Value and Affordability Task Force Reports

Value and Affordability in Paediatrics

Ensuring Equitable Care in Paediatrics in the Toronto Central Local Health Integration Network (TC LHIN)

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EXECUTIVE SUMMARY

Based on the Terms of Reference (Appendix 1) the Value and Affordability in Paediatrics Task Force (Task Force) set out to:

- Address opportunities to ensure appropriate access to and utilization of Emergency Departments (EDs) for children and youth
- Support children and youth with complex medical needs with a particular emphasis on community partnerships
- Support transitions of youth with complex medical needs to adult care
- Realize any other opportunities to increase value and affordability in the provision of health care services to children and youth.

Upon initial discussions, the Task Force determined that there were other groups currently focused on ED utilization and transitions in the TC LHIN. After deliberation, the Task Force determined that in order to leverage the resources around the table two areas of focus would be addressed. They are to:

1. Support children and youth with complex medical needs with a particular emphasis on community partnerships.
2. Optimize continuum of care planning to identify ways of coordinating and linking resources to avoid duplication and facilitate seamless movement among care settings, with a focus on vulnerable communities.

The major accomplishments of the work undertaken through this process are twofold. First, there was a strengthening of the organizational collaborations required to address issues with the delivery of paediatric care in the TC LHIN. Second, formalizing the Task Force acted as a catalyst to move forward with ideas that have been percolating for some time in the Child Health System in the TC LHIN.

There are two major conclusions that the Task Force reached. First, the delivery of complex care for children in the TC LHIN is still fragmented and there is an opportunity to better address the needs of the patients and families served. Second, poverty is the underlying issue related to health inequities in the TC LHIN, all service providers - acute care hospitals, rehab centres, Community Care Access Center (CCAC) and Community Health Centers (CHCs) - in the TC LHIN have similar experiences with marginalized children and families which provides an opportunity to systematically change the way care is delivered to this vulnerable population in an integrated fashion.

Four recommendations are proposed based on the above areas of focus:

Recommendation #1: Launch a project with broad TC LHIN representation that will both develop the principles for an Integrated Care Model for children with complex and chronic health needs (CCCHN) in the TC LHIN and execute a proof of concept to validate the principles.

Recommendation #2: Launch a project to create a Paediatric Nurse Practitioner (NP-Peds) led clinic established at the current facilities of the Regent Park Community Health Centre.

Recommendation #3: Develop and implement a process to obtain meaningful data that will inform the identification and evaluation of interventions in the TC LHIN. This data would include:

- Inventory of the health care services for children offered by the clinics/agencies within the TC LHIN
- Volume and classification of ED visits and admissions within the TC LHIN hospitals for children from vulnerable (high poverty) neighborhoods compared to all children
- Analysis of LOS/morbidity/mortality/re-admissions/clinic cancellations of children from vulnerable neighborhoods compared to all children
- Number of births in the Toronto LHIN and the percentage of those newborns who have timely access to a health care practitioner (pediatrician, CHE, FHC, etc)

Recommendation #4: Link TC LHIN CHC's to community pediatricians and hospitals by connecting them to the Electronic Health Network (eCHN) to enhance "Circle of Care" for children in the TC LHIN

These recommendations will create value for the Paediatric patients in the TC LHIN. Value, as defined by Michael Porter, is the patient health outcomes per dollar spent, across the entire system.[1] Therefore to increase value, either health outcomes must be improved with the same level of funding, or the costs of delivering the outcomes must be decreased while not negatively affecting health outcomes. This Task Force set out with the goal of increasing value for patients, rather than containing costs, in line with the first principle of Michael Porter's value framework.[2] However, the hypothesis of this Task Force is that the recommendations address absolute redundancies for which there will be costs recovered that will be re-invested in the Child Health System in the TC LHIN.

The identification of any potential cost savings will be identified in the analysis of the outcomes of the projects related to the recommendations. There are anecdotal examples of redundancies and waste in the system that may be addressed through the two projects. However, upon completion of the projects and subsequent evaluation of the work, a more realistic view of potential system savings will be available. Evaluation of the two projects is expected to be done at both six and twelve months from launch – both projects include pilots that will act as proofs of concept of the service changes that will be proposed. Upon evaluation of the proofs of concept the expected potential cost savings should be evident.

In order to proceed with the two recommended projects, and two other recommendations, endorsement from the CEO Forum is required. This endorsement includes a commitment from the CEOs of the respective member organizations to allocate dedicated project team members, from current resources in the respective organizations, to the two projects for the life of the projects (up to 2 years). Additionally, the Task Force is requesting an investment of approximately $67,500 annually for the two years to support project management of the two recommended projects. The eCHN management team has committed to cover the initial investment and ongoing maintenance costs out of its current operating budget. This commitment will provide access to the information on eCHN for all health care professionals at all CHCs in the TC LHIN.

SUMMARY OF RECOMMENDATION VALUE PROPOSITION

Proposed Solution	Anticipated Savings			Complexity			Challenges	Mitigation	Benefit Realization
				Identify the level of complexity involved in implementing such a solution			Identify the level of complexity involved in implementing such a solution	Describe how the Task Force proposes	How long before the anticipated savings will be achieved (# of months)?
	High ($1.0M or more)	Medium ($1.0M to $500K)	Low ($500K to $250K)	High	Medium	Low			
Short-term to implement proposed solution (3 to 6 months) Total Investment required: 67,500 annually for two years (on top of the required investment eCHN to invest $17,600 one time and $3,520 annually)									
Recommendation 1			X		X		Integrating planning between acute, community and rehab services	Project team to include leadership commitment and representation from all areas	Evaluation post implementation will address realized benefit and determine a more specific amount for re-investment
Recommendation 2			X		X		Payment mechanisms for acute care health professionals work in the community setting	Ensure policy review and establishment of acceptable payment mechanisms for acute health care workers in the community	Evaluation post implementation will address realized benefit and determine a more specific amount for re-investment

Recommendation 3			X			X	Access to LHIN wide data and coordination of poverty data collection across the TC LHIN	Secure dedicated LHIN resources to coordinate such an effort	Evaluation post implementation will address realized benefit and determine a more specific amount for re-investment
Recommendation 4			X			X	Coordinating implementation and user adoption across 22 CHC locations in the TC LHIN	Strong communication of the benefits and expectation related to access to eCHN at the TC LHIN CHCs	Evaluation post implementation will address realized benefit and determine a more specific amount for re-investment

A. INTRODUCTION AND CONTEXT

Background

Based on the Terms of Reference (Appendix 1) the Value and Affordability in Paediatrics Task Force (Task Force) set out to:

- Address opportunities to ensure appropriate access to and utilization of Emergency Departments (EDs) for children and youth
- Support children and youth with complex medical needs with a particular emphasis on community partnerships
- Support transitions of youth with complex medical needs to adult care
- Realize any other opportunities to increase value and affordability in the provision of health care services to children and youth.

Upon initial discussions, the Task Force determined that there were other groups currently focused on ED utilization and transitions in the TC LHIN. After deliberation, the Task Force determined that in order to leverage the resources around the table two areas of focus would be addressed. They are to:

1. Support children and youth with complex medical needs with a particular emphasis on community partnerships.
2. Optimize continuum of care planning to identify ways of coordinating and linking resources to avoid duplication and facilitate seamless movement among care settings, with a focus on vulnerable communities.

Value and Affordability

The impetus for the Task Force was to identify opportunities to increase the value and affordability of services in the Child Health System in the TC LHIN. Value, as defined by Michael Porter, is the patient health outcomes per dollar spent, across the entire system.[3] Therefore to increase value, either health outcomes must be improved with the same level of funding, or the costs of delivering the outcomes must be decreased while not negatively affecting health outcomes. This Task Force set out with the goal of increasing value for patients, rather than containing costs, in line with the first principle of Michael Porter's value framework.[4] However, the hypothesis of this Task Force is that the recommendations address absolute redundancies for which there will be costs recovered that will be re-invested in the Child Health System in the TC LHIN. This is based on the second principle of the value framework - to "use quality improvements to drive value and cost containment, where quality is health outcomes."[4] The background information below will provide specific examples of opportunities for quality improvement in the Child Health System in the TC LHIN.

