London Health Sciences Centre

PRESIDENT AND CEO
REPORT TO THE BOARD AND COMMUNITY
APRIL 2016

PERFORMANCE EXCELLENCE

CANCER CARE ONTARIO --FOCAL TUMOUR ABLATION

In March 2015, Cancer Care Ontario released the *Focal Tumour Ablation in Ontario: Recommendations Report 2015*. The recommendations in the report outline the framework for delivery and organization of focal tumor ablation services with a focus on access, quality, and funding for Ontarians. The Report provides clinical and organizational guidance for clinicians and regional cancer programs to ensure patients have access to the highest quality services, tailored to their individual needs.

Cancer Care Ontario has asked each Regional Cancer Program to submit a Regional Focal Tumour Ablation Service Plan which outlines how and where patients in the region will access these services.

The South West Regional Cancer Program is working with physicians across the region to develop the Regional Focal Tumour Ablation Service Plan. A work team has been established that includes representation from interventional radiology, regional imaging, and surgery. The team is lead by Zahra Kassam (Regional Imaging Lead, South West Regional Cancer Program) and Amol Mujoomdar (Radiologist, LHSC).

LAUNCH OF ONTARIO PALLIATIVE CARE NETWORK (OPCN)

The launch of the Ontario Palliative Care Network on March 11 was attended by key representatives from the South West Regional Cancer Program and the South West LHIN, and signaled a new direction for palliative care in the province. The OPCN is a partnership of community stakeholders, health service providers and health systems planners who are developing a coordinated, standardized approach for delivering palliative care services in the province. It will work closely with the ministry to ensure its work supports and aligns with the Ministry of Health and Long-Term Care's *Patients First: A Roadmap to Strengthen Home and Community Care*, which highlights a commitment to improved access and equity in palliative and end-of-life care at home and in the community.

Currently, the OPCN is gathering information through surveys and environmental scans to support the formation of 14 Regional Palliative Care Programs. South West Regional Cancer Program staff are engaged in this work at both the leadership and the local collaborative tables in each sub region.

COLON CANCER AWARENESS MONTH

In March, Cancer Care Ontario launched a provincial campaign targeted specifically to men between the ages of 55-64. The campaign was entitled, "Call the Shots on Colon Cancer" and encouraged men to speak to their health care provider about colon cancer screening and the Fecal Occult Blood Test. Men were specifically targeted this year because they are less likely than women to speak to their doctor about screening. The age group identified was the age determined to have the most impact in terms of changing behaviour and finding relevant lesions through screening.
In the South West, two local men shared their experience on video:
Lou's Story: https://youtu.be/l8Y7ktsLPvY
Brian's Story: https://youtu.be/t7NH-7KyP9E

The stories were posted to the website, shared via social media, and housed on YouTube. Lou's story was also promoted at Woodstock Hospital, where he received his chemotherapy close to home.

A media release was distributed to local media outlets to promote the provincial campaign, as well as the My CancerIQ tool. Dr. Jan Owen, Regional Primary Care Lead and Kathy McGuire, colon cancer survivor and volunteer at LRCP, conducted an interview with CTV London: http://london.ctvnews.ca/video?clipId=833969

Posters advertising the campaign were distributed to hockey arenas throughout the region, seven public health units, and all regional hospital sites.

Melissa Beilhartz and Krista Feddes of the Southwest Regional Cancer team also hosted a booth at the London Knights game on March 4 to raise awareness of colon cancer screening. The team distributed information kits to over 500 visitors.

CANCER IN FIRST NATIONS IN ONTARIO - RISK FACTORS AND SCREENING

On April 1, Cancer Care Ontario and the Chiefs of Ontario released a new report to address the information gap associated with First Nations-specific health data. The report captures significant key findings in the categories of tobacco, alcohol, healthy eating, body weight and active living, and cancer screening. It also calls for a strategy to increase the availability of health data specific to First Nation populations in Ontario to effectively address chronic disease prevention priorities in this at-risk group. View the report:
https://www.cancercare.on.ca/firstnationsreport?utm_name=First%20Nations%20Report&utm_medium=Email&utm_source=Regional%20Comms&utm_term=na&utm_content=EN

SEVEN DAY MODEL FOR ALLIED HEALTH PILOT PROJECT—APRIL 1

This is a six month pilot that was generated as a result of an identified gap in the discharge planning process through the Admission and Discharge System Design (ADSD) project and is funded through Pay for Results. The aim is to enhance assessments and treatments over the weekend and decrease length of stay with consistent support from all Allied Health disciplines, including Clinical Nutrition, Occupational Therapy, Physiotherapy and Social Work. Additionally,

there is also nurse case manager support being provided seven days a week for the admitting Medicine Clinical Teaching Units (CTU) to facilitate discharge planning.

EXEMPLARY COMMUNITY PARTNERSHIPS

CONNECTING SOUTH WEST ONTARIO (CSWO) HITS NEW MILESTONES

The cSWO Program continues to rapidly deploy eHealth solutions that enable clinicians and health care professionals to securely access patient information to support the delivery of safe and timely care. Recent key achievements include:

- Over 1,000 clinicians now receive hospital reports directly into their electronic medical records (EMRs) through the provincial solution Hospital Report Manager (HRM) deployed by OntarioMD. This surpasses cSWO's target of 948 and delivery partners continue to deploy this solution to clinicians.
- The first hospital sites, outside of the Greater Toronto Area (GTA), contributing data to the Provincial Acute Clinical Data Repository (CDR), are from the cSWO area. Beginning the last week of March, Leamington District Hospital, Chatham-Kent Health Alliance, and Bluewater Health have been successfully sending patient demographic information to the provincial repository.
- Over 40,942 registered users (117 per cent of target) are now able to securely access data through cSWO Regional Clinical Viewer, ClinicalConnect™.

