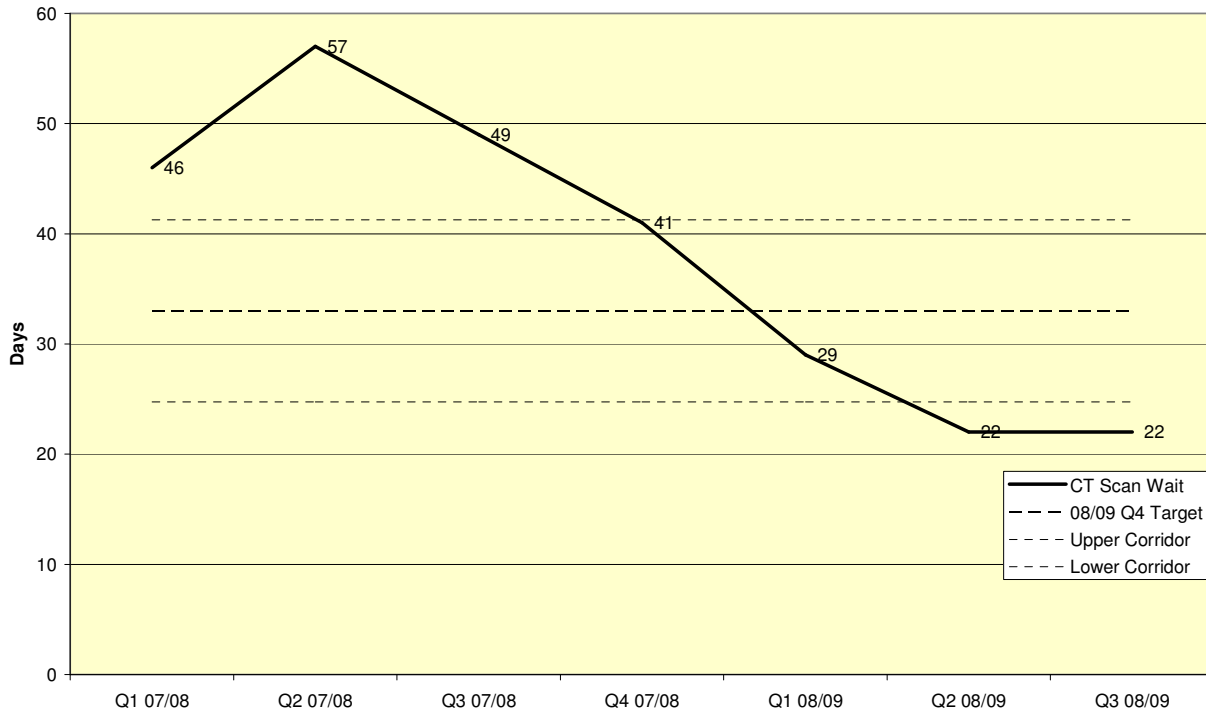
WWLHIN 90th Percentile Wait for Hip and Knee Replacement