Background on Complex Care through Community Partnerships

As medical, surgical, and technological advances lead to continuing drops in mortality rates of children, there has been an 'epidemiologic transition', resulting in a dramatic increase over the past four decades in the prevalence of children with complex and chronic health needs (CCCHN) [5-11] . Various terms have been historically used to describe this population including 'medically complex children', 'medically fragile children', but the term CCCHN incorporates the notion that these children be defined by their health needs and not by their medical conditions [12]. Examples include children with severe congenital or acquired brain injuries, and children with multi-system genetic conditions with health and functional issues such as feeding, respiratory, and developmental challenges. Collectively, CCCHN comprise a relatively large cohort (roughly 0.5% of all children) [13] with similar health consequences: neurodevelopmental and functional impairments, dependence on medical technology, requirements for highly specialized care, and substantial demands on their families and the health care system over many years. Once discharged from hospital, they form a vulnerable group characterized by multiple and prolonged hospitalizations, high risk for ICU admission,[14] frequent medical errors [15 16], poor care coordination [3 14 17] and extraordinary stress on caregivers [18 19]. From a health services utilization perspective, while only comprising of roughly 0.5% of all children, CCCHN account for 24% of all medical expenditures and, on average, they account for over 6-fold more expenditures than children with a single 'moderate' chronic condition such as asthma, epilepsy or major depression [20]. While the importance of understanding the health issues and improving the care for CCCHN is widely recognized, to date little has been done to measurably improve the quality of care that these vulnerable children receive [21].

Background on Optimizing Continuum of Care for Vulnerable Communities

The health care professionals on the Task Force see many of the challenges being faced by children and their families on a daily basis as they navigate their way, not only through the complex healthcare system, but the social and educational systems as well.

There is an increasing body of literature[22-23] which suggests that many health disparities in our society have their origins during early childhood and compound over time which underscores the profound effects that early investments can have on child development. These health disparities are especially prevalent in marginalized populations.[24] Marginalized populations in the TC LHIN were identified as the following: visible minorities, new immigrants, single parent families, those living in United Way High Priority Neighbourhoods, and aboriginal communities. The underlying issue with all of these populations is poverty which results in experienced health inequities for these children and families. Data produced in collaboration between The United Way of Toronto and SickKids is presented below, it shows how health disparities can be traced directly to neighbourhood poverty levels in Toronto.

High-poverty neighbourhoods constitute 25% of the total number of neighbourhoods in Toronto and contain 58% of all children, with 40% of these children living below the Statistics Canada low income cut off (LICO) point.[25] At SickKids children from high-poverty neighbourhoods in Toronto constitute the majority of the patients however we define them. According to research conducted by Dr. Ted McNeill, Director of Social Work and Child Life at SickKids, in 2006-07 and 2008-09 children from high-poverty neighbourhoods in Toronto make up at SickKids:

Category	***2006-07***	***2008-09***
Admissions	56%	55%
Total length of stay	62%	57%
Total weighted cases	63%	56%
Clinic Visits	52%	52%
Clinic No-Shows	60%	60%
Deaths	65%	n/a

The World Health Organization states "The poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health."[26] The recommendations in this report will help to inform the development of a more equitable Child Health System in the TC LHIN.

Burning Platform /Opportunity Statement

There is a burning platform from both a health equity perspective and a financial perspective to improve the way care is delivered to children in the TC LHIN. The work of this task force has focused on solutions that are practical for the organizations within the TC LHIN and focus on the most effective use of system resources.

Recommendations are based on building confidence in the community so that children receive the right care in the right place in a reasonably accessible fashion. A major issue that arose regarding the right care in the right place is the boundary of the TC LHIN. Paediatric care does not occur solely within the TC LHIN boundary. The organizations involved in the Task Force service patients from both inside and outside of the LHIN, and there is a wide variance between hospitals. For example, in 2008-09 paediatric inpatients in TC LHIN hospitals from outside of the TC LHIN ranged from 40% at St. Joseph's Health Centre to 82% at SickKids (data from Decision Support at St. Joseph's Health Centre and The Hospital for Sick Children). The Task Force recommendations will first focus on how to assist the children that live within the TC LHIN with the backdrop of attempting to understand how any service changes effect children that live outside of the TC LHIN.

There is an opportunity to increase coordination between multiple health service providers that deliver paediatric services in the TC LHIN. For example, the paediatric services offered outside of the hospital setting are not well documented in the TC LHIN. An inventory of these services could assist in eliminating redundancies in paediatric clinics and inform equitable distribution of service offerings. Additionally, there is an opportunity to share paediatric sub-specialist services between the acute care setting and the community setting, as the lack of sub-specialist services in the community is often the reason that children remain inpatients beyond the time that their acute health issue has been addressed when they could be discharged to an alternate level of care.

B. Overview of the Current and Potential Future State

Current State

Complex Care
The current state of complex care in Ontario was summarized succinctly in the REPORT OF THE PAEDIATRIC COMPLEX CARE COORDINATION EXPERT PANEL submitted to the Ministry of Health and Long Term Care in May 2008, an excerpt is found below.

Health care needs for the paediatric population have changed significantly over the past two generations. Immunizations and highly effective antimicrobials have resulted in less acute illness overall and less acute illness requiring hospitalization. Advances in diagnostics, therapeutics and medical technologies have resulted in some children who previously would have died in infancy or early childhood living longer. As a result, the prevalence of children with chronic disease is ever higher, and the complexity of the care needs for these children is increasing dramatically.

As currently structured, the health care system does not function to provide seamless integrated care for these paediatric patients with complicated lives, resulting in:

- *Suboptimal health outcomes.*
- *Dissatisfied children and youth, their families and caregivers, with a compromised quality of life for all.*
- *Busy providers who experience additional stresses and frustrations with the systems on which they depend.*
- *Inefficient use of health care resources.*

Continuum of Care for Vulnerable Communities
A clear recognition has emerged that the solution for many health problems lies in addressing their root causes – the social determinants of health - many of which are outside the direct control of the health sector. It is clear that the social determinants of health contribute to health outcomes and health equity issues for children. This means it is necessary to integrate effective health dimensions into other sectors such as education, health promotion and social services, in cross-sectoral policies. For example, determinants such as poor housing, poor nutrition habits, and pollution all contribute to compromising optimal health outcomes for children. The most influential of the social determinants of health is poverty.

Children from the lowest 20% of incomes have been shown to consistently demonstrate significantly lower functional health levels than those in all other income brackets[27]. Social stratification leads to those living at the bottom to be exposed to difficult living conditions resulting in a greater incidence of disease, injury and other health related problems which can manifest themselves in the form of other social consequences.[27] Additionally, poverty contributes to parental depression and its consequences hugely influence the management of a child's disease. Moreover, the implications of poverty have the potential to exacerbate problems like social exclusion, racism, community safety and household violence. The Task Force agrees with the TC LHIN Health Equity Strategy that, "the roots of health disparity lie far beyond the health system in wider social and economic inequity… but a great deal can be done within the healthcare system to address the harsh impact of overall disparities and enhance the wellbeing of even the most disadvantaged,[28]". The Child Health System in the TC LHIN needs to have programs in place to both address obstacles to care and mitigate the effects that poverty can have on overall health outcomes.

Desired State

The desired state for the Child Health System in the TC LHIN is for children and youth to receive the right care in the right place in a reasonably accessible fashion. This includes ensuring children and youth receive care from expert paediatric health care practitioners in the appropriate community and/or acute care setting.

