

Toronto Central
LOCAL HEALTH INTEGRATION NETWORK
RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
du Centre-Toronto

Long-Term Ventilation Strategy Development for Ontario

Submitted to:
Hugh MacLeod
Associate Deputy Minister
Executive Lead, Health Results Team
Ministry of Health and Long-Term Care

Submitted by:
Toronto Central Local Health Integration Network

PROGRESS REPORT

June 28, 2007

Table of Contents

1.0	INTRODUCTION	2
1.1	THE CRITICAL CARE IMPERATIVE	2
1.2	THE CHRONIC VENTILATION STRATEGY TASK GROUP	2
1.3	THE MINISTRY'S INVESTMENT.....	3
1.4	THE LONG-TERM VENTILATION STRATEGY DEVELOPMENT STEERING COMMITTEE	4
2.0	THE TARGET POPULATION	4
3.0	THE VISION FOR THE LONG-TERM VENTILATION STRATEGY	5
4.0	PROGRESS TO DATE	6
4.1	STRATEGY DEVELOPMENT.....	6
4.1.1	<i>Implementation Planning</i>	7
4.1.2	<i>Centres of Excellence</i>	8
4.1.3	<i>Long-Term Ventilation Registry</i>	9
4.1.4	<i>Strategy Secretariat</i>	13
4.1.5	<i>Communication Plan</i>	13
4.2	STATUS OF BED IMPLEMENTATION	14
4.2.1	<i>The Plan for Additional Beds</i>	14
4.2.2	<i>Implementation Progress</i>	14
4.2.3	<i>Identifying Transfer Candidates from ICUs</i>	15
5.0	NEXT STEPS	15

List of Appendices

APPENDIX A: CHRONIC VENTILATION STRATEGY TASK GROUP RECOMMENDATIONS.....	16
APPENDIX B: STEERING COMMITTEE MEMBERSHIP	18
APPENDIX C: STEERING COMMITTEE TERMS OF REFERENCE	20
APPENDIX D: CENTRES OF EXCELLENCE IMPLEMENTATION TEAM DRAFT TERMS OF REFERENCE	22
APPENDIX E: HIGH-LEVEL BUSINESS REQUIREMENTS FOR THE REGISTRY	24
APPENDIX F: COMPARISON OF PROVINCIAL DISEASE-SPECIFIC NETWORKS.....	25
APPENDIX G: ADVICE FROM OTHER PROVINCIAL NETWORKS.....	34
APPENDIX H: DRAFT LONG-TERM VENTILATION STRATEGY COMMUNICATIONS PLAN	35

1.0 INTRODUCTION

1.1 *The Critical Care Imperative*

In 2004/05, as part of its Access to Services and Wait Times Strategy, the Ministry of Health and Long-Term Care (the ministry) launched a four-year Critical Care Transformation Strategy. The purpose of the transformation strategy was to improve the quality of care and system performance in adult critical care services in Ontario.

As a first step, the ministry convened the Ontario Critical Care Steering Committee (the committee) with a mandate to conduct a comprehensive review of the state of these critical care services and to prepare recommendations for a system-wide transformation.

During its research, the committee discovered that many intensive care unit (ICU) beds in Ontario were occupied by ventilator-dependent individuals¹ who were otherwise medically stable. These individuals did not need the critical care services available in an ICU, and did not receive the rehabilitative and other services they did require. However, no adequate alternative setting was available for these individuals.

Accordingly, the committee identified the need for a detailed care strategy and associated resource allocation recommendations to address the needs of these of the individuals. In its report,² the committee made the following recommendation:

The Ministry of Health and Long-Term Care enhance the capacity of critical care resources in Ontario by increasing the number of chronically ventilated beds in Ontario in a timely fashion. These beds should be sited where the need is the greatest. In addition, the Ministry should support the expansion of innovative chronic ventilatory services such as home ventilation to meet the needs of these patients. (Recommendation #8)

The ministry then convened the Ontario Critical Care Expert Advisory Panel to oversee all aspects of the Critical Care Transformation Strategy. The Expert Advisory Panel in turn established the Ontario Chronic Ventilation Strategy Task Group (the task group) to address the committee's recommendations.

1.2 *The Chronic Ventilation Strategy Task Group*

The task group's immediate mandate was to identify effective short-term strategies to facilitate the transfer of medically-stable, ventilator-dependent individual out of Ontario's ICUs and into a more appropriate care setting. The task group's mandate

¹ The Committee referred to these individuals as "chronically-ventilated patients". This Steering Committee prefers the term "ventilator-dependent individuals." Similarly, this Committee uses the phrase "long-term ventilation" instead of "chronic ventilation".

² Final Report of the Ontario Critical Care Steering Committee. March 2005.

included the preparation of a detailed care strategy and associated resource allocation recommendations to address the needs of ventilator-dependent individuals.

The task group made nine recommendations to guide the planning and delivery of care for individuals who are, or who are at risk of becoming, ventilator dependent. In brief, these recommendations include:

- 1) Establishing additional chronic assisted ventilatory care (CAVC) and weaning beds and ensuring that ventilated patients living in ICUs have priority access to these new resources.
- 2) Exploring supportive care (attendant housing) options as an alternative to CAVC beds and home care as well as providing respite care beds for families in these settings.
- 3) Reviewing funding levels for CAVC beds and expanding the funding for outpatient services.
- 4) Establishing a network of organizations to coordinate services for individuals who are ventilator-dependent or who are at risk of becoming so and empower this network to lead performance improvement, advise on resource allocation and support the network with an electronic registry to collect a minimum data set on all relevant individuals.
- 5) Designating a provincial weaning centre to act as resource for the entire province.
- 6) Improving training provided to healthcare professionals caring for this population.
- 7) Working with health care education partners to launch education and awareness programs aimed at community health care professionals to foster early identification of at risk individuals.
- 8) Working with appropriate patient advocacy groups to launch education and awareness programs aimed at patients and families that focus on health care options and choices.
- 9) Improving supports to ventilator-dependent individuals living at home and their families.

The detailed recommendations are reproduced in Appendix A.

1.3 The Ministry's Investment

In spring 2007, the ministry announced an investment of \$5.2 million annually to fund additional inpatient resources for ventilator-dependent individuals:

- Fourteen new chronic assisted ventilatory care (CAVC) beds for ventilator-dependent individuals who cannot live at home.
- Two additional weaning beds at Toronto East General Hospital.

The funding was also intended to support:

- West Park Healthcare Centre to act as a CAVC Centre of Excellence to improve CAVC services throughout the province.
- Toronto East General Hospital to provide clinical leadership to improve weaning practices across Ontario.

The ministry also provided one-time funding for the Toronto Central LHIN to:

- Develop the strategy and
- Create an electronic registry to coordinate care for these high-need individuals.