Planning for the integration of HRM for London and area hospitals is scheduled for May. This will enable clinicians to receive local hospital reports electronically as opposed to previous methods which included fax, courier or mail.

ONE TIME FUNDING SUPPORTING PROJECT WORK FOR STROKE SURVIVORS

The South West Local Health Integration Network (LHIN) allocated one-time funding for 2015-16 of up to $10,000 to support project work associated with the transition of recovering stroke patients from acute care at LHSC to inpatient rehabilitation at Parkwood Institute. Through this support, work has taken place to identify pilots to be implemented in the coming months. Outcomes will be measured and a summary will be shared with internal stakeholders at both LHSC and Parkwood Institute along with community partners and the LHIN.

LHSC ADULT EATING DISORDERS SERVICE COMPLETES MOVE INTO NEW HOME

This week, staff and patients of LHSC's Adult Eating Disorders Service (AEDS) moved into their new home at 54 Riverview Avenue. The new facility will allow patients of the program to receive their treatment under one roof, and increases the capacity of the residential treatment program from four to eight beds for patients requiring intensive support. LHSC is proud to be the first hospital in Ontario working in partnership with the Canadian Mental Health Association Middlesex to offer a community-based residential eating disorders program. LHSC looks forward to being part of the Riverforks community and appreciates the warm welcome we have received.

FOUNDATION ALIGNMENT

LHSC and London Health Sciences Foundation (LHSF) have been working closely over the past year to partner in implementing new approaches to develop fundraising cases that more directly align with LHSC's strategic priorities. This work has paved the way for a more integrated approach to communications and marketing. To formalize that, Tony LaRocca - VP Communications and Stakeholder Relations at LHSC - will assume additional accountability for strategic oversight of the Communications and Marketing activity of the London Health Sciences Foundation. In this dual role, Tony will have reporting accountability to the President and CEO at both LHSC and LHSF.

HEALTHCARE REGIONAL UPDATES

SOUTH WEST LHIN REPORT CARD QUARTER 3

The LHIN Board will continue to share these reports with Health Service Provider Boards each quarter to assist in each hospital's governance discussions and impact on system outcomes. The LHIN will engage the Board-to-Board Reference Group in the coming months as we transition to the IHSP 2016-19 and develop new reporting tools, scorecards and views. Please find the report card appended to this report (Appendix I).

PROVINCIAL HOSPITAL INFORMATION SYSTEM DIRECTION

The Ministry of Health and Long Term Care will be outlining strategy for future development of hospital information systems. The proposal will focus on developing regional hubs for hospitals, built around patient referral patterns.

LHSC IN THE NEWS

There were 35 media stories that referenced London Health Sciences Centre from March 15, 2016 to April 14, 2016. There were 35 positive, 16 neutral, 2 negative stories. There were 3 media releases issued and 17 web features posted on the public website.
Notable coverage from this month includes:

1. **LHSC doctor honoured for lifetime commitment to organ donation awareness**
   Dr. Sharpe received a Lifetime Achievement Award from the Trillium Gift of Life Network in recognition of his dedication to organ donation advocacy and advancing donation practices. Positive coverage from Blackburn News, Corus Radio and CTV News London.

2. **Canadian robotic surgical first**
   The colorectal surgery team at LHSC has performed the first robotic ventral rectopexy in Canada to treat a condition called obstructive defecation syndrome (ODS). Using this much less invasive robotic approach, patients can expect just one overnight stay in hospital. Positive coverage from CTV London and CBC Radio London.

3. **LHSC announces 2016/17 fiscal plan**
   LHSC announced its 2016/17 fiscal plan, which includes the need to find savings of approximately $20 million, including an estimated reduction in staff hours worked

equivalent to 64.5 full-time positions. Neutral coverage from Corus Radio (AM 980) and London Free Press.

Respectfully Submitted,

Murray Glendining,
President and CEO

Our Mission

An academic hospital, committed to improving health and delivering value for citizens of London, the South West Region and beyond. Building on our tradition of leadership, stewardship and partnership, we champion patient-centred care, with a spirit of inquiry and discovery, and a commitment to life-long learning.

South West **LHIN**

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www.southwestlhin.on.ca

April 13, 2016

To: Health Service Provider Board Chairs

From: Jeff Low, Board Chair

Re: South West LHIN Report on Performance Scorecard – 2015/16 Q3 Report

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The South West LHIN Board of Directors recently reviewed the *South West LHIN Report on Performance Scorecard* showing progress against our 3 big dot outcomes, 12 system metrics, and 4 key drivers/enablers as well as the *Interventions Report* highlighting actions underway or planned to make an impact on achieving Integrated Health Service Plan (IHSP) 2013-16 strategic goals.

It is the LHIN Board's goal to support and cultivate shared accountability in transforming the health care system. Board Governors are encouraged to continue dialogue at their respective board tables about how their health service provider organization's strategy aligns with the directions, objectives and outcomes of the IHSP.