In order to ensure access and navigation issues are identified and alleviated, a continued effort to build and strengthen partnerships between the stakeholders who deliver paediatric health care is essential. Through continued efforts to enhance integration the pressures on access can be reduced as the coordination between the acute setting and the community setting is strengthened. Through education around this integrated service continuum, patients

and families will feel as if they are partners in care delivery, minimizing the complexities of navigating the Child Health System in the TC LHIN.

Strengthening communication between the paediatric acute care setting and its community partners in relation to electronic patient records is also a key enabler to achieving this desired state. Enhanced communication can have the effect of eliminating duplication of tests and diagnostic procedures, speed up the delivery of services, and create a greater continuity of care from the acute to community setting. This can be achieved through a comprehensive expansion of eCHN to all community providers in the TC LHIN.

A crucial component of this desired state is ensuring marginalized children and youth have access to, and receive services that meet their unique needs. Based on the data presented around neighbourhood poverty, and experiences from many cases at the Task Force member organizations, this vulnerable population of children and youth are severely under serviced resulting in poorer health outcomes compared to children and youth that are not marginalized. These findings are consistent with what is seen in the literature on this topic.[24]

Achievements towards this desired state relies heavily on both education and knowledge transfer, the sharing of both resources and training methods, and a focus on recruitment and retention efforts as a system. The development of a fully integrated Child Health System in the TC LHIN, with planned strategic partnerships between acute and community service providers, and engaging the families as partners in care, will help to achieve this desired state.

C. Summary of Opportunities and Recommendations

i. Overview of Recommendations

Recommendation #1: Launch a project with broad representation across the TC LHIN that will both develop the principles for an Integrated Care Model for children with complex and chronic health needs (CCCHN) in the TC LHIN and execute a proof of concept to validate the principles.

Value Proposition

- While comprising of roughly 0.5% of all children in a population, CCCHN account for 24% of all medical expenditures and, on average, they account for over 6-fold more expenditures than children with a single 'moderate' chronic condition such as asthma, epilepsy or major depression. Discovering and implementing efficiencies based on the coordination of care for these children is essential due to the material impact the cost of care for these children has on the system.
    - The expected benefits of implementing this recommendation are increased coordination of services and reductions in overlapping roles in the acute care and community care settings.
    - The hypothesis is that there will be no net new investments required for the change of services related to this project. The focus will be on the efficient utilization of current resources in a more integrated and coordinated fashion between the organizations that care for CCCHN. These efficiencies will likely result in a reduction of redundancy in services that would result in re-investments in the Child Health System in the TC LHIN.
    - A proof of concept project will take twelve to fifteen months to develop, implement and evaluate.
    - This project links directly to one of the proposed recommendations of the Integrated Care for Complex Populations Task Force

Risks

No	Risk	Impact	Probability	Timeframe
1	**IF**, project costs cannot be covered by current resources	High	Medium	Mid-Term
	THEN (consequence), scope may have to be decreased or timelines extended to ensure quality is not impacted			
	RESPONSE: Mitigate by identifying and securing resources before project is initiated			
2	**IF**, strategies do not adequately address the needs of children, families and/or society	High	Low	Mid-Term
	THEN (consequence), implementation may be challenging due to a lack of perceived value of the initiative			
	RESPONSE: Mitigate though strong community engagement that solicits opinions from the children and families that will be affected by these			
3	**IF**, providers experience professional burnout	High	Low	Far-Term
	THEN (consequence), care providers will not utilize the new models and change management concepts will be unsuccessful			
	RESPONSE: Mitigate through planned models of care delivery			

Implementation

- See Appendix 4 for complete project charter
- The required resources are twofold:
    - Dedicated project team members from Task Force member organizations (in-kind)
    - One 0.5 FTE dedicated project manager (if available from one of the Task Force member organizations, if not contract out rate will be approximately $45,000 per annum)

Actions

- TC LHIN hospital CEO's and CCAC endorsement of this recommendation
- Project team members identified
- Project manager resourced appropriately

Recommendation #2: Launch a project to create a Paediatric Nurse Practitioner (NP-Peds) led clinic established at the current facilities of the Regent Park Community Health Centre.

Value Proposition

- The NP-Peds clinic will improve access to care, integrate services and improve efficiencies within the system. NPs will be able to use their expertise in advanced health assessment, diagnosis, treatment, education, referral, coordination and advocacy of infants, children and adolescents with respiratory diseases.
    - The expected benefits are that the NPs will function in a broad circle of care in collaboration with health and social services providers within the TC LHIN (specifically with SickKids, Toronto East General Hospital, Children's Aid, and other community practitioners).
    - The expectation is that the availability of sub specialist clinics closer to home for the population in Regent Park would potentially reduce the number of non-urgent visits to respective TC LHIN EDs
    - Additionally, children seen in the community that need to be seen in an acute setting will experience much greater transitions due to appropriate tests being prescribed before their clinic visit in the acute hospital
    - A proof of concept project will take twelve to sixteen months to develop, implement and evaluate.

Risks

No.	Risk	Impact	Probability	Timeframe
1	**IF**, project costs cannot be covered by current resources	High	Medium	Mid-Term
	THEN (consequence), scope may have to be decreased or timelines extended to ensure quality is not impacted			
	RESPONSE: Mitigate by identifying and securing resources before project is initiated			
2	**IF**, strategies do not adequately address the needs of marginalized children	High	Low	Mid-Term
	THEN (consequence), implementation may be challenging due to a lack of perceived value of the initiative			
	RESPONSE: Mitigate though planning based on data analysis of burden of disease in the Regent Park area			
3	**IF**, community providers and hospital providers experience challenges in co-locating	High	Low	Far-Term
	THEN (consequence), patients will not be able to fully benefit from this integrated approach to care			
	RESPONSE: Mitigate by ensuring strong communications both during the planning and implementation of this project in both the acute care and community care setting			

Implementation

- See Appendix 5 for complete project charter
- The required resources are twofold:
    - Dedicated Nurse Practitioner(s) and project team members from Task Force member organizations
    - One 0.25 FTE dedicated project manager (if available from one of the Task Force member organizations, if not contract out rate will be approximately $22,500 per annum)

Actions

- TC LHIN hospital CEO's and CCAC endorsement of this recommendation
- Project team members identified
- Project manager resourced appropriately

Recommendation #3: Develop and implement a process to obtain meaningful data that will inform the identification and evaluation of interventions in the TC LHIN. This data would include:

- **Inventory of the health care services for children offered by the clinics/agencies within the TC LHIN**
- **Volume and classification of ED visits and admissions within the TC LHIN hospitals for children from vulnerable (high poverty) neighborhoods compared to all children**
- **Analysis of LOS/morbidity/mortality/re-admissions/clinic cancellations of children from vulnerable neighborhoods compared to all children**
- **Number of births in the Toronto LHIN and the percentage of those newborns who have timely access to a health care practitioner (pediatrician, CHE, FHC, etc)**

Value Proposition

- The expected benefits would be a better understanding of the number and scope of health care services and providers for children outside of the acute care setting in the TC LHIN. The anticipated value is the potential elimination of duplicated services and the shifting of resources to areas that are of high need if evidence is uncovered that services are not currently optimized geographically based on patient populations.
- There is an opportunity to leverage the work done by the Child Health Network of the GTA around inventories of service offerings in the Central LHIN
- The anticipated timing to organize this data could be anywhere from one to three months depending on the priority this work is given and the resources that could be dedicated to do this work.

Risks

No.	Risk	Impact	Probability	Timeframe
1	**IF**, no resources are dedicated to do this work	High	Medium	Mid-Term
	THEN the compilation of services and analysis of high poverty health care service utilization will not be completed and this data will not be available for future system planning initiatives.			
	RESPONSE: Mitigate, to offset this risk a resource should be dedicated from one of the member organizations of the Task Force, or a combination of resources, and the TC LHIN to get this work done.			