1.4 The Long-Term Ventilation Strategy Development Steering Committee

The ministry asked the Toronto Central LHIN to facilitate the establishment of a Long-Term Ventilation Strategy Development Steering Committee (the steering committee) to:

- Advise the Toronto Central LHIN on strategy development and action planning. Implementation of the action plan is outside the scope of this project.
- Support the establishment of a Strategy Secretariat to facilitate the implementation of the Committee's action plan.

The steering committee's membership includes health care providers representing a variety of relevant professions (e.g., respirologists, respiratory therapists, nurses), health care administrators, policy makers (e.g., representatives from the LHINs and the ministry), a consumer representative and a family member. A list of the steering committee membership is provided in Appendix B.

The steering committee's terms of reference are included as Appendix C.

2.0 THE TARGET POPULATION

The task group identified three main types of diagnosis for individuals who become ventilator dependent:

1. Acute lung injury/acute respiratory distress syndrome (ARDS).
2. Chronic Obstructive Pulmonary Disease (COPD).
3. Non obstructive ventilatory failure, which includes the following conditions:
 - a) Degenerative neuromuscular diseases (NMDs)
 - b) Thoracic cage deformities (e.g., kyphoscoliotics)
 - c) A high spinal cord injury.

The onset of some of these diseases is during childhood (e.g., muscular dystrophy), while others are more likely to affect the individuals as young adults. With these

diseases (except spinal cord injury, which is the result of trauma), the individual's condition gradually deteriorates over time, until the he or she becomes fully dependent on mechanical ventilation. In general, the deterioration of the respiratory system accompanies the decline in neuromuscular function. Therefore, these individuals, in addition to the ventilatory requirements, are often in need of special assistive devices and total care.

For the purpose of this work, the target population was defined as ventilator-dependent individuals. The task group chose the following specific definition for this population:

“those patients suffering from a severe respiratory impairment who require ventilatory support for more than six hours per day for more than 21 days, but who do not require additional services provided by a critical care unit (i.e., patients who are otherwise medically stable).”

With the exception of individuals who are ventilator dependent because of an acute catastrophic event, the individual is typically already in the care of a physician (e.g., general practitioner, neurologist, respirologist, pediatrician) even before the disease has advanced to the stage where the individual requires mechanical ventilation. The task group chose to refer to this period in the continuum of care, before mechanical ventilation has been started, as the “at risk” period.

3.0 THE VISION FOR THE LONG-TERM VENTILATION STRATEGY

The steering committee has adopted the following elements of the vision for delivering care to this population as articulated by the task group:

- **Meet the immediate need for capacity** by increasing the number of weaning and CAVC beds to create capacity to transfer the approximately 45 ventilator-dependent individuals currently in ICU beds across the province to a more appropriate setting, thereby improving the individuals' quality of life and liberating ICU beds for more acutely ill individuals.
- **Manage ventilator-dependent individuals proactively** to avoid admission to an ICU through interventions while the individual is still living in the community and outreach programs to inpatient wards.

This committee's work is about transitions. The development of a patient registry will be instrumental in helping health care professionals to anticipate and plan for the ventilator-dependent individual's short- and long-term care needs. Through this strategy, these individuals will receive care in the most appropriate setting, and the transition to that setting will be timely and seamless.

The committee has identified any change in setting as a target transition, including the following:

- From ICU to a weaning bed or a home ventilation rehabilitation bed, if appropriate,
- From ICU to a CAVC bed or the community (e.g., supported housing or private residence),
- From CAVC to the community,
- From CAVC or the community to acute care or ICU, when needed,
- From one CAVC to another CAVC (e.g., closer to home),
- From home to supported housing, and
- From pediatric care to adult care.

4.0 PROGRESS TO DATE

4.1 Strategy Development

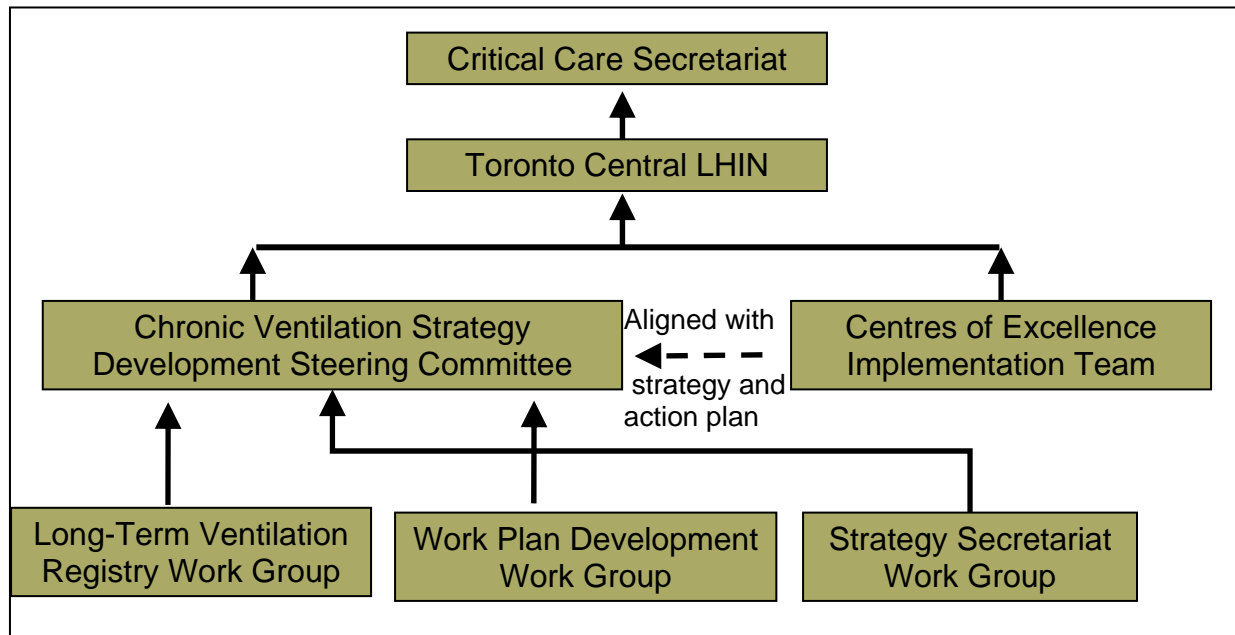
The steering committee is approaching the development of the implementation plan through four initiatives:

1. The development of a detailed implementation plan that includes all of the activities and action plans needed to implement the task group's recommendations.
2. The development of a patient registry.
3. The establishment of a Strategy Secretariat that will oversee the implementation of the action plans developed by the steering committee.
4. The establishment of the two Centres of Excellence (i.e., for weaning and for CAVC).

For the first three initiatives, the steering committee has established work groups to assist in the planning and implementation. The project team is working independently on the establishment of the Strategy Secretariat, under the guidance of the steering committee.

The proposed project governance is presented graphically in Figure 1.

Figure 1: Project Governance



The steering committee will have three full-day meetings, the first of which was held on June 14, 2007. The second meeting will be scheduled for mid-September. The final meeting will be in October, at which time the members will have an opportunity to review a draft report. The three work groups will update the steering committee on their activities at each meeting.