WWLHIN 90th Percentile Wait for MRI Scans



WWLHIN 90th Percentile Wait for CT Scans



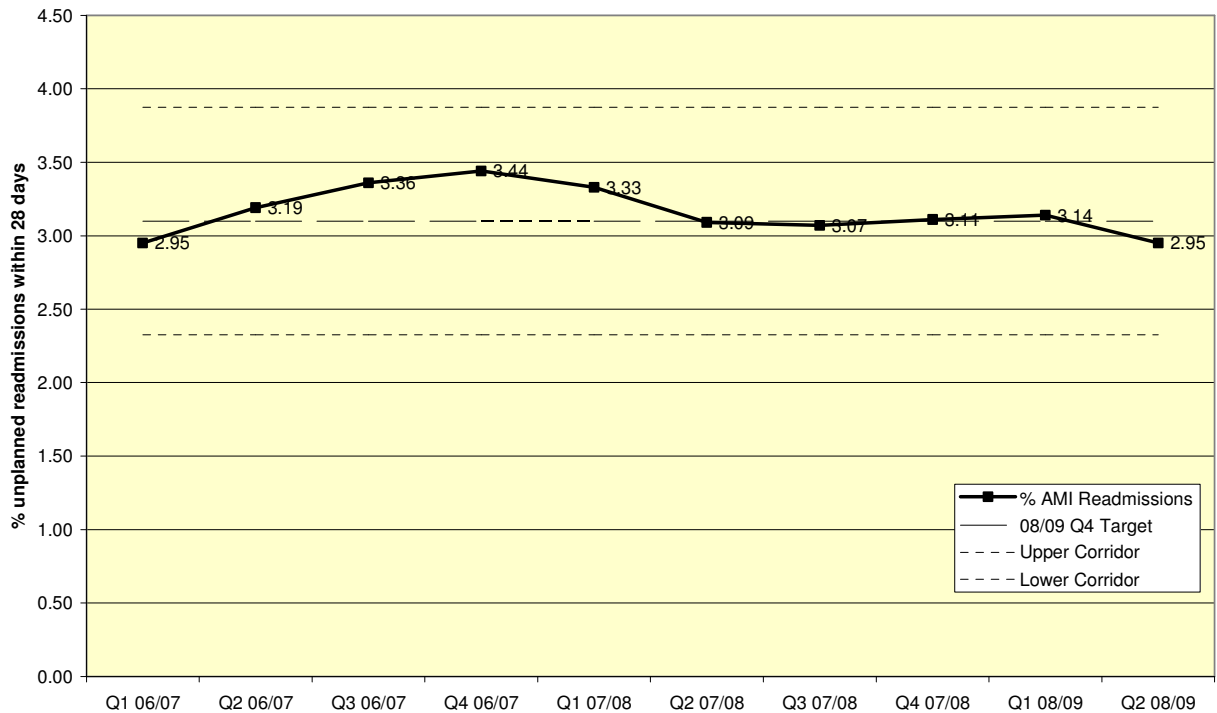
Performance results with respect to access to priority services continue to track well this quarter. All the results meet or exceed year-end performance targets in each area with the exception of MRI wait times, where the target of 60 days was missed by one day.

In 2009/10 the MRI target changes to 28 days in 2009/10. Despite having a coordinated management of wait lists between our two MRI hospitals and an upcoming upgrade of the MRI at Grand River hospital, we do not believe the capacity provided by our two MRIs is enough to achieve our 28 day target. Last year, we submitted a letter of support for the implementation of a new MRI at Cambridge Memorial Hospital. This implementation was supported by our WWLHIN Wait Times Steering Committee and all our acute care hospitals. We continue to support this proposal and Ministry consideration of our request.

We have also identified to the Wait Times Office an issue around the increase in wait for cardiac by-pass procedures. Cardiac programs have transitioned from the Cardiaccess program provided by the Cardiac Care Network to the Wait Times Information System. As a result, the ability to suspend a patient on the wait list is now eliminated unless it is due to patient preference. If the delay is for a clinical reason, such as a new infection, the wait time continues to be logged. We have identified this to the Wait Times Office and continue discussions on whether the appropriate resolution is a system modification, process change or a change to our target.