As I have done with previous quarterly reports, please find attached the most recent version of the *Report on Performance Scorecard* and *Interventions Report* to support these discussions. Additionally you will find a tool containing a series of key questions that may guide conversations to gain insight into an organization's contributions to improving the health care system.

The LHIN Board will continue to share these reports with Health Service Provider Boards each quarter to assist in your governance discussions on your organization's involvement and impact on system outcomes. The LHIN will engage the Board-to-Board Reference Group in the coming months as we transition to the IHSP 2016-19 and develop new reporting tools, scorecards and views.

For more information, please do not hesitate to contact myself or Mark Brintnell, Senior Director, Performance and Accountability at Mark.Brintnell@lhins.on.ca.

Thank you

cc: Health Service Provider CEO/ED/Administrator

STRATEGY MAP

Our mission, values and key drivers help us to execute strategic directions and objectives to achieve our vision

VISION A health system that helps people stay healthy, delivers good care to them when they are sick and will be there for their children and grandchildren.

GOALS
- Improve population health & wellness
- Improve person experience with the health system
- Improve sustainability of our health system

STRATEGIC DIRECTIONS

IMPROVE ACCESS TO FAMILY HEALTH CARE

Objectives:
1. Increase timely access to family health care
2. Integrate family health care as the first point of contact for people living with multiple complex and chronic conditions and those at risk
3. Increase access to local and LHIN-wide interdisciplinary teams in and across health care settings
4. Facilitate access to specialized services and community-based services and supports
5. Divert avoidable ER visits to the appropriate care setting

IMPROVE COORDINATION AND TRANSITIONS OF CARE FOR TARGETED POPULATIONS

Objectives:
1. Continually respond to the needs of the population of people with the greatest unmet health care needs utilizing a significant proportion of health care resources
2. Create a collaborative person-centered response to better support the growing population of people living with chronic conditions and those at risk
3. Enable people to manage their health

DRIVE SAFETY THROUGH EVIDENCE-BASED PRACTICE

Objective:
1. Implement coordinated prevention strategies to reduce safety issues across health sectors and during transitions of care for falls, wounds, adverse drug events and infections

INCREASE THE VALUE OF OUR HEALTH CARE SYSTEM FOR THE PEOPLE WE SERVE

Objectives:
1. Maximize capacity and efficiencies in hospitals, long-term care homes and community-based services to drive improvements in quality, equitable access and wait times
2. Implement cross-sector system redesign strategies

KEY DRIVERS

TECHNOLOGY TO CONNECT AND COMMUNICATE

Objectives:
1. Strengthen electronic exchange of patient/client/resident information between providers and between providers and individuals
2. Expand the use of technology to enhance "hands on" care and leverage human resources
3. Implement decision support electronic applications
4. Improve electronic system navigation tools and information

QUALITY AND VALUE

Objectives:
1. Champion improvements to the care experience through Experience Based Design techniques
2. Leverage multi-provider accountability agreements, accreditation outcomes, quality improvement plans, alignment of provider strategic plans to IHSP
3. Build a culture of continuous quality improvement and performance monitoring
4. Expand partnerships within LHIN and non-LHIN funded services, particularly with local social services, Public Health Units and Health Quality Ontario

CONNECTING AND EMPOWERING PEOPLE

Objectives:
1. Partner with people and their caregivers
2. Confirm strategies to improve health care for Francophone and Aboriginal priority populations and diverse populations
3. Advance health promotion, prevention and alignment of social determinants of health with partners
4. Identify and spread human resources best practices

VALUES Compassion • Courage • Evidence Informed • Innovation • Integrity • Trust and Respect • Culture and Diversity

MISSION The South West LHIN is accountable for bringing people and organizations together to build a health system that balances quality, access and sustainability to achieve better health outcomes.

South West LHIN REPORT ON PERFORMANCE SCORECARD THIRD QUARTER, 2015-16

The Scorecard is aligned with provincial performance indicators as well as IHSP 2013-2016 objectives and big dot outcomes. Collectively over the next 3 years, these measures will work towards achieving the big dot outcomes and will result in people spending more days at home.

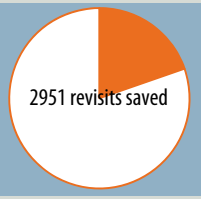
Progress on Big Dots:

1. Increasing the availability of family health care –

Our goal is that 745 more clients see their family health care provider within 7 days of discharge from hospital (for selected CMGs).

2. Reducing emergency room visits –

Our goal is to save 15,000 revisits to the emergency department within 7 days.



3. Increasing availability and access to community supports for people—

Our goal is to reduce 17,000 days spent in hospital over the next 3 years.