At the end of the first steering committee meeting, members were asked for feedback on the process so far. Two suggestions were made:

- It was suggested that the best way to build and evaluate a care strategy is to work through a couple real cases to see how the system handles these examples.
- It is difficult to brainstorm via teleconference. It was strongly suggested that all future meetings also be in-person meetings.

4.1.1 Implementation Planning

During the first meeting, members volunteered for the Work Plan Development Work Group, which has the task of developing a detailed action plan for long-term ventilation care in support of:

- A provincial system for transferring ventilator-dependent individuals from ICUs to more appropriate care settings (a short-term goal).
- Initiatives to enhance hospital outpatient services and to improve home care and community supports, including respite care. (medium- and long-term goals).

The work group will be using the task group's report as an important guide to its activities. However, the committee members have been encouraged to not be constrained by the task group's specific wording and to be creative and innovative in developing the implementation plan.

Accordingly, the committee members added the following considerations for the action plan:

- A process is needed to ensure that ventilator-dependent individuals in CAVC beds have access to acute care.
- A collaborative education and action plan is needed. The development of this plan should include a representative from long-term care.
- We need to be innovative in delivering care to outpatients. For example, assigning a respirologist to follow an individual after discharge from acute care can contribute to continuity of care and greater access to care for the individual.

The committee is planning to host a stakeholder consultation session in September to solicit input on its draft work plan. This session is in the early planning stage.

4.1.2 Centres of Excellence

The Centres of Excellence are important components of the Long-Term Ventilation Strategy. An implementation team, consisting of representatives from both Toronto East General and West Park Healthcare Centre, has been established to spearhead the development of each Centre of Excellence. The focus of the implementation team will be to identify strategies and related tasks to support the overall goals and objectives of the strategy with emphasis on the following:

- Training and education of ventilator-dependent individuals, care providers and organizations across the continuum of care.
- Development and dissemination of best practices such as standardized care plans and protocols.
- Consultation and support for the management of complex cases.

West Park Healthcare Centre, as the CAVC Centre of Excellence, will work closely with the Strategy Secretariat to provide clinical leadership to improve the quality of care and quality of life for individuals that use long-term ventilation from acute care to complex continuing care and rehabilitation to the community.

Toronto East General, as the provincial Weaning Centre of Excellence, will champion improvements in weaning practices across Ontario. It will also establish a provincial process for transferring "hard to wean" individuals from across Ontario to Toronto East General. Staff will work with the Strategy Secretariat to facilitate repatriation, and/or referral to the most appropriate setting when required.

To date, the centres have received notification of their roles and associated funding. A first meeting of the implementation team was held on June 20, 2007. An action plan has been initiated that will detail the work that needs to be done by the two Centres of Excellence in support of the Long-Term Ventilation Strategy.

The Long-Term Ventilation Centres of Excellence Implementation Team terms of reference are included as Appendix D.

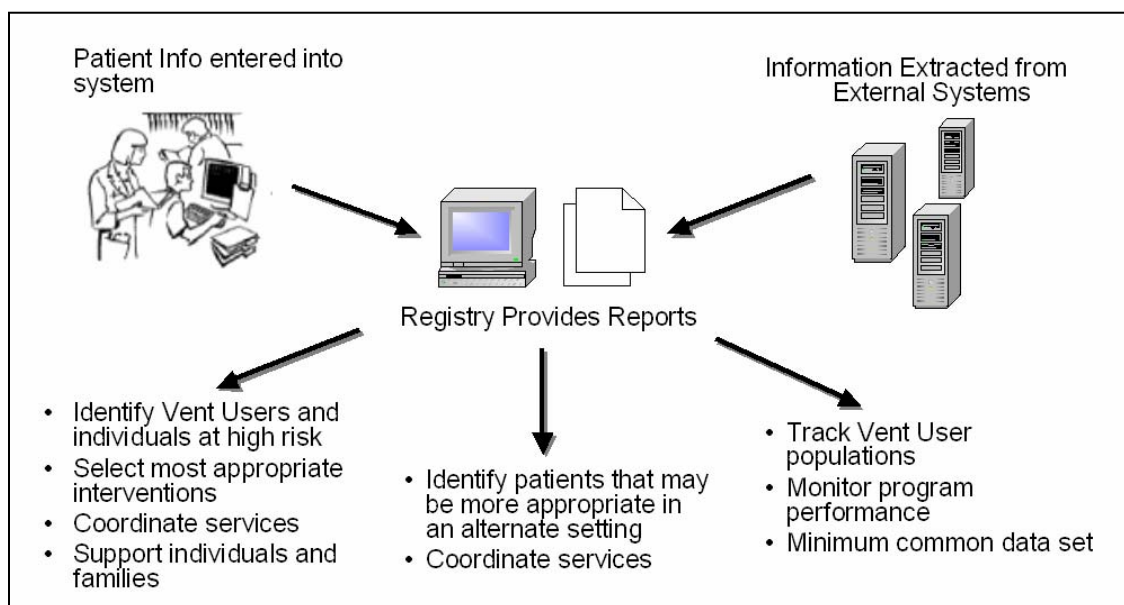
4.1.3 Long-Term Ventilation Registry

The Long-Term Ventilation Registry (LT Vent Registry or Registry) will be a key enabler for successful implementation of the task group's mandate and long-term ventilation strategy. The Registry will help health care professionals to anticipate and plan for the ventilator-dependent individual's short- and long-term care needs. In addition, the registry will identify individuals at high risk for long-term ventilation.

The Registry will be a clinical information system comprising a database to store information on the vented population and software applications to sort this information into views and reports. The Registry will capture, manage and report information on individuals who require long-term ventilation and individuals at-risk for ventilation. The Registry will be a powerful tool for population management, measurement, and evaluation. (See Figure 1.)

It will support organized coordination of services, selection of most appropriate interventions and identification of candidates for transfer from ICU beds across the province to a more appropriate care setting. Furthermore, the registry will assist in proactive management of ventilator-dependent individuals living in the community to avoid unnecessary admissions to ICU.

Figure 2: The Registry Enables Strategic Vision and Objectives



Registry Project Objectives

The following primary objectives were identified for the Registry:

1. To help avoid inappropriate utilization of ICU beds by ensuring ventilator-dependent individuals receive the appropriate level of care in the appropriate setting. The registry will help identify ventilator-dependent individuals that may be candidates for one or more of the following programs:
 - Progressive weaning
 - Home ventilation training with community supports, or
 - CAVC placement.
2. To provide data to inform future capacity planning for the province.
3. To help clinicians identify and support individuals that are at high risk for long-term ventilation in order to better manage their condition and potentially avoid becoming ventilator-dependent.

The following secondary objectives were identified for the Registry:

4. To evaluate the impact of the Long-Term Ventilation Strategy.
5. To provide a minimum data set on this population for research purposes.