Implementation

- This recommendation could be acted upon at any time dedicated resources are allocated to do this work.
- No net investment required, utilization of current resources is sufficient.

Actions

- Secure LHIN resources to coordinate data collection for all LHIN hospitals (leverage Decision Support Working Group)

Recommendation #4: Link the TC LHIN CHC's to community pediatricians and hospitals by connecting them to the Electronic Health Network (eCHN) to enhance "Circle of Care" for children in the TC LHIN

Value Proposition

- The expected benefits would be a better flow of information from the acute setting to the community setting. Health care professionals at CHCs would be able to review patient charts to obtain a more comprehensive patient history and understanding of current diagnoses and medications.
- eCHN will provide the investment required for both start up and ongoing yearly maintenance fees to have eCHN accessible in a read only format to all CHCs in the TC LHIN

Risks

No.	Risk	Impact	Probability	Timeframe
1	**IF** CHC health care professionals need capabilities to upload data to eCHN	High	Medium	Mid-Term
	THEN more funding than eCHN could provide would be required to be identified to make the investment to fully integrate CHC patient data systems with eCHN			
	RESPONSE: To mitigate this risk, especially with regards to recommendation two, all health care professionals who are hospital based have access to eCHN remotely through VPN access to their respective hospital electronic charting tool if available			
2	**IF** there is not wide uptake from CHC users	High	Medium	Short/Mid
	THEN there is a potential that care will not be improved and investment may not have a positive ROI in terms of value			
	RESPONSE: Mitigate through multiple communication methods to show the value of eCHN to the community practitioners			

Implementation

- This recommendation could be acted upon at any time eCHN has dedicated the resources to connect all CHCs in the TC LHIN with read only access so that health care professionals at the CHCs may access patient charts
- A total initial investment of $17,600 is required to establish the proper network implementation and provide security and project management for all 22 CHCs in the TC LHIN. Additionally, a total yearly maintenance cost of $3,520 (20%) which covers all CHCs in the TC LHIN is required to support the access to patient charts that originate from all hospitals in the GTA.

Actions

- Initiate implementation work with eCHN and the CHCs

ii. Categorization of Recommendations

All recommendations above should fall into one of the following categories

- Recommendations for LHIN-wide Policy / process changes
- Recommendations that could generate absolute dollar savings
- Recommendations that will contain costs and/or growth in demand
- Recommendations requiring significant one-time investments

Recommendation	LHIN-wide Policy/Process Change	Generate Absolute Dollar Savings	Savings ($)	Contain Costs/Growth in demand	Investment required ($)
Recommendation 1	X	X	TBD	X	$45,000 per year two years
Recommendation 2	X	X	TBD	X	$22,500 per year two years
Recommendation 3	X			X	Nil
Recommendation 4				X	$17,600 one time $3,520 annual maintenance (costs to be covered by eCHN)

iii. Prioritization of Recommendations

All four recommendations are high priority for the Child Health System in the TC LHIN. The criteria for this ranking is based on funding threshold, all below $50,000, the timing, all can be acted upon in the short term, and the expected outcome for each is that absolute redundancies will be eliminated and the respective costs will be recovered and re-invested in the Child Health System.

v. High Level Stakeholder Engagement Required for Implementation of Priority Recommendations

Recommendation	Stakeholders	Engagement Plan
Recommendation 1	TC LHIN hospitals, CCAC, rehab	▪ See project charter – Appendix 6
Recommendation 2	TC LHIN hospitals, CHCs	▪ See project charter – Appendix 5
Recommendation 3	TC LHIN hospitals	▪ TC LHIN to communicate through Decision Support Working Group
Recommendation 4	eCHN, TC LHIN hospitals, CHC	▪ TC LHIN to communicate with CHCs around benefits/expectations ▪ SickKids and eCHN to establish communications with CHCs implementation

D. Closing Comments / Lessons Learned

All of the above recommendations are crucial to addressing current gaps in the Child Health System in the TC LHIN. Each recommendation is actionable with little to no additional investments from the TC LHIN. Although ultimate dollar savings cannot be determined, based on the time frame provided, the recommendations address absolute redundancies for which the costs will be recovered and re-invested in the Child Health System. **The anticipated outcomes are a more efficient and integrated Child Health System in the TC LHIN which will serve as a model for health care delivery across the province.**

The process followed by the Task Force was excellent. The entire Task Force met for one and one half hours three times during the summer. The Task Force was split in to two sub committees who focused on the two main objectives respectively. These sub committees met an additional three times to develop their respective recommendations and project charters. While the Task Force managed to provide meaningful recommendations, it would have been beneficial to have more time to complete the due diligence for sustainable change. However, this work has been incorporated into the two projects outlined in this report.

The Paediatric community is very engaged and this was very apparent through this process. A clear burning platform was identified in the first Task Force meeting and gaps in and concerns with the current system were quickly identified so that the majority of the time the Task Force spent together was focused on identifying solutions to address value and affordability goals for paediatrics in the TC LHIN.

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Appendix 1: Terms of Reference

Toronto Central **LHIN**

HAPS and IHSP-2 Value and Affordability Task Forces

Value and Affordability in Paediatrics Task Force
Terms of Reference - *DRAFT*

PURPOSE

The Value and Affordability in Paediatrics Task Force is one of several initiatives being undertaken as part of the Value and Affordability priority of the Toronto Central LHIN. This Task Force will contribute directly to shaping decisions for the 2010/12 Hospital Accountability Planning Submissions (HAPS) which all TC LHIN hospitals are required to submit by November 30th, 2009. Task Force recommendations will also contribute to longer term planning for collaborative changes that can be undertaken to strengthen value, affordability, and sustainability of clinical programs within TC LHIN hospitals.

SCOPE OF WORK

The Task Force will make recommendations relating to how to increase coordination between multiple health service providers in order to:

- Address opportunities to ensure appropriate access and utilization of ERs for children and youth
- Support children and youth with complex medical needs with a particular emphasis on community partnerships
- Support transitions of youth with complex medical needs to adult care
- Realize any other opportunities to increase value and affordability in the provision of health care services to children and youth.

The Task Force will identify specific questions / issues that should be explored with health care consumers. The TC LHIN will then conduct a process to solicit consumer inputs to further inform task force conclusions.

TERM

The Task Force will begin deliberations in summer 2009 and will submit an initial report to the Toronto Central LHIN by Friday, September 11, 2009. This report will be circulated to all TC LHIN hospital CEOs and discussed as part of a CEO Forum being scheduled for early September.

MEMBERSHIP

The Task Force Chair will be Chaired by Mary Jo Haddad, President & CEO of the Hospital for Sick Children. The Task Force members will be vice president and senior directors from a cross-section of TC LHIN hospitals as well as representatives from the TC CCAC and the TC LHIN, The Task Force has the option of creating sub-groups and/or inviting additional participants to meetings based on the subject matter to be discussed.

ACCOUNTABILITY

The Task Force is jointly accountable to the Toronto Central LHIN and the collective CEOs of TC LHIN hospitals.

Ontario
Local Health Integration Network

Appendix 2: Overview of Methodology and Analysis

The Task Force met initially to accept the terms of reference and brainstorm the areas of focus going forward. The Task Force was split into two sub-committees, one group for each of the two areas of focus.

Task Force Membership

Haddad, Mary Jo (Chair); Underwood, Ene (LHIN Project Lead); Smith, Aaron (Project Support); Adamson, Bonnie; Braidek, Sheila; Cohen, Eyal; Cooper, Ana; Crawford, Trish; Daub, Stacey; Keatings, Margaret; Keilty, Krista; Kitsch, Tracy; Lau, Eddy; Milo-Manson, Golda; Quigley, Alison

Organizations Represented

Toronto Central LHIN

The Hospital for Sick Children

Toronto East General Hospital

St. Joseph's Health Centre

Bloorview Kids Rehab

Toronto CCAC

Child Health Network of the GTA

Regent Park Community Health Centre

Task force sub-committee structure established as follows:

Complex Care through Community Partnerships	Optimizing Continuum of Care for Vulnerable Communities
○ Eyal Cohen (Lead) ○ Krista Kielty ○ Tracy Kitsch ○ Linda Young ○ Stacey Daub	○ Margaret Keatings (Lead) ○ Allison Quigley ○ Trish Crawford ○ Eddy Lau MD ○ Sheila Braidek ○ Anna Cooper

Each of the sub-committees met a total of three times to review the current state, identify potential recommendations and prepare reports for the larger Task Force meetings, of which there were two additional meetings for a total of three over the time period of July 13, 2009 – August 13, 2009.