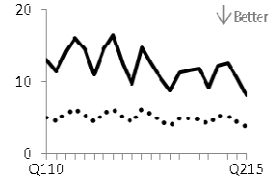
Improve access to family health care

1. Reduce wait time to specialist from family health care

Coming Soon

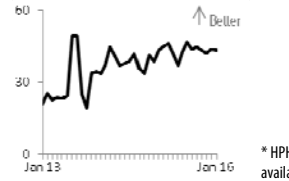
Baseline: 000
Current:
Target: TBD

2. Reduce rate of ER visits best managed elsewhere *(per 1,000 population aged 1-74)*



Baseline: 12.3
Current: 8.12
Target: 11.1

3. Increase percent of discharge summaries sent from hospital to community care provider within 48 hours

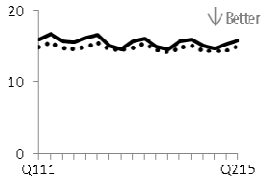


Baseline: 22.9
Current: 43.3*
Target: 50.0

* HPHA and AMGH data not available in the last 3 months

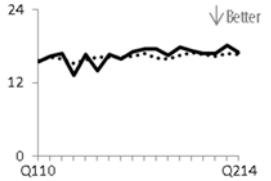
Improve coordination and transitions of care for those most dependent on health services

1. Reduce ER revisit rates within 7 days *(per total unscheduled emergency visits)*



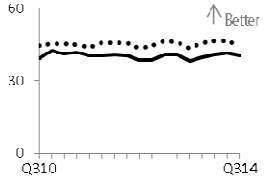
Baseline: 15.7
Current: 15.9
Target: 14.9

2. Reduce hospital readmission rate within 30 days for selected CMGs *(per 100 discharges for selected CMGs)*



Baseline: 16.8
Current: 16.9
Target: 16.0

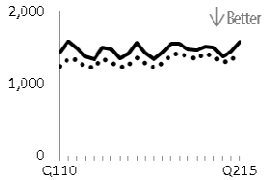
3. Increase percent of clients seeing family health care provider within 7 days of discharge (from hospital)



Baseline: 39.6
Current: 40.3
Target: 45.0

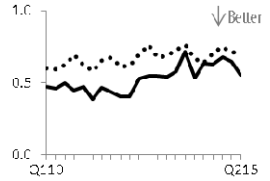
Drive safety through evidence-based practice

1. Reduce rate of ER visits resulting from falls *(per 100,000 population aged 65 and over)*



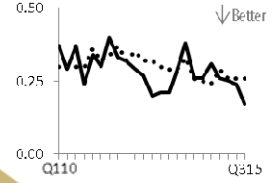
Baseline: 1,434
Current: 1,568
Target: 1,362

2. Reduce pressure ulcer related hospitalizations *(percent of all discharges)*



Baseline: 0.47
Current: 0.55
Target: 0.45

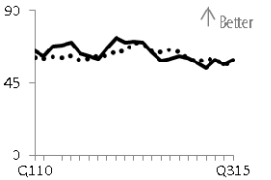
3. Reduce hospital acquired infection rates (c diff) *(per 1,000 patient days)*



Baseline: 0.27
Current: 0.17
Target: 0

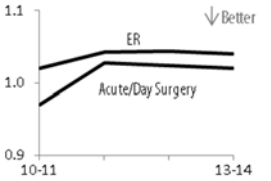
Increase the value of our health care system for the people we serve

1. Increase timeliness of diagnostic services *(percent within target)*



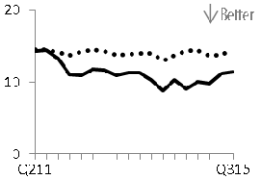
Baseline: 70.3
Current: 59.7
Target: >80.0

2. Reduce LHIN cost variance (HBAM hospitals) for acute/day surgery and ER *(actual/expected costs)*



Baseline: 1.0/1.0
Current: 1.0/1.0
Target: <=1.0

3. Reduce ALC rate *(per total inpatient days)*



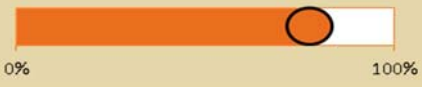
Baseline: 9.6
Current: 11.4
Target: 12.7

South West LHIN ••••••••••• Ontario

KEY DRIVERS

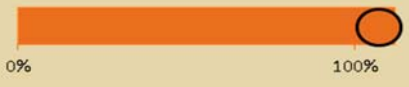
Increase the communication between health care providers through SPIRE/HRM.

Baseline: 54%
Current: 633/824 clinicians (77%)



Increase providers using Clinical Connect.

Baseline: 0
Current: 14,542/13,000 users

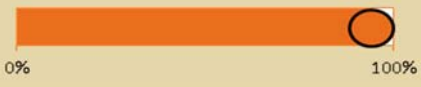


Increase organizations using the 'Regional Integrated Decision Support System' (2015-16).

Baseline: 0 active organizations
Current: 11/20 active organizations

Increase the proportion of key initiatives (P4R, BSO, P4Q) meeting LHIN Experience Based Design criteria.

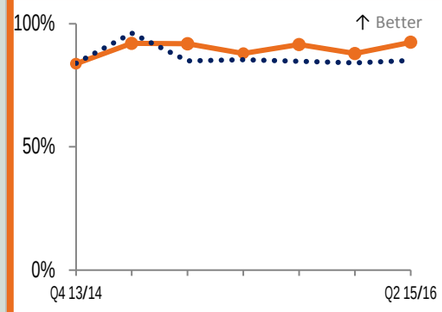
Baseline: 0
Current: 17/18 criteria met by early adopter programs



South West LHIN - Ministry LHIN Accountability Agreement (MLAA) Performance Indicators - Q3 2015/16