Registry Requirements

The following high-level requirements have been identified:

- Facilitate the matching of ventilator-dependent individuals with the most appropriate discharge setting and the necessary supports
- Serve providers from all settings including hospitals and the community

- Integrates specialist expertise and primary care
- Facilitate discharge planning
- Facilitate monitoring of capacity across the continuum of care

It was identified that the Registry could collect data from two sources:

- Information entered directly into the system by providers
- Information extracted from existing external systems (i.e., Ventilation Equipment Pool Registry).

An assessment of whether additional information could be extracted from other systems (e.g. Critical Care Information System) will be completed.

The Registry will provide reporting at a number of levels to support the Long-Term Ventilation Strategy, including:

- **Patient reports:** Patient information and prompts will identify individuals at high risk for long-term ventilation, deliver recommended interventions and capture information to update patient records.
- **Registry-generated exception reports:** Based on predetermined criteria, these reports will identify individuals that could receive care in an alternate setting.
- **Aggregate reports:** Census information across the continuum of care will help to document the percentage of ventilator-dependent individuals that are not in the most appropriate setting.

These requirements will be more fully developed to create the project scope statement. Project budget, timeline, and resource requirements will be identified to support the project scope that is agreed upon by the steering committee.

The draft minimum data set identified in Appendix G of the Long-Term Ventilation Strategy report will be mapped against proposed Registry functionality to determine if gaps exist.

Furthermore, the Registry Working Group will review the business requirements identified in Appendix E, leading to the formation of Request for Proposal requirements that will aid in the vendor selection process.

Project Approach

This project will begin in July 2007. It will be divided into five phases over 14 months, and will select, develop, implement and evaluate a registry to support the objectives set out by the steering committee. The five phases are shown in Table 1.

Table 1: Project Phases for Registry Development

Project Phase	Time Required	Key Activities
1. Planning	3 months	Ensure that all the project details, expectations and scope are clearly developed, documented, and understood.
2. Design	4 months	Develop functional requirements and technical specifications. Document architecture and interface requirements. Develop evaluation framework and determine performance metrics. Conduct RFP for disease registry.
3. Development	4 months	Develop clinical content. Set up hardware and install enhancements. Perform usability testing at and implement the registry.
4. Implementation	4 months	Conduct on-site training. Continue technical and clinical change management activities. Go-live and initiate support services.
5. Benefits Evaluation	3 months	Conduct benefits measurement and project evaluation.

Project Resources

The Toronto Central LHIN will oversee this initiative with advice from the steering committee and in collaboration with all stakeholders. The Toronto Central LHIN will ensure the allocation of appropriate hospital and community resources required for a successful implementation of the Registry.

Shared Information Management Services (SIMS)³ will conduct work on the Registry initiative on behalf of the Toronto Central LHIN and will report into the LHIN and the steering committee. The Registry Working Group will include clinical and technical working teams:

- The clinical team will primarily be responsible for developing Registry requirements (in preparation for Request for Proposal), content development and workflow adaptations.
- The technical team will work with vendors and internal technical teams to ensure that the necessary infrastructure and functionality is operational in each unique environment.

The membership of these teams will include clinical experts from relevant disciplines, information technology personnel, consumer representatives,

³ Shared Information Management Services (SIMS) is the information management and technology group that is shared between nine health care organizations in the Greater Toronto Area.

administrative process representatives, community partners (i.e., community care access centres) and private sector participants. SIMS will work with the LHIN and ministry to ensure alignment with associated projects and strategies.

4.1.4 Strategy Secretariat

As a first step, the project team conducted a review of four existing provincial networks:

- The Cardiac Care Network of Ontario (CCN),
- The Ontario Stroke System (which grew out of the Ontario Stroke Strategy),
- The Child Health Network (CHN), and
- The End-of-Life Care Network.

This review included background material describing the networks^{4,5,6,7} and interviews with key informants where written material was not available or sufficiently detailed.^{8,9} The review included an assessment of the each network's origin, membership, vision and mission, responsibilities and key activities. The team also looked the provincial and regional governance model as well as the resources available at both levels. A summary comparison of the four networks is provided in Appendix F.

The project team also found documentation from three of the networks on lessons the networks had learned during their own growth. This advice, which is repeated in Appendix G, will be considered in the development of the Strategy Secretariat.

The project team is still reviewing this information and has not developed any conclusions from regarding how the long-term ventilation secretariat should be structured. This work is in progress.

4.1.5 Communication Plan

The project team prepared a draft communication plan for review by the steering committee at the first meeting. This plan will be implemented in close consultation with the ministry.

A copy of the draft plan is provided in Appendix H.

⁴ Ideas, Innovation and Integration: The Story of The Child Health Network for the Greater Toronto Area. 2001.

⁵ S M, Trypuc J, Lindsay P, O'Callaghan C, Dishaw A. HAS Ontario's Stroke System Really Made a Difference? Healthcare Quarterly Vol. 9 No. 4. 2006 Special Report

⁶ Black D, Lewis M, Monaghan B, Trypuc J. System Change in Healthcare: The Ontario Stroke Strategy. Hospital Quarterly Vol. 6 NO. 4. 2003.

⁷ Ideas, Innovation and Integration: The Story of The Child Health Network for the Greater Toronto Area. 2001.

⁸ Personal communications, Caroline Gangji, Heart and Stroke Foundation of Ontario.

⁹ Personal communications, Susan King, Former Provincial EOL Care Strategy Coordinator.

4.2 Status of Bed Implementation

4.2.1 The Plan for Additional Beds

In response to the task group's recommendation for additional capacity for weaning and CAVC, the ministry approved 16 new beds (i.e., two new weaning beds and 14 new CAVC beds).

In deciding where to establish the new beds, the ministry wished to balance geographic dispersal, so that ventilator-dependent individuals could live closer to home, with the need to consider the impact program size can have on the quality of care provided. Based on the need to trade off these competing priorities, the ministry assigned the new beds as follows:

- The two new weaning beds were assigned to Toronto East General Hospital to help it consolidate its role as a provincial service for treating hard to wean individuals in ICU beds. This addition increases weaning capacity at this centre from six to eight beds.
- The 14 new CAVC beds were assigned to existing units rather than establishing new CAVC units. The addition of these new beds brings the provincial capacity to 62, as shown in Table 2.

The hospitals that have been identified to receive funding for new beds are expected to have the new CAVC beds ready for occupancy by October 1, 2007.

Table 2: Existing and Recently Funded Inpatient Capacity at Centres Receiving New Funding

Provider	Number of beds			Bed Designation
	Existing (Jun 07)	Funded Increase	Total (Oct 07)	
St. Joseph's, London	3	2	5	CCC
St. Joseph's, Hamilton	1	2	3	Acute
Sisters of Charity, Ottawa	8	2	10	CCC
Grand River, Kitchener	4	2	6	CCC
West Park, Toronto	22	6	28	CCC
Toronto East General (CAVC)	10	0	10	CCC
Subtotal beds excluding weaning	48	14	62	
Toronto East General (Weaning)	6	2	8	Acute
Total beds including weaning	54	16	70	

4.2.2 Implementation Progress

The Program Coordinator, Capacity Investments and Surge Management for the Ontario Critical Care Strategy requested a progress report from hospitals that will receive incremental funding. She received responses from all centres.