Improving Quality

WWLHIN Readmission Rate For Acute Myocardial Infarction

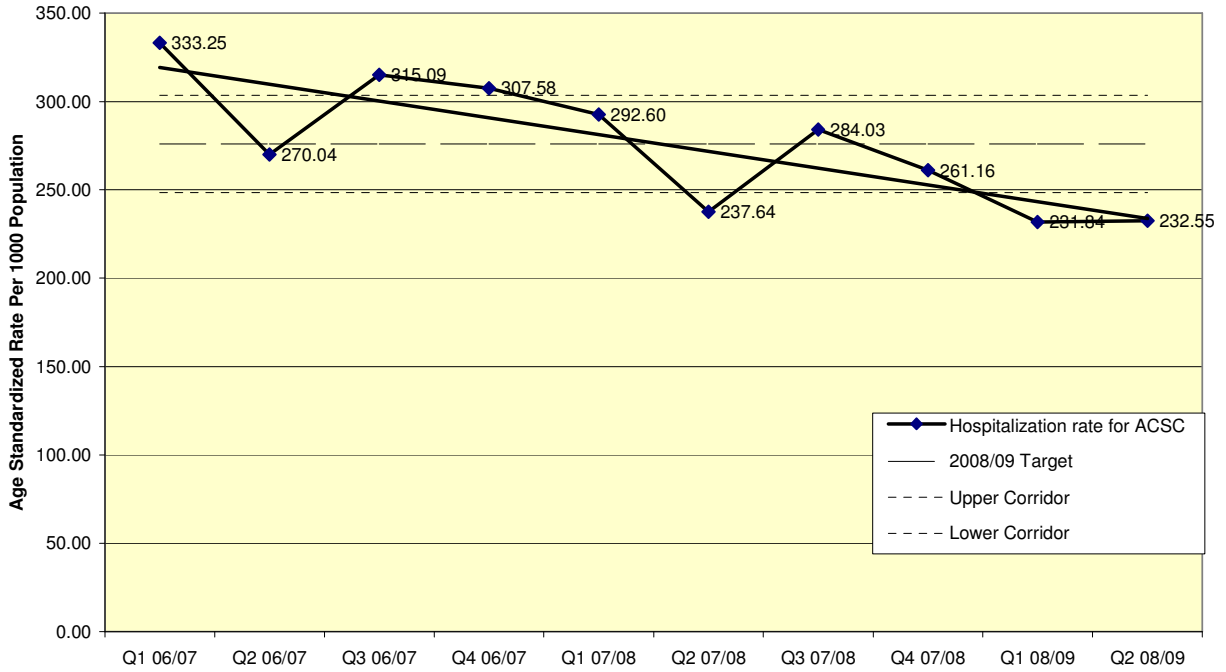


The one quality indicator on the MLAA scorecard is Readmission Rates for Acute Myocardial Infarction. The trend shows a consistent decline in the rate since early 2007/08. At a rate of 2.95 per 100 admissions, the WWLHIN has exceeded the target for 2008/09 of 3.10%.