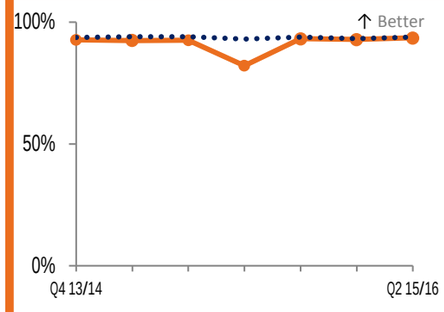
Home and Community

% of Home Care Patients with Complex Needs Who Received 1st Personal Support Visit within 5 days of Authorization of Services



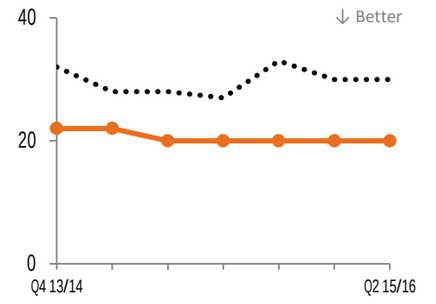
Baseline: 88.9% 15/16 Target: 95% Current: 92.46%

% of Home Care Patients with Complex Needs Who Received 1st Personal NursingVisit within 5 days of Authorization of Services



Baseline: 92.5% 15/16 Target: 95% Current: 93.59%

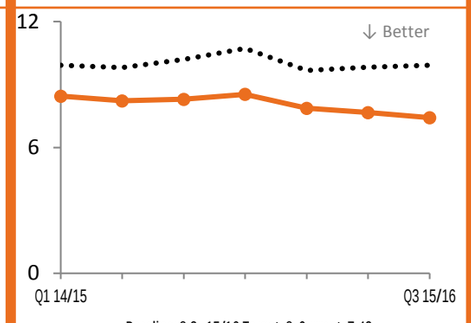
90th Percentile Wait Time (Days) from community for CCAC In-Home Services



Baseline: 21 15/16 Target: 21 Current: 20

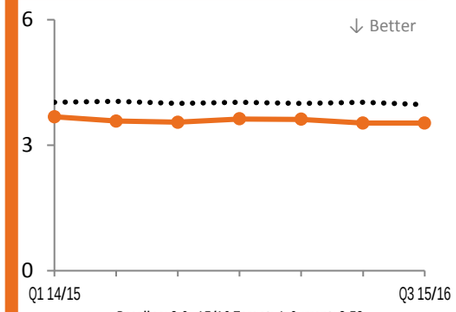
System Integration and Access

90th Percentile ED Length of Stay (hrs) for Complex Patients



Baseline: 8.3 15/16 Target: 8 Current: 7.42

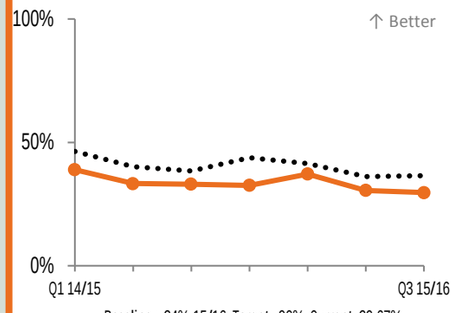
90th Percentile ED Length of Stay (hrs) for Non-Admitted Minor Uncomplicated Patients



Baseline: 3.6 15/16 Target: 4 Current: 3.53

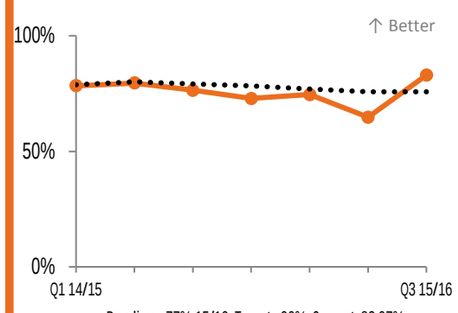
System Integration and Access

% Priority II, III and IV Cases Completed Within Access Target - MRI



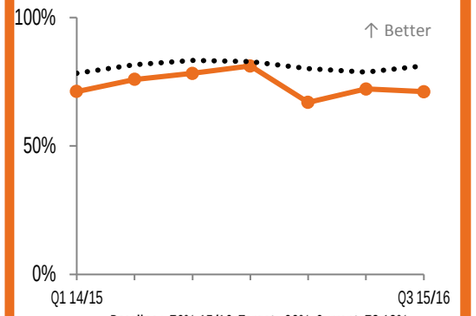
Baseline: 34% 15/16 Target: 90% Current: 29.67%

% Priority II, III and IV Cases Completed Within Access Target - CT



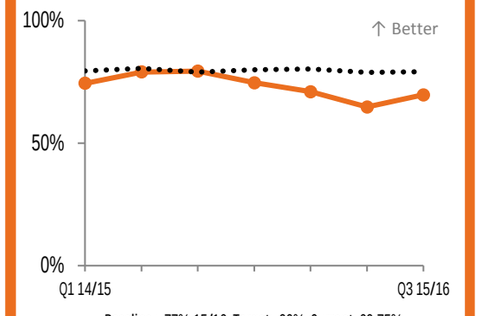
Baseline: 77% 15/16 Target: 90% Current: 82.97%

% Priority II, III and IV Cases Completed Within Access Target - Hip Replacement



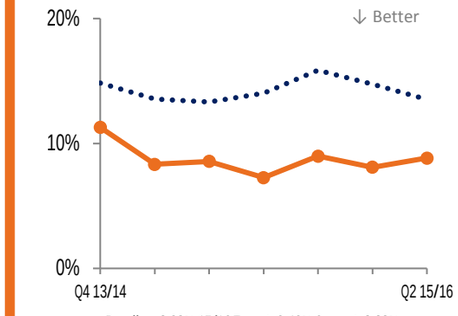
Baseline: 76% 15/16 Target: 90% Current: 73.12%