In general, the centres are well into the planning phase for the new beds. They have established working groups and steering committees that are beginning to deal with the full range of implementation issues including, at a minimum:

- Recruitment and training of staff,
- Identification of needed equipment and initiation of the purchasing process,
- Renovations to accommodate the new beds, and
- Operating budgets.

At this time, all centres are working towards October 1, 2007 to have the beds ready for occupancy.

Some centres have expressed concern about the ability to recruit the needed health care professions, either because of human resource shortages in the area or because of the limited budget available.

4.2.3 Identifying Transfer Candidates from ICUs

The ministry has identified an intensivist in each LHIN to act as a Critical Care Leader for the LHIN. These physicians have been asked to develop an inventory of ventilator-dependent individuals occupying ICU beds in their regions in anticipation of developing a plan for the transfer of these individuals to a more appropriate setting. The Critical Care LHIN Leaders are meeting this summer to determine the priorities for assigning these individuals to the new CAVC beds.

5.0 Next Steps

At a high level, the next steps are as follows:

- Set final dates for the next two steering committee meetings.
- Begin detailed planning for the stakeholder consultations in September.
- Facilitate meetings and work plan development between the Centres of Excellence
- Confirm membership of the work groups and begin activities in these areas.
- Finalize and implement the communication plan, in collaboration with the ministry.

APPENDIX A: Chronic Ventilation Strategy Task Group Recommendations

Recommendation 1: Immediately establish six new beds for weaning and up to 20 new beds for institutional long-term care for medically-stable, ventilator-dependent patients at facilities that are capable of opening these beds in the very short term. Patients in an ICU would have priority access to these beds. Each expanded site should dedicate at least one of the new beds to respite care and designate some of the additional capacity for reassessment of patients living in the community. This capacity should be made available as quickly as possible, preferably within six months.

Recommendation 2: In addition to creating additional institutional capacity, ask all institutions (including intensive care, chronic assisted ventilatory care and complex continuing care units) to identify any ventilator-dependent patient in their care who would prefer to be in a community setting and their medical condition would allow discharge to an appropriate community setting. For each of these patients, a supportive care (attendant housing) option should be provided if the patient and family are agreeable and an appropriate placement can be established. Where demand is high, these services could include beds for respite care. This capacity should be made available as quickly as possible, preferably within six months.

Recommendation 3: All inpatient beds for chronically ventilated patients identified in this report (existing and proposed) should be funded according to the average cost of the existing programs (i.e., at a rate that reflects the incremental costs of providing care for these patients beyond the average cost for a step-down or complex continuing care bed) and include reimbursement for ventilator equipment and supplies required by the patient. All outpatient clinics and outreach programs for this patient population should be funded according to the resources required to staff these programs to meet expected demand.

Recommendation 4: Establish a Chronic Ventilation Network that includes all centres and organizations in Ontario that provide services to patients who are, or who are at risk of becoming, ventilator dependent. The Network's responsibilities would include:

- Working with Local Health Integration Networks (LHINs) to assess the on-going need for these services and the adequacy of the services provided and to develop solutions that reflect the unique characteristics of the local network.
- Identifying and documenting best practices for the care of ventilator-dependent patients across the continuum of care.
- Facilitating the timely flow of communication between all providers in the service continuum.
- Advising the Ministry on the needed supports and infrastructure for successful community living.
- Fostering the development and delivery of training programs for health care professionals to care for this patient population.

The Network should be supported through the development and operation of a central patient registry to collect a minimum data set on all chronically ventilated patients (whether in the community or an acute care or long-term care institution) to support continuity of patient care at any of the multiple participating institutions in the province, the evaluation of

the proposed strategy, planning for future capacity, and key areas of research, especially those identified by this Task Group as needing attention.

Recommendation 5: Designate one centre as a provincial Centre of Excellence in the weaning of ventilator-dependent patients that would serve to assist and train health care professionals in other parts of the province (where the need justifies the investment and the resources are available to provide the service) to deliver as close to their communities as possible the highly specialized care needed to wean ventilator-dependent patients.

Recommendation 6: Develop and implement a formal training program for physicians (e.g., respirologists, critical care specialists, general internists, pediatricians, neurologists, general practitioners) and allied health professionals (e.g., registered nurses, respiratory therapists, nurse practitioners, occupational therapists and physiotherapists) to care for this patient population. This program would have a provincial mandate.

Recommendation 7: Develop and launch an education program for health care professionals in the community (e.g., physicians, respiratory therapists, registered nurses, personal support workers and therapists) to help them identify those patients who are at risk of developing respiratory failure. The program should include the importance of referring these patients to an appropriate clinic or, if there is no clinic in the immediate area, the program should provide the education and training the physician will need to plan and manage patient-centered care for these patients, including end-of-life decision making.

Recommendation 8: In cooperation with patient advocacy groups including, for example, the Canadian Lung Association, the ALS Society, Muscular Dystrophy Association, Heart and Stroke Foundation, support and enhance existing educational programs and, where needed, develop and launch new educational programs for patients and caregivers regarding options for care to enable informed decision making for their long-term care.

Recommendation 9: Improve the support provided for ventilator-dependent patients living in the community by:

- Providing and funding additional services for ventilator-dependent patients living in the home. These additional services would include respiratory therapist services. These services could be delivered through CCACs or a hospital-based service.
- Establishing a higher limit on the number of hours (i.e., a total of eight hours per day) of care that can be made available to the patient and family in a given period for other services including shift nursing.
- Providing and funding, through either the Assistive Devices Program and its Ventilator Equipment Pool or CCACs, the full range of equipment and supplies required by ventilator-dependent patients living in the community. Consideration should be given to the funding of equipment that will support the management of non-invasive ventilation, such as cough-assist devices and equipment used for volume augmentation. Consideration should also be given to facilitating an equipment recycling program for ventilator-dependent patients.
- Subsidizing the incremental costs incurred by having a ventilator-dependent patient in the home (e.g., incremental hydroelectric use for the ventilators and related equipment, and transportation).