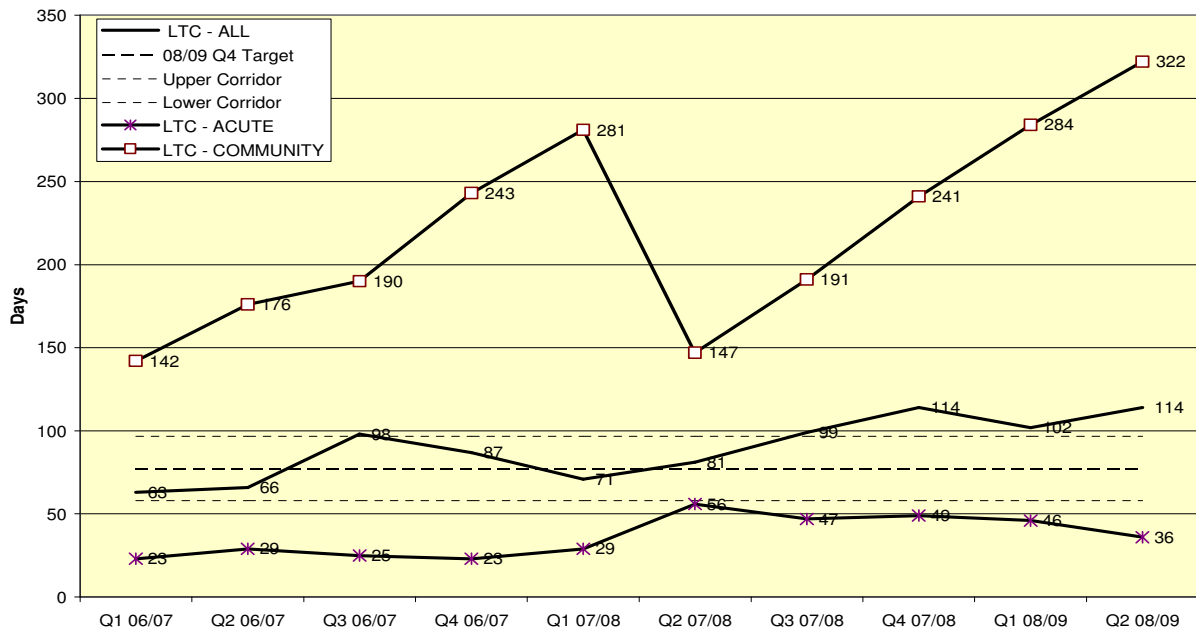
Improving Integration

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
Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC) ^{2 3}	Integration	290.76 per 100,000	276.00	276.00	276.00	303.60	248.40	232.55	2008-09 Target Exceeded
Median Wait Time to Long-Term Care Home Placement - All Placements ²	Integration	50 Days	87.00	74.00	77.25	96.56	57.94	114.00	Attention Required
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution ²	Integration	9.46%	13.00	11.20	11.65	12.82	10.49	16.40	Attention Required
Rate of Emergency Department Visits that could be Managed Elsewhere ^{2 3}	Integration	11.79 per 1,000	17.99	15.00	15.75	17.32	14.17	16.55	Improving
Readmission Rates for Acute Myocardial Infarction (AMI) ²	Quality	3.80%	3.11	3.10	3.10	3.88	2.33	2.95	Improving

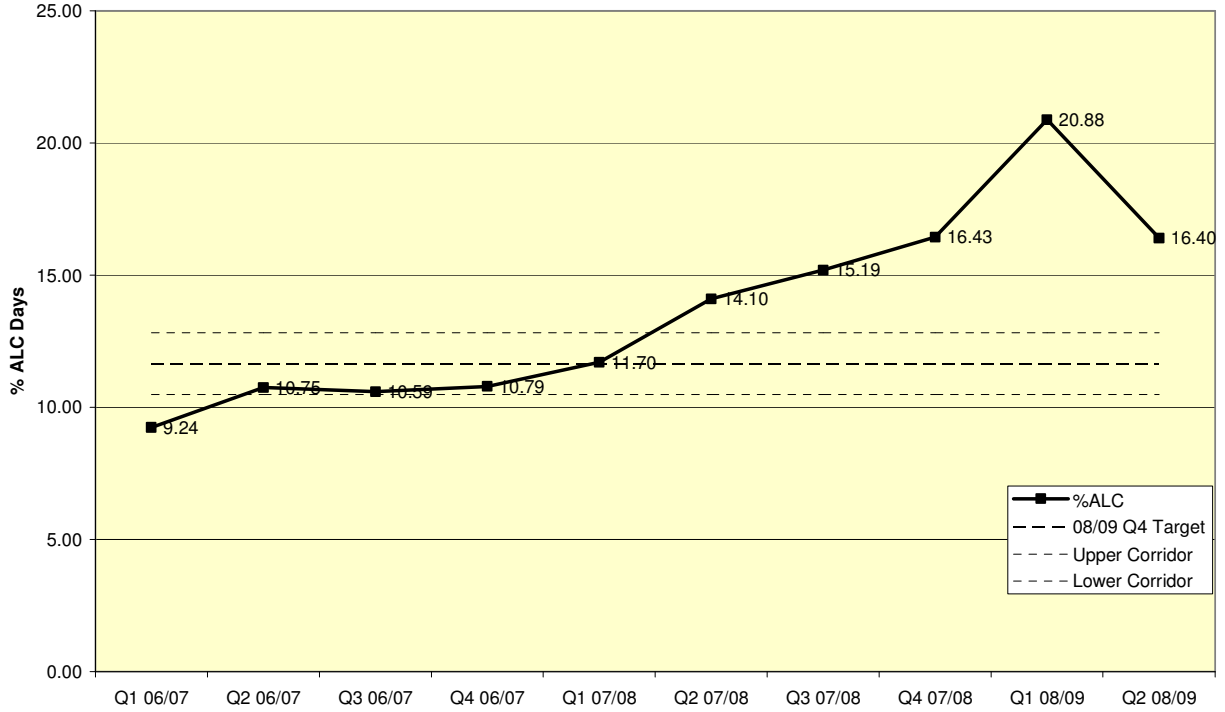
WWLHIN Hospitalization Rate for Ambulatory Care Sensitive Conditions