% Priority II, III and IV Cases Completed Within Access Target - Knee Replacement



Baseline: 77% 15/16 Target: 90% Current: 69.75%

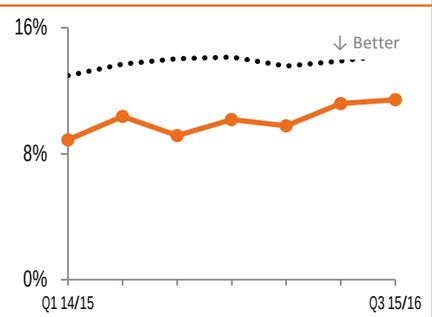
% of Alternate Level of Care Days



Baseline: 8.93% 15/16 Target: 9.46% Current: 8.83%

System Integration and Access

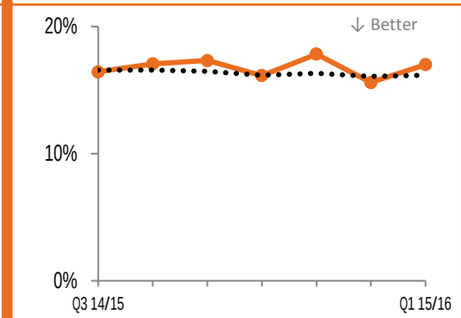
ALC Rate



Baseline: 9.61% 15/16 Target: 12.7% Current: 11.43%

Sustainability and Quality

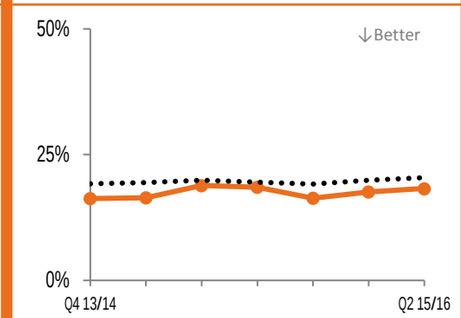
Readmissions Within 30 days for Selected HIG Grouper Conditions



Baseline: 16.74% 15/16 Target: 15.5% Current: 17.01%

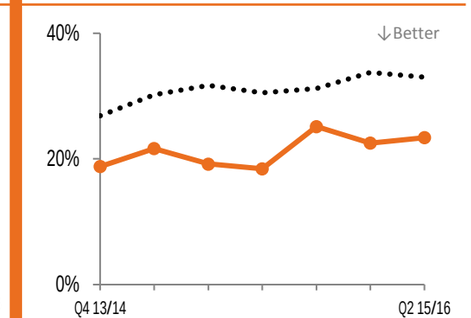
Health and Wellness of Ontarians - Mental Health

Repeat Unscheduled ER Visits within 30 Days - Mental Health



Baseline: 17.36% 15/16 Target: 16.3% Current: 18.25%

Repeat Unscheduled ER Visits within 30 Days - Substance Abuse



Baseline: 19.62% 15/16 Target: 22.4% Current: 23.38%

LEGEND

- South West LHIN
- Ontario

MOHLTC Priorityy	Report on Performance Scorecard Indicator *or* *MLAA Indicator*	Progress Against Baseline?	Key Current South West LHIN Interventions & Actions for Improvement
	Improve Access to Family Healthcare		
	Reduce wait time to specialist from family health care	*Information will not be publicly available for monitoring 2013-16 IHSP.*	
	Reduce rate of ER visits best managed elsewhere (per 1,000 population aged 1-74)	Improved	**Performance Improvement: Reporting, monitoring and accountability** – sub-LHIN level analysis has yielded insights to variable utilization (i.e. rural v urban) to inform planning.
	Increase percent of discharge summaries sent from hospital to community provider within 48h	Improved	**Hospital Service Accountability Agreements (SAA) Reporting:** Local obligation to encourage hospitals and physicians to understand their critical role in connecting discharged patients to family health providers. **Provincial IDEAs improvement interventions (STEGH & LHSC**): targeted improvements to ensure timely sending of discharge summaries (hospital to primary care) for patients discharged from hospital.
	Improve Coordination and Transitions of Care for Those Most Dependent on Health Services		
	Increase percent of clients seeing family health care provider within 7 days of discharge (from hospital)	Improved *(Not updated this quarter)*	**Partnering for Quality: Increase adoption of Advanced Access Scheduling** through Primary Care Leads' leadership, eHealth training and encouraging utilization of HQO resources. **Quality improvement learning collaboratives** that support best practices in managing chronic disease and the use of information systems to enhance patient flow and care. **STEGH IDEAs** – scheduling post discharge follow up appointments. **Discharge planning toolkit and care planning for high users** – to improve transitions and continuity of care for clients who have been discharged from hospital.
	Reduce emergency revisits within 7 days (per total unscheduled ER visits)	Worse	**Health Links: Care planning & process to define target population of high users –** Health Link teams are working to identify patients with 'high care needs' and develop care planning processes to improve their community support. **Enhanced Community Capacity: Crisis Response & Transitional Case Management –** Five stabilization beds and 24/7 walk-in access to the Crisis Centre plus 24 hour crisis response and support by the Mobile Response Team provide short-term support for individuals with a mental health and/or addictions crisis. Case Managers are supporting clients living with mental health and substance abuse conditions. Partners also collaborating to develop a Coordinated Access model of care and Supportive Housing units will be expanded. **Focus on London Emergency Department Frequent Users:** partners are working to identify gaps and improvement opportunities and connect patients with community services and supports.
Health & Wellness	***Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions***	Worse	
Health & Wellness	***Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions***	Worse	
Sustainability & Quality	**Reduce hospital readmission rate within 30 days for selected Case Mix Groups (CMGs)** (per 100 discharges for selected CMGs)	Worse *(Not updated this quarter)*	**Health Links; Chronic Disease Prevention & Management; and Technology to Connect & Communicate:** care planning, telehomecare & processes to identify target population of high users, as above. **South West LHIN Local Partnership Committee: QBP Implementation Assessment-** to identify and promote cross-provider sharing and collaboration related to reducing clinical practice variation, implementation of Clinical Handbooks, and improved quality and cost efficiencies. **Connecting Care to Home (CC2H):** - A collaborative Integrated Funding Model project led by LHSC and CCAC caring for COPD patients on a standardized care pathway, enabled by technology.
Sustainability & Quality	***Readmissions within 30 Days for Selected HIG Conditions***	Worse	
	Drive Safety through Evidence-based Practice		
	Reduce rate of ER visits resulting from falls (per 100,000 population aged 65 and older)	Worse	**South West LHIN Falls Prevention Program: Exercise and Falls Prevention classes** - evidence-based tools/protocols/training to screen, identify, manage and/or refer individuals to appropriate services, implemented through PT Reform.