Appendix 3: Summary of Opportunities

1. Support children and youth with complex medical needs with a particular emphasis on community partnerships.

   Short Term (0-6 months)

   - Develop principles of a valuable and affordable and family centred model of care coordination including:
     - Shared Care – "the right people, with the right information, doing the right things, in the right order, at the right time"
     - Team-based Care - a multi-disciplinary team that utilizes the unique skills of team members
     - Navigation and Key Worker - practically speaking there needs to be a "lead" who assumes responsibility for ensuring coordination, communication and follow-through with the plan of care.
     - Joint Accountability – Remove traditional barrier of silos to integrated care that occurs when providers are accountable to a single organization (e.g. a hospital, or a community agency)
   - Identification of patients/clients who could receive this model of care

   Medium Term (6-12 months)

   - Undertake a proof of concept to evaluate the feasibility & value and validate an Integrated Care Model for children with complex and chronic health needs (CCCHN) in the Toronto Central LHIN

   Long Term (12 months +)

   - Address policy issues that may be impediments to system wide implementation of a Integrated Care Model for CCCHN including:
     - The multiple ministries, funders, policy makers and providers - no system-wide mechanisms to support information sharing, joint planning and collaboration
     - Service Availability & Limits - e.g. some (local) evidence in support of the use of a blended care delivery model with both regulated and unregulated providers
     - Continuity across service locations - e.g. hospital to home transitions, no CCAC in child care settings
     - Resource Availability and Stability - a major issue throughout health care BUT especially in home care sector AND for children
     - Focus on the family - e.g. structuring programs and services to support the family/caregiver AND more flexible service delivery/case management options to support families in self-managing (or to direct funding) for their child's care

2. Optimize continuum of care planning to identify ways of coordinating and linking resources to avoid duplication and facilitate seamless movement among care settings, with a focus on vulnerable communities.

   Short Term (0-6 months)

   - Undertake a process to obtain meaningful data that will allow us to identify and evaluate appropriate interventions.
   - Enhance "Circle of Care" for children in the LHIN by linking the CHC's to pediatricians and hospitals by linking them to the Electronic Health Network eCHN

   Medium Term (6-12 months)

   - Undertake a proof of concept to evaluate feasibility & value of a Pediatric NP led clinics at the CHC's. The objectives would be: Timely access; Timely and appropriate references; Improved efficiency (Diagnostic Intervention prior to specialist consultation)
   - Have community partners participate in Diversity Education and Training at SickKids

   Long Term (12 months +)

   - Explore/expand clinics for new immigrant families in the TC LHIN

Appendix 4: Project Charter Complex Care Through Community Partnerships: Integrated Care Model Project for children with complex and chronic health needs

Project Charter

Complex Care Through Community Partnerships:

Integrated Care Model Project for children with complex and chronic health needs

Document Version History

Author:	The Hospital for Sick Children
Role:	Project Co-Lead
Creation Date:	August 28, 2009

Distribution List

Name (Individual or Group)	Title	Department	Location

Project Charter Roadmap

As medical, surgical, and technological advances lead to continuing drops in mortality rates of children, there has been an 'epidemiologic transition', resulting in a dramatic increase over the past few decades in the prevalence of children with complex and chronic health needs (CCCHN) [1-7] . Various terms have been historically used to describe this population including 'medically complex children' and 'medically fragile children', but we will utilize the term CCCHN to incorporate the notion that these children be defined by their health needs and not by their medical conditions [8]. Examples include children with severe congenital or acquired brain injuries, and children with multi-system genetic conditions with health and functional issues such as feeding, respiratory, and developmental challenges. Collectively, CCCHN comprise a cohort of children with similar health consequences: neurodevelopmental and functional impairments, dependence on medical technology, requirements for highly specialized care, and substantial demands on their families and the health care system over many years. They form a vulnerable group characterized by multiple and prolonged hospitalizations, high risk for ICU admission [10], frequent medical errors [11] [12], poor care coordination [10] [13] and extraordinary stress on caregivers [14] [15]. From a health services utilization perspective, while only comprising of ~0.5% of all children, CCCHN account for 24% of all medical expenditures and, on average, they account for over 6-fold more expenditures than children with a single 'moderate' chronic condition such as asthma, epilepsy or major depression [16]. While the importance of understanding the health issues and improving the care for CCCHN is widely recognized, little has been done to improve measurably the quality of care that these vulnerable children receive. The goal of this project is to develop an Integrated Model of Care for the Toronto Central LHIN that will aim to address the above issues from a system perspective and enhance the care provided to children with complex and chronic health needs.

The project objectives are as follows;

1. ***Develop an Integrated Model of Care (ICM)***
2. ***Develop an ICM Implementation Plan for the Toronto Central Local Health Integration Network (LHIN)***
3. ***Secure funding to operationalize the ICM***

Objective	*In Scope*	*Out of Scope*	*Dependencies*
1. Develop an Integrated Model of Care (ICM)	***a. Define guiding principles*** ***b. Define population*** ***c. Define ICM***	• ***Other patient populations***	• ***resource availability with required skill sets***

Objective	*In Scope*	*Out of Scope*	*Dependencies*
2. Develop an ICM Implementation Plan for the Toronto Central Local Health Integration Network (LHIN)	***a. Develop Pilot (including proof of concept)*** ***b. Execute Pilot*** ***c. Evaluation Pilot*** ***d. Develop LHIN roll-out Plan*** ***e. Determine ongoing stewardship***	• ***mental health*** • ***other LHIN regions***	• ***resource availability with required skill sets***
3. Secure funding to operationalize the ICM	***a. Secure senior-level support*** ***b. Secure funding*** ***c. Transition from project to operations***	• ***Funding for any other LHIN initiatives***	• ***resource availability with required skill sets***

This section estimates planned dates for performing project work (focusing on sequencing, best estimates for project work effort and duration) and ***should*** include the following;

- Milestones (including sequencing)
- Fixed/Firm dates (must implement/go live by…)
- Timelines (quarterly or monthly acceptable at this stage)
- Vacation plans (if known) for major project resources

Milestone / Key Activity	Scheduled Dates
1. Develop an Integrated Model of Care (ICM)	Q3 (fiscal 2009-2010)
2. Develop an ICM Implementation Plan for the Toronto Central Local Health Integration Network (LHIN)	Q4 (2009-2010) – Q2 (2010-2011) • ***Develop Pilot (including proof of concept) – 2 mths*** • ***Execute Pilot – 12 mths*** • ***Evaluation Pilot – ongoing major at 6 months and 12 months*** • ***Develop LHIN roll-out Plan - 1 mth*** • ***Determine ongoing stewardship – 1mth***
3. Secure funding to operationalize the the ICM	Q3 – Q2 (ongoing)

Project Budget Identification - Which type of project costing will be applied?

☐ Allocated budget with internal costs tracked as well (i.e. human resources, overhead, etc.)