APPENDIX B: Steering Committee Membership

Barry Monaghan (Chair)	Chief Executive Officer, Toronto Central Local Health Integration Network, Toronto
Monica Avendaño, MD	Respirologist, Assistant Professor, Department of Medicine, University of Toronto, Respiriology Program, West Park Health Care Centre, Toronto
Janice Cosgrove	Director, Complex Care, Parkwood Hospital, St Joseph's Health Care, London
Sandi Cox, RN	Chief Nurse Executive and Senior Director Rehabilitation and Complex Continuing Care Bloorview Kids Rehab, Toronto
Winnie Doyle, RN	Vice President Clinical Services and Chief Nursing Executive, St. Joseph's Healthcare, Hamilton
Gwen DuBois-Wing	Chief Executive Officer, North West Local Health Integration Network, Thunder Bay
Rheta Fanizza	Senior Vice President – Operations, St. Elizabeth Health Care, Markham
Ian Fraser, MD	Chief, Department of Medicine Program Medical Director, Medicine Health Service, Toronto East General Hospital, Toronto
Betty Kuchta	Executive Director, Erie St. Clair Community Care Access Centre, Chatham
Bill Innes	Executive Director, North Simcoe Muskoka Community Care Access Centre, Barrie
Robert McKay	Project Manager, Critical Care Secretariat, Ministry of Health and Long-Term Care, Toronto
Douglas McKim, MD	Medical Director, Respiratory Rehabilitation Services, Consultant Sleep Medicine, Associate Professor of Medicine, University of Ottawa, Ottawa Hospital Rehabilitation Centre, Ottawa
Elaine McNaughton	Executive Director, Personal Choice Independent Living/Choix personnel vie autonome, Ottawa
Jane Montgomery	Manager, Respiratory Services, London Health Science Centre
Regina Pizzuti	Manager, Ontario Ventilator Equipment Pool, Kingston General Hospital, Kingston
Renée Prince, MD	Medical Director, CAVC – Sisters of Charity of Ottawa Health Service, Ottawa
Jenny Rajaballey	Vice-President, Mental Health, CCC and Rehabilitation, Grand River Hospital - Freeport Health Centre, Kitchener
Rachel Solomon	Director, Health System Integration, Shared Information Management Services (SIMS), University Health Network, Toronto

Thomas Stewart, MD	Director, Critical Care Medicine, Mount Sinai and University Health Network, Mount Sinai Hospital, Toronto
Rosalind Tarrant	Performance and Integration Consultant, Hamilton Niagara Haldimand Brant Local Health Integration Network, Grimsby
Tom Wagner	Consumer Representative – Waterloo
Margaret Wagner	Family Representative – Waterloo
Krisztina Weinacht	Volunteer Representative from The Lung Association and Physiotherapist, Toronto East General Hospital, Progressive Weaning Unit and Pulmonary Rehabilitation, Toronto

Ex-Officio

Jan Walker	Project Lead, Toronto Central Local Health Integration Network, Toronto
Marcella Sholdice	Project Support, Toronto Central Local Health Integration Network, Toronto
Donna Renzetti	Project Support, Toronto Central Local Health Integration Network, Toronto

APPENDIX C: Steering Committee Terms of Reference

Background

In 2004/05, the Ministry of Health and Long-Term Care (the ministry) launched a four-year Critical Care Transformation Strategy as part of a broader Access to Services and Wait Times Strategy. In the first year, the ministry established the Ontario Critical Care Steering Committee (the committee) with a mandate to conduct a comprehensive review of the state of these critical care services and to prepare recommendations for a system-wide transformation.

The committee identified a need for a detailed strategy for the care of ventilator-dependent but medically stable patients that were occupying intensive care unit (ICU) beds. The Ontario Chronic Ventilation Strategy Task Group (the task group) was established to address the committee's recommendations. Based on the task group's Final Report, the ministry designated the Toronto Central Local Health Integration Network (Toronto Central LHIN) to coordinate the development and implementation of this provincial strategy.

The Toronto Central LHIN is bringing together key stakeholders in a collaborative process to develop an integrated service delivery plan that will further define and support the implementation of the Ontario Chronic Ventilation Strategy. These stakeholders will operate as the Ontario Long-Term Ventilation Strategy Development Steering Committee (the steering committee).

Mandate

The steering committee will support the advancement of a provincial strategy through the development of a detailed action plan for the care of ventilator-dependent individuals in Ontario with short-, medium- and long-term goals. The action plan will support:

- The creation of a provincial system for transferring patients from ICUs to more appropriate care settings,
- The development of protocols for the transfer of patients between care settings (e.g., from pediatric care to adult care, from institution to home, from home to acute care) as needed,
- The development and implementation of training programs to improve the individual's quality of life and the quality of care these individuals receive from health care professionals and from caregivers,
- The identification of initiatives to enhance hospital out-patient services and to improve home care and community supports, including respite care for caregivers,
- The development of a patient registry to track a minimum common data set to guide resource allocation and facilitate program development and integrated care.

In addition, the steering committee will support the establishment of a Strategy Secretariat that will facilitate the implementation of this action plan.

The steering committee's role is to work closely with the Strategy Secretariat to provide clinical leadership to improve the quality of care for this population across Ontario. The implementation of the action plan is outside the scope of this project.

A progress report is to be prepared for June 30, 2007, with a final report due the fall of 2007. Both reports are to be submitted to the ministry. The steering committee will be supported by a project team working out of the Toronto Central LHIN.

Membership

Steering Committee Chair – Barry Monaghan
Membership – See Appendix B.

Timeframe and Accountabilities

The steering committee will begin its work in June 2007. The project team is proposing three half-day meetings. The first meeting will be held in mid-June and the final meeting will be held no later than October 31, 2007.

Reimbursement

Steering committee members will be reimbursed for out-of-pocket expenses incurred to attend the three meetings (e.g., transportation and accommodation costs, as appropriate).

APPENDIX D: Centres of Excellence Implementation Team Draft Terms of Reference

Background

In 2004/05, the Ministry of Health and Long-Term Care (the ministry) launched a four-year Critical Care Transformation Strategy as part of a broader Access to Services and Wait Times Strategy. In the first year, the ministry established the Ontario Critical Care Steering Committee (the committee) with a mandate to conduct a comprehensive review of the state of these critical care services and to prepare recommendations for a system-wide transformation.

The committee identified a need for a detailed strategy for the care of ventilator dependent but medically stable individuals that were occupying ICU beds. The Ontario Chronic Ventilation Strategy Task Group (the task group) was established to address the committee's recommendations. Based on the task group's Final Report, the ministry designated the Toronto Central Local Health Integration Network (Toronto Central LHIN) to take the lead to coordinate the development and implementation of this provincial strategy.

In addition there was the designation of two Centres of Excellence:

- Toronto East General Hospital – Weaning Centre of Excellence
- West Park Health Care Centre – Chronic Assistive Ventilatory Care Centre of Excellence

The Toronto Central LHIN is bringing together key stakeholders in a collaborative process to develop an integrated service delivery plan that will further define and support the implementation of the Ontario Long-Term Ventilation Strategy. These stakeholders will operate as the Long-Term Ventilation Strategy Development Steering Committee (the steering committee) and will support the establishment of a Strategy Secretariat to facilitate implementation. Through an implementation team, the Centres of Excellence will support the steering committee to advise the Toronto Central LHIN on strategy development and action planning and will work closely with the Strategy Secretariat to provide clinical leadership to improve the quality of care and quality of life for this patient population across Ontario.

Mandate

The Centres of Excellence will support the Long-Term Ventilation Strategy as articulated by the Long-Term Ventilation Strategy Development Steering Committee.