MOHLTC Priorityy	Report on Performance Scorecard Indicator *or* MLAA Indicator	Progress Against Baseline?	Key Current South West LHIN Interventions & Actions for Improvement
	Reduce pressure ulcer related hospitalizations (percent of all discharges)	Worse	**South West Regional Wound Care Program: Engagement and partnership activities** – broadening resources and toolkit availability beyond Long-Term Care (LTC) Homes to the community and hospital sectors.
	Reduce hospital acquired infection rates (c diff) (per 1,000 patient days)	Improved	**Hospital Service Accountability Agreements (SAA): Performance Management & Accountability** -plans for improvement reported following quarterly SAA reviews and in annual hospital Quality Improvement Plans.
	Increase the Value of Our Health Care System for the People We Serve		
	Reduce LHIN cost variance (HBAM hospitals) for acute/day surgery and ER (actual/expected costs)	Worse *(Not updated this quarter)*	**Health System Funding Reform (HSFR) Implementation:** A focus on Quality Based Procedures (QBPs) and CCC/Rehab bed realignment has heightened awareness of funding changes and for efficiency improvements.
System Integration & Access	**Increase timeliness of diagnostic services** (percent within target)	Worse	**MRI Performance Improvement Program (PIP) Scorecard:** ongoing monitoring of key performance indicators (access, timeliness, quality). The scorecard is helping to better understand referrals, demand, complexity of cases and efficiency. Demand for this modality is increasing. **ED Pay for Results (P4R) & Knowledge Transfer Initiatives:** Process improvement initiatives to realize gains in cost avoidance. **Patient Flow:** Working with a subgroup of leaders (hospital and CCAC) to prioritize improvement opportunities and identify high impact solutions to improve patient flow in the South West LHIN. **Clinical Services Planning:** Improved delivery of stroke, cataract, orthopaedic and endoscopy services. **Surgical Wait List Management System Planning and Implementation:** Pilot underway led by STEGH. All South West hospitals are completing a business case prior to decision to implement. The system will assist with managing wait lists in surgeons' offices, and will integrate with other systems such as hospital booking and the Wait Time Information System. **Hospital Service Accountability Agreements (SAA): Performance Management & Accountability** – LHIN-driven analysis, and formal cross-sector provider follow-up for SAA performance indicators. Plans for improvement reported and tracked following quarterly reviews.
	Percent of priority 2, 3,and 4 cases completed within access target for MRI scans	Worse	
	Percent of priority 2, 3,and 4 cases completed within access target for CT scans	Improved	
	90th percentile ER length of stay for complex (CTAS I-III) patients	Improved	
	90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients	Improved	
	Percent of priority 2, 3,and 4 cases completed within access target for hip replacement	Worse	
	Percent of priority 2, 3,and 4 cases completed within access target for knee replacement	Worse	
	Reduce ALC rate (per total inpatient days)	Worse	**Access to Care (Coordinated Access—Complex Continuing Care/Rehab, Assisted Living/ Supportive Housing/ Adult Day Programs):** Implementation of redesign recommendations to improve access to the right service at the right time by the right provider, including improved access to Assisted Living spaces. **Access to Care (Home First):** Completed Home First implementation across the South West LHIN including screening for potential high needs patients who frequent the emergency department and hospital and who require complex discharge plans. Value for Money assessment underway assessing sustainability of practices. Additional investment provided to CCAC to support sustainability of Home First outcomes. **Behavioral Supports Ontario (BSO):** Implementing coordinated prevention, care and educational strategies across sectors including hospitals, primary care, Alzheimer Societies, Long-Term Care homes, CCAC and community organizations.
	Percentage of Alternate Level of Care (ALC) Days	Improved	
Home & Community	***Percentage of home care patients with complex needs who received their first personal support visit within 5d of authorization***	Improved	
	Percentage of home care patients who received their first nursing visit within 5d of authorization	Improved	
	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service	Improved	