☒ Allocated budget with no internal costs tracked

☐ No allocated budget and no internal costs tracked

Item	Purchase Cost	Fiscal Year	Ongoing Costs	Details
Project Management	$		$	
TOTALS	**$**		**$**	

Other financial Considerations: Other project costs will be absorbed by project partners as follows;

-

7.1 Project Stakeholders ***- Groups or organizations whose interests may be impacted by the execution or completion of the project, and who may exert influence over the project and its deliverables. It should always include the Project Sponsor (authorizes the project) and the client/business owner (the person/group who will accept the project deliverables upon completion -may be the same as the sponsor)***

Group/Individual	Role (Project Interest or Impact)	Internal/External
Toronto Central LHIN	Jurisdictional LHIN	External
Toronto CCAC	*Project Co-Lead*	*External*
Bloorview Kids Rehab	*Project Co-Lead*	*External*
The Hospital For Sick Children (SickKids)	*Project Co-Lead*	*Internal*
All Toronto Central LHIN Health Service Providers	*Group potential impacted by outcomes*	*External*
Children and Families	*Consumers of Toronto Central LHIN Health Services*	*External*

7.2 Project Team - Names for critical resources and/or identified team members who will be responsible for performing the work of the project.

Name	Organization	Role
TBD		Project Manager
Eyal Cohen	*SickKids*	*SickKids Lead*
Stacey Daub	*Toronto Community Care Access Centre (CCAC)*	*CCAC Lead*
Tracy Kitsch	*Bloorview Kids Rehab (Bloorview)*	*Bloorview Lead*
Linda Young	*Toronto East General Hospital (TEGH)*	*TEGH Team Member*
Krista Keilty	*SickKids*	*SickKids Team Member*
Anna Cooper	*Toronto CCAC*	*CCAC Team Member*
Sherri Adams	*SickKids*	*SickKids Team Member*

8.1 Risk List - the following list identifies early project risks, assumptions, constraints, etc. including, (but not limited to) the scope, schedule, budget (including vendor management), resource availability, organizational structure, legal requirements, etc.

#	Risk (uncertain event that may be impact the project either positively or negatively)
1.	Costs – direct and indirect
2.	Child/family/society/inequity
3.	Provider burnout

8.2 Risk Analysis – the following analysis expands upon the risks listed above to consider the following;

- Impact of the risk occurring – High, Medium, Low
- Probability of the risk occurring – High, Medium, Low
- Timeframe in which the risk might occur – Near, Mid, Far
- Consequence of the risk occurring – potential impacts on the project
- Strategy - for managing the risk

This analysis will be discussed by the Project Manager (PM), Sponsor and Client/Business Owner. Ranking should be determined by the PM, based on anticipated levels of Impact/Probability/Timeframes.

No.	Risk (from list above)	Impact	Probability	Timeframe
1	**IF**, project costs cannot be covered by current resources	High	Medium	Mid-Term
	THEN (consequence), scope may have to be decreased or timelines extended to ensure quality is not impacted			
	RESPONSE: Mitigate			
2	**IF**, strategies do not adequately address the needs of children, families and/or society	High	Low	Mid-Term
	THEN (consequence), implementation may be challenging due to a lack of perceived value of the initiative			
	RESPONSE: Mitigate			
3	**IF**, providers experience professional burnout	High	Low	Far-Term
	THEN (consequence), care providers will not utilize the new models and change management concepts will be unsuccessful			
	RESPONSE: Mitigate			

9.1 Acceptance of Project Objectives (taken from section 2.0 Project Objectives above)

Project Objectives ***(deliverables, outputs, documentation, etc.)***	*Acceptance Criteria* ***(critical success factors, KPI, evaluation plan, other, etc…)***	*Lead (Doer)*	*Acceptor*
1. Develop an Integrated Model of Care (ICM)	***Accepted by Working Group***	***PM***	***Sponsor***
2. Develop an ICM Implementation Plan for the Toronto Central Local Health Integration Network (LHIN)	***Accepted by Working Group and LHIN representative(s)***	***PM***	***Sponsor***
3. Secure funding to operationalize the ICM	***???***	***PM***	***Sponsor***

9.2 Acceptance of Project Overall

Overall Project Objectives	*Acceptance Criteria (critical success factors, KPI, evaluation plan, other, etc…)*	*Lead (Doer)*	*Acceptor*
1. All objectives, deliverables, outputs, documentation, etc. completed	***Per above criteria***	***PM***	***Sponsor***
2. Completed Project documentation	***Accepted throughout project***	***PM***	***Sponsor***
3. Feedback provided on Project Team performance to Direct Managers of team members	***Completion of objective via telephone conversation, in-person conversation or email***	***PM***	***Sponsor***

SIGNATURE DISCLAIMER: **BY SIGNING BELOW, YOU CONFIRM THAT YOU HAVE READ ALL THE CONTENTS OF THE PROJECT CHARTER AND AGREE TO THE AFOREMENTIONED DETAILS. BY YOUR SIGNATURE, YOU ENDORSE THIS PROJECT AND COMMIT TO SUPPORT THE PROJECT TEAM IN ITS AIM TO ACHIEVE THE STATED GOALS AND OBJECTIVES. YOUR APPROVAL WILL BE REQUIRED IF/WHEN THE PROJECT BASELINE CHANGES AND A FORMAL CHANGE REQUEST WILL BE REQUIRED. THE CHANGE CONTROL PROCESS FOR THIS PROJECT WILL BE DEFINED IN THE PROJECT MANAGEMENT PLAN.**

(Name and Title)		
Project Sponsor	Signature	Date

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11. Sacchetti A, Sacchetti C, Carraccio C, Gerardi. M. The potential for errors in children with special health care needs. *Acad Emerg Med* 2000;7(11):1330-3.

12. Slonim A, LaFleur B, Ahmed W, Joseph. J. Hospital-reported medical errors in children. *Pediatrics* 2003;111(3):617-21.

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17. Srivastava R, Stone B, Murphy N. Hospitalist care of the medically complex child. *Pediatr Clin N Am* 2005;52(4):1165-87.

Complex Care Subgroup Report

1) *Principles of a valuable and affordable model of care coordination*

1. Shared Care – "*the right people, with the right information, doing the right things, in the right order, at the right time"*
    a. no one organization, discipline or provider can adequately meet all the needs of the chronically ill paediatric patient and family.
    b. inefficiencies commonly occur when multiple organizations independently try to tackle complex health problems in a patient.
    c. promote complex medical support in a variety of settings including acute care hospitals (e.g. SickKids, St. Joe's, TEGH), transitional care settings (e.g. BKR), and the community (the home, the school, the primary care office).

2. Team-based Care
    a. multi-disciplinary team that utilizes the unique skills of team members
    b. involve expertise from a number of different disciplines (e.g. nursing, occupational therapy, physiotherapy, medicine, dietetics, respiratory therapy, education, social work and personal support.)
    c. not every team member needs to be involved in the care of every child
    d. sufficient flexibility needs to be developed in the construction of the team to ensure that each child received appropriate care delivery

3. Navigation and Key Worker
    a. practically speaking there still needs to be a "lead" who assumes responsibility for ensuring coordination, communication and follow-through with the plan of care.
    b. without such a role, assumptions may be made as to roles and accountabilities leaving the patient and family at risk of "falling through the cracks".
    c. "key worker"
    - ❖ acts as a single point of contact for a family, helping coordinate care, within the healthcare system and also across systems (education, social services, financial resources, recreation, transportation, etc).
    - ❖ the individual or disciplinary training of the person who is assigned to be the 'key worker' may vary by patient and/or time (e.g. NP or SW)
    - ❖ supports the patient and family throughout their illness experience
    - ❖ links in to networks of providers and services to ensure continuity and coordination of care.
    - ❖ empowers patients and families develop skill in negotiating the "maze" of health-care in a timely/effective fashion

4. Joint Accountability –
    a. Remove traditional barrier of silos to integrated care that occurs when providers are accountable to a single organization (e.g. a hospital, or a community agency).

b. A successful model within TC-LHIN will allow (and promote) the movement of team members to move with the patient to the multiple locations of care wherever it is provided and that partnering organizations facilitate this by sharing resources for seamless provision of care.
c. requires innovative partnership between hospitals, CCAC, and other providers/agencies

2) *Identification of patients/clients who would receive this model of care*

b. No consensus definition of 'complexity'
c. Most accurate to ascertain these children utilizing the definition of the provincial task force on complex care coordination AND known patient lists from teams who care for these children through the services provided by CCAC, BKR, and/or HSC
d. Suggest focusing on children with the highest needs and resource utilization.