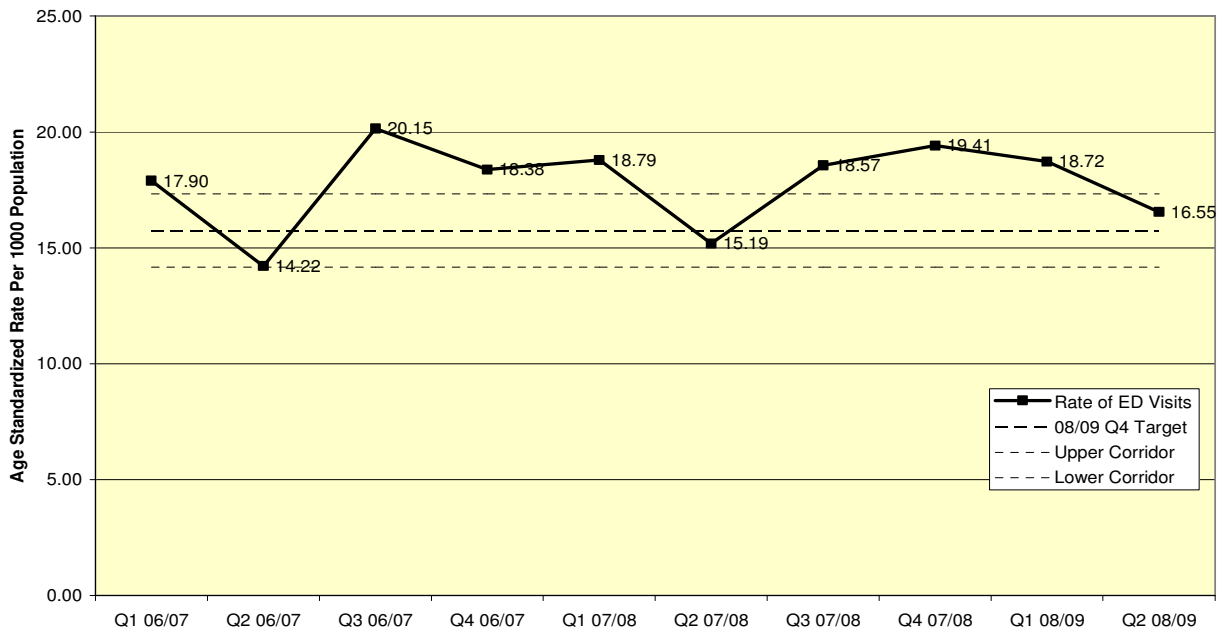
WWLHIN Median Wait For Long Term Care



WWLHIN Percentage Alternate Level of Care Days



WWLHIN Rate of Emergency Department Visits That Could Be Managed Elsewhere



The WWLHIN has exceeded the performance target with respect to Hospitalization Rate for Ambulatory Care Sensitive Conditions, and is within the performance corridor and below the starting point for Emergency Department Visits that could be Managed Elsewhere.

Implementing the strategy to address the percentage of Alternate Level of Care Days and the Median Wait Times for Long-Term Care remain key priorities for the WWLHIN. Actual performance data for Q2, 2008/09 shows the percentage of Alternate Level of Care Days in WWLHIN has declined from a high of 20.11% in Q1 2008/09 to 16.40% (At the time of reporting in Q3 this Q1 data was unavailable). The Q2 ALC decline likely demonstrates a seasonal decrease which is typical of previous years. Q3 and Q4 historically have seen increases in ALC, with factors such as outbreaks and seasonal illnesses affecting the results.

The WWLHIN monitors ALC numbers provided directly from the hospital on a more immediate basis. This information indicates that the ALC days increase in Q3 and Q4 with an apparent leveling off of that increase over this period. Although relatively early, this Q4 leveling off of the percentage of ALC days appears to reflect the impact of several WWLHIN initiatives targeting performance in this area, particularly including the Aging At Home investments, the WWLHIN Transition Program, and initiatives through Grand River Hospital's Pay for Results efforts.