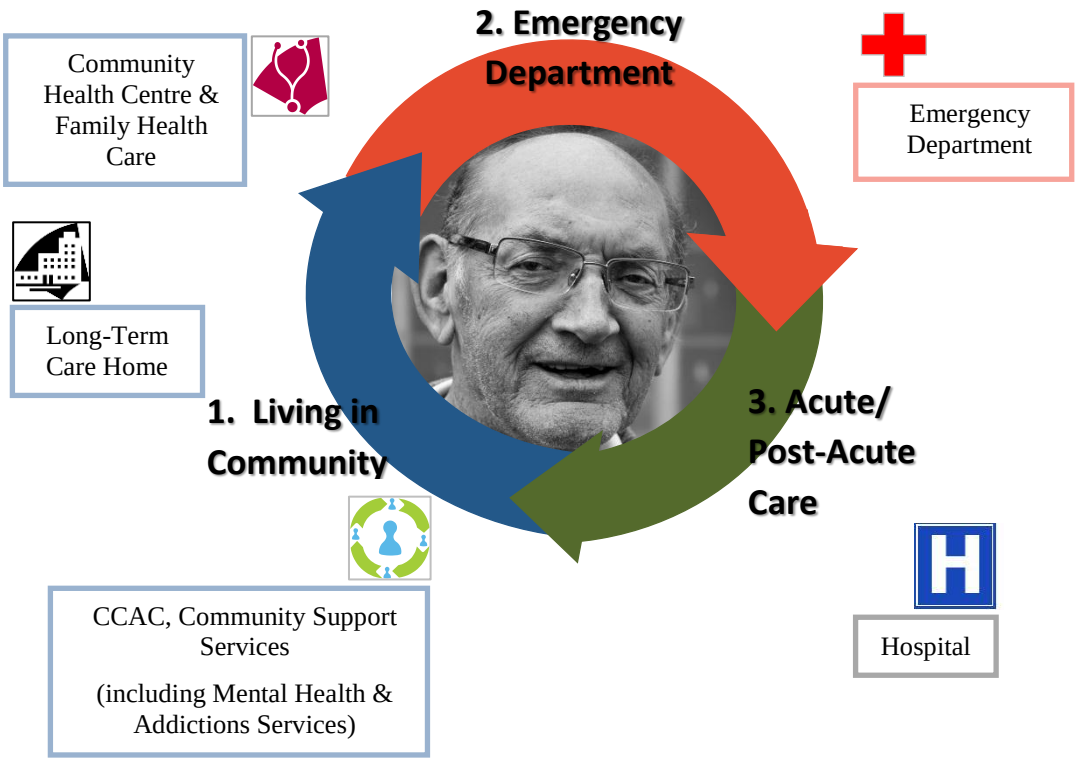
NOTES:

1. *Interventions included in this report were limited to: a. interventions identified as having a primary alignment with the noted indicators, b. those that are happening now (implementation) or those that will be implemented within the next quarter.*
2. *Progress is measured as current quarter performance over established baseline for each of the indicators noted.*

Monitoring IHSP 2013-16 Impact—Our Organization's Contributions

Following the release of the Integrated Health Service Plan (IHSP) 2013-16, the South West LHIN Board of Directors hosted six sessions throughout our region focusing on our shared accountability in transforming the health system. Board Governors were encouraged to continue dialogue at their respective board tables about how their health service provider organization's strategy aligns with the directions and objectives of the IHSP.

The South West LHIN monitors the impact or effectiveness of the IHSP through its Report on Performance Scorecard[1]. Thinking about "Will's" health care journey and asking the questions below that link to Scorecard measures, Board Governors will gain important insights into their own organization's contributions to improving the health care system.



[1] http://southwestlhin.on.ca/goalsandachievements/Performance.aspx

Key Questions to Understand Health Service Providers' Contributions to Improving the Health Care System

	▪ How many visits to the Emergency Department (ED) have we prevented by effectively managing common infections within our practice? ▪ How reliably do we see our patients within 7 days of discharge from hospital?
	▪ What progress have we made in reducing falls in our Long-Term Care home and communities and avoiding visits to the ED through the use of evidence-based falls prevention strategies?
	▪ Of those people receiving our services, who are the frequent users of the ED? ▪ What services do we provide that are helping avoid repeat visits to the ED? What is the evidence of our effectiveness?
	▪ How are we collaborating to improve coordination and transitions of care to keep people at home and avoid readmissions to hospital? What is the evidence that we are making progress? ▪ What is our Alternate Level of Care (ALC) rate (proportion of beds that are unavailable because they are occupied by ALC patients)?
	▪ How reliably do we notify family health providers within 48 hours of discharge from hospital? ▪ What is our Health-Based Allocation Model (HBAM) cost variance (actual cost compared to expected cost)? What strategies are in place to reduce this variance? ▪ What progress have we made in preventing: i) infections and ii) pressure ulcers? ▪ How long do people wait to have surgery? ▪ How long do people wait for our Diagnostic Imaging services?
	▪ What percentage of our ED patients return within 7days? What strategies do we have to prevent ED revisits? ▪ How long do people wait in our ED? How long does it take for an admitted patient to get to an inpatient bed?