3) *Policy Issues Identified (a short list …)*

a. Multiple funders, policy makers and providers

- no system-wide mechanisms to support information sharing, joint planning and collaboration
- families need single, easy to access source of information about all of the services and resources that are available and how they can be accessed.

b. Service Issues and Limitations

i. CCAC service limits

- e.g. some (local) evidence in support of the use of a blended care delivery model with both regulated and unregulated providers.
- 'key workers' who are highly knowledgeable of the child and families unique care needs, and the abilities of the homecare providers (scope and individual competence) may be able to determine best case mix

ii. continuity across service locations

- e.g. no CCAC in child care settings

c. Resource Availability and Stability

- a major issue throughout health care BUT especially in home care sector AND for children
- also little planning of medical care for these children (remuneration incentives for MDs, integration of community paediatricians with community teams)

d. Focus on the family

- E.g. structuring programs and services to support the family/caregiver
- E.g. more flexible service delivery/case management options to support families in self-managing (or to direct funding) for their child's care

Appendix 5: Project Charter Paediatric Nurse Practitioner Led Clinic in the Toronto Central Local Health Integrated Network (LHIN)

Project Charter

Paediatric Nurse Practitioner Led Clinic in the Toronto Central Local Health Integrated Network (LHIN)

Distribution List

Name (Individual or Group)	Title	Department
TBD	TBD	TBD

Document Version History

Creation / Change Date	Created / Changed by	Reason Description	Approved By
September 3, 2009	The Hospital for Sick Children	Initial document	The Hospital for Sick Children

Project Charter Roadmap

PROJECT OVERVIEW (MANDATORY)

Pediatric Nurse Practitioners (NP-Peds) are well positioned to improve access to care, provide community education and advocate for vulnerable populations within the context of providing integrated health care services for infants, children and youth. The Hospital for Sick Children (SickKids) has a well developed and respected group of NP-Peds who have been building bridges in children's services within sub-specialty populations for over 20 years. The NP-Peds have consistently demonstrated high levels of clinical competence, collaboration within and across teams, and coordination and integration of a variety of services in the acute and community sectors in order to improve the effectiveness of pediatric care for patients.

This project proposes the introduction of an NP-Peds clinic, staffed by SickKids NP-Peds, located within the current Regent Park Community Health Centre (CHC) to further system efficiencies, improve access and integrate services within the Toronto Central LHIN. This clinic will address the high need for respiratory care for infants, children and youth that is a high burden of illness within a vulnerable (high poverty) population.

The NP-Peds are uniquely positioned to leverage their expertise in advanced health assessment, diagnosis, treatment, education, referral, coordination and advocacy of infants, children and adolescents with respiratory diseases. The NP-Peds will function in a broad circle of care in collaboration with health and social services providers within the Toronto Central LHIN (specifically with SickKids, Toronto East General Hospital (TEGH), Children's Aid, and other community practitioners).

The clinic will be overseen by SickKids in collaboration with members of the Regent Park CHC. Clinical supervision of the NP-Peds will be provided by SickKids and with administrative oversight provided by an Advisory Committee established to oversee the development, implementation and evaluation of this innovative and integrating strategy.

PROJECT OBJECTIVES (MANDATORY)

1. Develop a NP-Peds clinic in the Regent Park CHC
    - A. Establish clinic infrastructure
        - I. Space/Equipment Needs
        - II. Patient Flow
        - III. Hire/Appoint and Orient Clinic Staff
        - IV. Launch Clinic
        - V. Evaluate Operations and Impact of Clinic
    - B. Establish governance infrastructure for NP-Ped Clinic
        - I. Address liability issues
        - II. Develop collaborative governance structure
2. Develop a plan for the TC LHIN to establish NP-Peds clinics in appropriate CHCs.
    - A. Perform needs assessment for all of TC LHIN CHCs
    - B. Develop sustainability plan
        - I. Engage stakeholders
        - II. Review literature
        - III. Develop strategy to link needs with current resources

IV. Review strategy with key stakeholders
V. Develop TC LHIN implementation plan

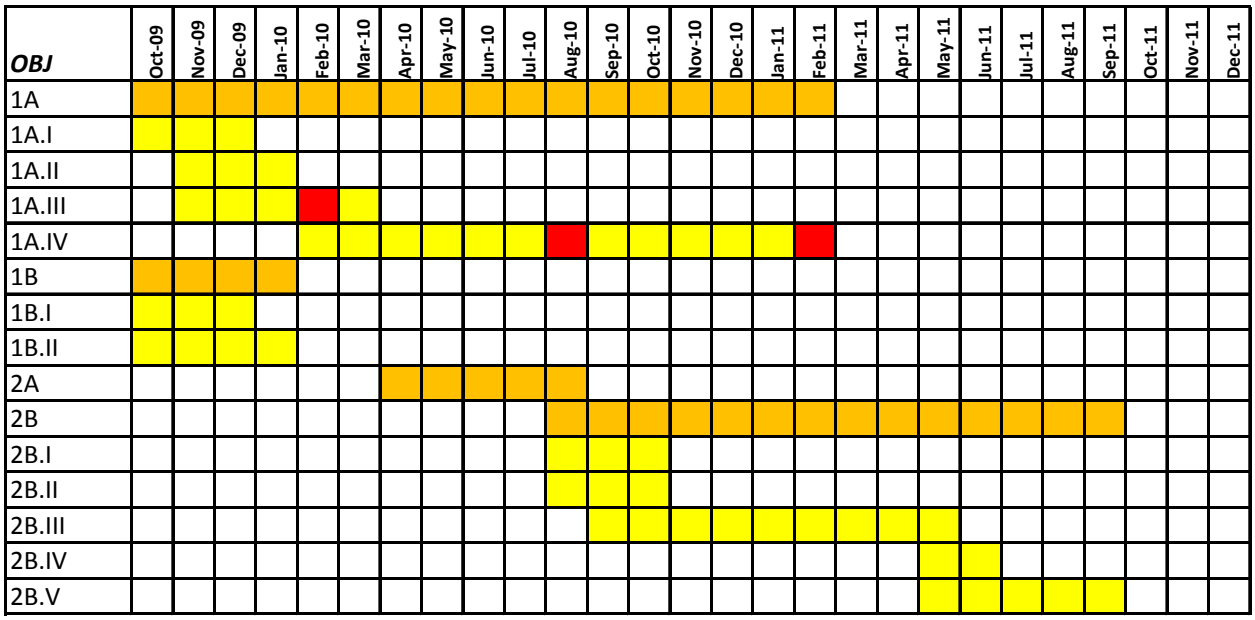
PROJECT SCOPE (MANDATORY)

A high level description of the scope of the project that expands upon the objectives listed in Section 2.0 – identifying work that will be required to accomplish each objective, work that will not be performed as part of the project and any dependencies that may impact each objective.