Continued investment to address this indicator is supported in WWLHIN through the ED/ALC Overarching Plan. This work provides the evidence base to support our investment and planning decisions. System solutions – existing, planned and proposed – will be assessed in terms of their impact. Many of these solutions are already being implemented, including:

- 32 transition beds (expanding to 58 in 2009/10)
- 8 over beds (expanding to 9 in 2009/10)
- GEM nurses in Emergency Departments (doubling in 2009/10)
- Complex Continuing Care Review
- Review of CCAC placement strategies
- Enhancing CCAC PSW funding targeting ALC patients
- 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
- 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.

A Variance Report is provided in Appendix 1 for this indicator.

Within the overall ALC strategy are also specific initiatives targeting reduction in the Median Wait for Long-Term Care.

The wait time for long-term care beds in the WWLHIN continues to be a challenge. Key elements of initiatives to address the waits include identifying 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 1: *Risk management Plan for Performance Indicators Where Variance Has Been Identified: **Percentage of Alternate Level of Care (ALC) Days***

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

3.0 WWLHIN Risk Summary

See excel **Spreadsheet 1 - Attachment 5 - WWLHIN (Q4) - 2008/09 – Risk Summary Template.**

4.0 Appendices

Appendix 1 - Risk Management Plan for Performance, Indicators Where Variance Has Been Identified: **Percentage of ALC days.**

Appendix 2 - Risk Management Plan for Performance, Indicators Where Variance Has Been Identified: **ED Visits That Could Be Managed Elsewhere.**

Appendix 1: Risk Management Plan for Performance Indicators Where Variance Has Been Identified - Percentage of ALC days

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).

Percentage of ALC days

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 percentage of ALC days at Q2 2008/09 was 16.4 days. As has been shared in presentations to the Ministry, local monitoring of a proxy of this provincial indicator has also shown that since that date, the number has continued to rise but at a decreasing rate. Much of this rise can be attributed to a growing population accessing hospital services and limited availability of LTC beds. Limited availability of palliative care, supportive housing, complex continuing care, inpatient rehabilitation and other services also contribute to the growing ALC issue.

The more recent levelling off of ALC days is observed to coincide with the implementation of local system solutions including, but not limited to, Transition Beds, CCAC service enhancements, and ED improvements, including GEMs nurses. This is anticipated to be observed in the provincial indicator as data becomes available.

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*).

Actions underway and planned are outlined in the WWLHIN's ED/ALC Overarching Plan. These include:

- 58 transition beds (expansion from 32, effective April 1, 2009)
- 9 over beds (expansion from 8, effective April 1, 2009)
- Complex Continuing Care Review (completed in the fall of 2008; outcomes of this review and the implementation of the resulting recommendations will influence ALC)
- Supportive Housing Review (currently underway as an Aging at Home project; outcomes of this review and action on its recommendations will influence ALC)
- CCAC PSW funding (additional services launched October 2008)
- ED PIP launched across WWLHIN hospitals
- ED Pay for Results in Grand River Hospital Year 1 and expanded in Year 2
- Homewood mental health beds for rural hospitals
- Review of CCAC placement strategies currently underway
- Aging at Home initiatives
- Efforts to enhance understanding of the problem (local review of indicator, building consistency in coding across hospitals)

Our health service providers in all sectors have embraced the ALC issue and brought creative solutions to the WWLHIN for shared consideration.

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

The WWLHIN is monitoring the ALC numbers by hospital, including details regarding the planned destination of these patients. The wait lists for the ALC patient destinations are being monitored. Information made available through CIHI and EDRS will also be reviewed and monitored.

All projects initiated to influence ALC are monitored and evaluated to determine the impact on ALC and the efficacy of project continuation.

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 the 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 the 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 the 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
- 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?

The 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 (medical/surgical as well as rehabilitation, 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 the WWLHIN, WWCCAC and our hospitals, as are our ALC monthly reports.