The Centres of Excellence Implementation Team will support and coordinate the efforts of the two Centres of Excellence through the establishment of a detailed action plan that will address the following objectives:

- To identify strategies and related tasks to support the overall goals and objectives of the Long-Term Ventilation Strategy;
- To improve long-term ventilatory care across the province, including services provided in critical care units, complex continuing care, and the community. This work will include the provision of training, support and consultation for care providers and ventilator users in other institutions and in the community. It may also involve the development and implementation of educational initiatives with an academic focus.
- To support improvements in weaning practices in Ontario's critical care units. This work will include the provision of training, support and consultation to care teams in other institutions.
- To facilitate research to improve scientific knowledge regarding CAVC and progressive weaning services including post-weaning rehabilitation that will facilitate best practice across the continuum of care.

Chair and Participants

Chair: Toronto Central LHIN

Representation from Toronto East General and West Park Healthcare Centre

Meeting Frequency

There will be three meetings of the implementation team between June and October 2007.

Timeframe and Short Term Accountabilities

The implementation team will begin its work in June 2007. A progress report is to be prepared for June 30, 2007 with a final report due the fall of 2007. Both reports are to be submitted to the Ministry of Health and Long-Term Care.

APPENDIX E: High-Level Business Requirements for the Registry

Identify:

- i. All current ventilator-dependent individuals
- ii. Ventilator-dependent individuals who could be supported in community
- iii. Patients at high risk for long-term ventilation

Assess:

- i. Perform and document clinical assessment & diagnosis using standard forms that would help identify the most appropriate placement and level of support

Proactive Planning:

- i. Decision support to develop interdisciplinary care plan
- ii. Ensure ventilator-dependent individuals receive appropriate level of care in the most appropriate setting
- iii. View Clinical Practice Guidelines and Evidence-Based references on treatment options

Management, Education, Treatment

- i. Manage care plan, access clinical results, progress notes
- ii. Providers receive proactive alerts & reminders to promote best practice management of ventilator-dependent individuals
- iii. Case management for ventilator-dependent individuals and those at high risk for ventilation
- iv. Review care plan progress
- v. Education information for patients and families

Monitoring and Feedback

- i. Track ventilator-dependent individuals across continuum of care
- ii. Track patients with chronic conditions that put them at high risk of long-term ventilation (i.e., COPD, degenerative neuromuscular disease)
- iii. View performance indicators on individuals and populations
- iv. Communicate with client /clinicians
- v. Generate exception reports
- vi. Proactively identify navigation gaps

Program Evaluation and Refinement

- i. View program evaluation reports
- ii. Identify subpopulations for care
- iii. View program evaluation reports
- iv. Review performance reports-teams & program

APPENDIX F: Comparison of Provincial Disease-Specific Networks

	Cardiac Care Network of Ontario (CCN)¹⁰	Ontario Stroke System (OSS)^{11,12,13}	Child Health Network for the Greater Toronto Area (CHN)¹⁴	End of Life Care Network¹⁵
Established By	MOHLTC	Championed by the Heart and Stroke Foundation of Ontario, by working with the MOHLTC	MOHLTC at the recommendation of the HSRC	MOHLTC
Year	1995 (CCN's predecessor organization was established in 1990)	In 2005/06, the MOHLTC transferred the management of the OSS from a centralized provincial approach to a regional provider approach with central governance.	First operating plan was finalized in October 2000.	Strategy developed in 2004. Network established in 2005.
Reason	In response to concerns about mortality on the cardiac surgery wait list	Approval in 1996 by the FDA of t-PA for emergency ischemic stroke.	Recognition of the need for systems planning for maternal, newborn and children's health care services by tertiary hospitals in Toronto (particularly the Hospital for Sick Children) and the Metropolitan Toronto District Health Council. Also supported by the HSRC.	The ministry had recognized the need to provide end of life care in a more appropriate setting (e.g., the community instead of acute care hospitals).

¹⁰ Ideas, Innovation and Integration: The Story of The Child Health Network for the Greater Toronto Area. 2001.

¹¹ S M, Trypuc J, Lindsay P, O'Callaghan C, Dishaw A. HAS Ontario's Stroke System Really Made a Difference? Healthcare Quarterly Vol. 9 No. 4. 2006 Special Report

¹² Black D, Lewis M, Monaghan B, Trypuc J. System Change in Healthcare: The Ontario Stroke Strategy. Hospital Quarterly Vol. 6 NO. 4. 2003.

¹³ Personal communications, Caroline Gangji, (Need a title), Heart and Stroke Foundation of Ontario.

¹⁴ Ideas, Innovation and Integration: The Story of The Child Health Network for the Greater Toronto Area. 2001.

¹⁵ Personal communications, Susan King, Former Provincial EOL Care Strategy Coordinator.

	Cardiac Care Network of Ontario (CCN) ¹⁰	Ontario Stroke System (OSS) ^{11,12,13}	Child Health Network for the Greater Toronto Area (CHN) ¹⁴	End of Life Care Network ¹⁵
Goals	Develop an accurate, reliable database using common terminology that would standardize the process of triaging cardiac-surgery patients Advise the ministry on coordinating the system of cardiac care services in Ontario	Decrease the incidence of stroke and to improve patient care and outcomes for persons who experience stroke. By reorganizing stroke care delivery, ensure that all Ontarians have access to appropriate, quality stroke care in a timely manner.	Continuously improve the clinical outcomes and quality of life for mothers, newborns, children and youth by ensuring that care processes are coordinated, are of the highest quality, and are based on evidence-based practice. Provide channels for the effective creation, evaluation and dissemination of knowledge to improve the health of mothers and newborns, children and youth. Leverage the strength of the CHN to positively influence public policy on behalf of mothers, newborns, children and youth. Promote the development of appropriate care delivery models for mothers, newborns, children and youth throughout the GTA.	Shift care of the dying from acute setting to appropriate alternate settings of individual choice Enhance client-centred and interdisciplinary end-of-life service delivery capacity in the community Improve access, coordination and consistency of services and supports.