Objective	*In Scope*	*Out of Scope*	*Dependencies*
1. Develop a NP-Peds clinic in the Regent Park CHC	A. Establish clinic infrastructure I. Space/Equipment Needs II. Patient Flow III. Hire/Appoint and Orient Clinic Staff IV. Launch Clinic V. Evaluate Operations and Impact of Clinic B. Establish governance infrastructure for NP-Ped Clinic I. Address liability issues II. Develop collaborative governance	• Providing clinic services greater than two (2) half hour (1/2 h) clinics per week • Providing services for more than one sub-specialty • Anything else not specifically identified as in scope	• Dedicated project resources must be secured from respective organizations • Regent Park must stock clinic with supplies required
2. Develop a plan for the TC LHIN to establish NP-Peds clinics in appropriate CHCs.	A. Perform needs assessment for all of TC LHIN CHCs B. Develop sustainability plan I. Engage stakeholders II. Review literature III. Develop strategy to link needs with current resources IV. Review strategy with key stakeholders V. Develop TC LHIN implementation plan	• Needs assessment and sustainability for any services beyond those being proposed as part of the NP-Peds Clinic • Any other operations associated with other services / clinics • Anything else not specifically identified as in scope	• Dedicated project resources must be secured from respective organizations

PROJECT PRELIMINARY SCHEDULE (MANDATORY)

An estimation of the planned dates for performing project work that focuses on sequencing, fixed/firm dates, and best estimates for work effort and durations.



PROJECT COST (MANDATORY)

Project Budget Identification – Please identify which type of project costing will be applied.

- ☐ Allocated budget with internal costs tracked as well (i.e. human resources, overhead, etc.)
- ☐ Allocated budget with no internal costs tracked
- ☒ No allocated budget and no internal costs tracked

For Projects with allocated budgets – no allocated budget at present

Other financial Considerations – Project Management, Sessional fees for consultative physicians

PROJECT ORGANIZATION (MANDATORY)

7.1 Project Stakeholders - Groups or organizations whose interests may be impacted by the execution of the project, and/or who may exert influence over the project and its deliverables.

Group/Individual	Project Role	Internal/External
1. The Hospital for Sick Children	*Project Sponsor*	*Internal*
2. Regent Park CHC	*Project client / customer*	*External*
3. Toronto Central LHIN	*Jurisdictional LHIN, governance support, funders*	*External*
4. All TC LHIN hospital's and CHCs with a paediatric mandate	*Subject matter experts, key stakeholders of new serivce*	*External*
5. TC LHN Paediatricians	*Referrers to new service, key stakeholders*	*External*

7.2 Project Team - Critical resources and/or identified team members who will be responsible for performing the work of the project.

Name	Department	Project Role
1. TBD .25-.5 FTE	*TBD*	*Project Manager*
2. Director TBD	*Nursing and Interprofessional Practice*	*Organizational Lead*
3. Director TBD	*Regent Park CHC*	*Organizational Lead*
4. NP-Peds	*SickKids – Respiratory (.2 FTE)*	*Project Team Member*
5. Registered Nurse or Respiratory Therapist	*SickKids – Respiratory (.2 FTE)*	*Project Team Member*
6. Administrative Support	*Regent Park*	*Project Team Member*
7. Physician (Sessional)	*SickKids - Respiratory*	*Project Team Member*

PROJECT RISK IDENTIFICATION AND ASSESSMENT (MANDATORY)

8.1 Risk List – A list of the top 3-5 known project risks at this time (assumptions, constraints, dependencies, etc.).

Risk (uncertain event that may be impact the project either positively or negatively)

1. ***Project costs***
2. ***Addressing the populations needs***
3. ***Collaborative relationships between community and hospital health care professionals***
4. ***Link to Electronic Child Health Network (eCHN) for NP-Peds at CHC***
5. ***Inability to positively impact wait times***
6. ***Staff safety***
7. ***Increase in patient demand from outside of catchment area***

8.2 Risk Analysis – An analysis of the risks listed above to consider the impact, probability, timeframe and consequence of the risk occurring, as well as the planned response. This analysis should be discussed by the Project Manager, Sponsor and Client/Customer/Business Owner.

Risk from list above	**Consequence** of risk occurring	**Impact** high / medium / low	**Probability** high / medium / low	**Timeframe** near / mid / long-term	**Response** mitigate / transfer / avoid / accept / share / exploit / enhance
1. IF project costs cannot be covered by current resources	THEN scope may have to be decreased or timelines extended to ensure quality is not impacted	High	Medium	Near/ mid	Mitigate by securing support for project before initiation
2. IF strategies do not adequately address the needs of marginalized children	THEN implementation may be challenging due to a lack of perceived value of the initiative	High	Low	Mid/long	Mitigate through planning based on data analysis of burden of disease in the CHC area
3. IF community providers and hospital providers experience challenges in co-locating	THEN patients will not be able to fully benefit from this integrated approach to care	High	Low	Near/mid	Mitigate by ensuring strong communication during both the planning and implementation and provide orientation for both community and acute health care professionals
4. IF NP unable to link to eCHN	THEN benefit of the patient being seen in the community is not fully realized	Medium	Medium	Near	Avoid through the Regent Park CHC being potentially involved in eCHN proof of concept for the TC LHIN

Risk from list above	**Consequence** of risk occurring	**Impact** high / medium / low	**Probability** high / medium / low	**Timeframe** near / mid / long-term	**Response** mitigate / transfer / avoid / accept / share / exploit / enhance
5. IF clinic visits are unable to positively impact wait times	THEN clinic may not be seen as a success from some perspectives	High	Medium	Long term	Mitigate through effective inclusion of patient flow analysis and communication with acute setting of new referral base
6. IF staff are unaware of safety in new environment	THEN staff may be put in dangerous situation	High	Low	Mid term	Mitigate through proper education of safety issues in orientation for clinical staff
7. IF there is an increase in patient demand from outside of catchment area	THEN the clinic may not be fully utilized by local catchement	Medium	Low	Mid term/long term	Mitigate through education of referring physicians and NPs of local nature of CHC clinics

ACCEPTANCE CRITERIA (MANDATORY)

9.1 Acceptance of Project Objectives – taken from either section 2.0 Project Objectives (high level) or section 5.0 Project Preliminary Schedule (detailed level) above.

ID	*Project Objectives*	*Acceptance Criteria* ***Specific key performance indicators, critical success factors, evaluation plans, etc.***	*Acceptor*
1	**Develop a NP-Peds clinic in the Regent Park CHC**	***Clinic infrastructure and governance model accepted***	***SickKids***
1A	**Establish clinic infrastructure**	***Patient flow and staffing structures accepted; space/equipment needs adequately met and clinic opened with evaluation plan in place to assess impact and operations.***	***Project Advisory Committee and Regent Park CHC***
1B	**Establish governance infrastructure for NP-Ped Clinic**	***Governance model implemented with liability issues specifically addressed***	***Project Advisory Committee and Regent Park CHC***

ID	Project Objectives	Acceptance Criteria ***Specific key performance indicators, critical success factors, evaluation plans, etc.***	Acceptor
2	**Develop a plan for the TC LHIN to establish NP-Peds clinics in appropriate CHCs.**		***SickKids***
2A	**Perform needs assessment for all of TC LHIN CHCs**	***Needs Assessment formally submitted to the Toronto Central LHIN***	***Project Advisory Committee***
2B	**Develop sustainability plan**	***Sustainability Plan formally submitted to the Toronto Central LHIN***	***Project Advisory Committee and Regent Park CHC***

9.2 Acceptance of Project Overall

Overall Project Objectives	Acceptance Criteria	Lead ***(Doer)***	Acceptor
4. All objectives, deliverables, outputs, etc. completed	• ***Per above criteria***	• ***PM***	• ***SickKids***
5. All project documentation completed	• ***Accepted throughout the project life cycle***	• ***PM***	• ***SickKids***
6. All Project Team members released from project work and performance feedback provided to the supervisor of each	• ***Completion of objective via telephone conversation, in-person conversation or email***	• ***PM***	• ***SickKids***

FORMAL ACCEPTANCE & AUTHORIZATION TO PROCEED (MANDATORY)

Signature Disclaimer: By signing below, you confirm that you have read all the contents of the Project Charter and agree to the aforementioned details. By your signature, you endorse this project and commit to support the project team in its aim to achieve the stated goals and objectives. Your approval will be required if/when the project baseline changes and a formal Change Request will be required. The Change Control Process for this project will be defined in the Project Management Plan.

Name and title		
Project Sponsor	Signature	Date