	Cardiac Care Network of Ontario (CCN) ¹⁰	Ontario Stroke System (OSS) ^{11,12,13}	Child Health Network for the Greater Toronto Area (CHN) ¹⁴	End of Life Care Network ¹⁵
Members	13 cardiac centres	11 stroke regions	20 hospitals in the GTA that provide maternal, newborn and children's acute and rehabilitative services. 10 CCACs in the GTA	Initially, 16 regions (aligned with the District Health Councils).
Funded by	MOHLTC	MOHLTC	MOHLTC	MOHLTC
Vision and Mission				
Vision	As a dynamic partnership between professional providers, institutions, community members, and government, providing advice based on data analysis and scientifically valid information, we will be come an essential resource in improving the delivery of adult cardiac care in Ontario		Members will collaborate to set and achieve standards, and to carry out research and education activities, facilitate the planning and delivery of coordinated family-centered maternal, newborn and children's care of the highest quality. CHN and its members will work in partnership with other service providers and networks to plan and advocate for access to required maternal, newborn and child health services.	A full range of high quality client-centered palliative/end-of-life care services will be available in the care setting and community of choice through an integrated network of palliative care providers. (Northwestern Ontario End-of-Life Care Network Strategic Plan)

	Cardiac Care Network of Ontario (CCN) ¹⁰	Ontario Stroke System (OSS) ^{11,12,13}	Child Health Network for the Greater Toronto Area (CHN) ¹⁴	End of Life Care Network ¹⁵
Mission	We are an advisory body to the MOHTLC that is dedicated to improving quality, efficiency, access and equity in the delivery of the continuum of adult cardiac services in Ontario. Using data- and consensus-driven methods, we offer planning advice for the future of cardiac services and the provision of exemplary care in collaboration with the ministry and others.		The CHN will generate optimal health outcomes for mothers, newborns, children and youth, by establishing and enabling a common and consistent standard of family-centered care throughout CHN.	Provide leadership and the structure to facilitate the ongoing development, implementation, maintenance and evaluation of a comprehensive, integrated and coordinated system of palliative/end-of-life care (Northwestern Ontario End-of-Life Care Network Strategic Plan)
Responsibilities				
Development and Coordination		Make recommendations on funding allocations Recommend opportunities and approaches for integration and coordination of services delivery	Develop new approaches to care through improved standardization, enhancements and innovation in current practice	Focus on education
Clinical practice	N/A	Identify best practice.	Adopt common standards of family-centered care throughout the network.	Focus on common guidelines and assessment tools for target patient population

	Cardiac Care Network of Ontario (CCN) ¹⁰	Ontario Stroke System (OSS) ^{11,12,13}	Child Health Network for the Greater Toronto Area (CHN) ¹⁴	End of Life Care Network ¹⁵
Access			Improve access to high quality, effective health care for mothers, newborns, children and youth.	Develop access to supports and services
Management	Support and direct role of regional coordinators	Foster innovation and system change Set standards and targets Identify emerging issues		
Information and analysis	Facilitate development and maintenance of the CCN registry Review and monitor trends	Manage data		Develop inventories of services
Research	Approving requests for access to registry data Strong relationship with ICES, which studies the epidemiology of cardiovascular disease and provide periodic review of trends in cardiovascular care using CCN data.	Knowledge transfer and capacity building		Facilitate research
Key Activities				Varies by Region
Database Development	Patient registry for cardiac surgery, diagnostic caths, angioplasty, electrophysiology study, ablation and ICD implantation.		Initiated the development of the Electronic Child Health Network (eCHN).	

	Cardiac Care Network of Ontario (CCN) ¹⁰	Ontario Stroke System (OSS) ^{11,12,13}	Child Health Network for the Greater Toronto Area (CHN) ¹⁴	End of Life Care Network ¹⁵
Consensus Panels	Yes	Yes	No	
Clinical Standards	N/A	Yes	Development of standardized guidelines	
Communications	Internal and external	Yes	Internal and external	
Performance evaluation	Yes	Yes	Yes	
Provincial Governance				
Governing Body	CCN Board	Provincial Steering Committee	The Council	Provincial EOL Care Network
Chair appointed by	MOHLTC			
Membership	Clinicians and executives from member hospitals and representatives from the MOHLTC, district health councils, RCCCs, primary and secondary care physicians and consumers.		A representative of the Board of Governors from each member organization.	
Role		Provide provincial oversight and facilitate collaboration		Opportunity for collaboration at a provincial level, decrease duplication, shared projects, consistency in best practices

	Cardiac Care Network of Ontario (CCN) ¹⁰	Ontario Stroke System (OSS) ^{11,12,13}	Child Health Network for the Greater Toronto Area (CHN) ¹⁴	End of Life Care Network ¹⁵
Provincial Resources	Head office provides support for clinical practice, communications, informatics and operations and special projects.		Executive Director is supported by an administrative assistant, a senior health planner, two health planners, a clinical advisor & education coordinator and a part-time medical advisor. (5.1 FTEs in 2002?)	
Regional Governance				
Governing Body	N/A	Regional Steering Committee	Regional Clusters (no governing body)	
Membership		Representatives from the full continuum of stroke care engage in strategic planning and set regional stroke goals.		
Role		Engage in strategic planning and set regional stroke goals.		

	Cardiac Care Network of Ontario (CCN) ¹⁰	Ontario Stroke System (OSS) ^{11,12,13}	Child Health Network for the Greater Toronto Area (CHN) ¹⁴	End of Life Care Network ¹⁵
Regional Resources				
Regional Coordinators	Regional Cardiac Care Coordinators (RCCCs) (one at each cardiac centre)	Regional Rehabilitation Coordinator positions (10)	Four regional clusters (<i>no mention of regional staffing model</i>)	Funding provided towards regional coordinators
Background	Usually a clinician (registered nurse)	Usually a physiotherapist	N/A	
Role	Advocates for the patient and triages cardiac cases.	Supports the stroke rehabilitation vision from the Consensus Panel 2000 report and the implementation plan from the Consensus Panel 2007 report. Their responsibilities are directed at building links and partnerships in rehabilitation and leading implementation of best practices for stroke rehabilitation.	Clusters are expected to develop and implement a regional maternal, newborn and children's program consistent with CHN's standards, and facilitate implementation of CHN-wide initiatives	
Reporting relationship	Reports to a senior administrative person within their respective hospitals. Also accountable to the CEO of CCN for uniformly carrying out CCN's provincial policies			

	Cardiac Care Network of Ontario (CCN) ¹⁰	Ontario Stroke System (OSS) ^{11,12,13}	Child Health Network for the Greater Toronto Area (CHN) ¹⁴	End of Life Care Network ¹⁵
Other	Data entry clerks: Support RCCC to carry out the daily functions and maintain the computerized database.	Community and Long-term Care Specialists Advance current practices and processes regarding stroke survivor transition to long-term and community care. Focus is on identifying process improvements that support best practices in transition management and community re-engagement.		

MOHLTC = Ministry of Health and Long-Term Care
RCCC = Regional Cardiac Care Coordinator

HSRC = Health Services Restructuring Committee

APPENDIX G: Advice from other Provincial Networks

The Cardiac Care Network of Ontario (CCN) offered the following factors that it believes are important components for the success of any network:¹⁶

- A clear purpose for the network that helps to establish boundaries and provides a firm foundation for goal setting and activities.
- An approach that establishes clear priorities sets realistic timeframes and focuses on meeting goals. This will help convince members and partners that their investment of time, expertise and money is worthwhile.
- Clinical leadership and partnership which is critical for networks that have a strong clinical component and focus.
- Information and data that help identify key activities, trends and areas for improvement.
- Funding that is used to support dedicated staff whose job it is to manage the activities of the network.
- A process by which the appropriate government ministry is kept apprised of the network's activities and achievements.

The Ontario Stroke System offered the following contributing factors to its success:^{17,18}

- The ongoing involvement of the Foundation as an "honest broker."
- A dedicated infrastructure – including staff and active committees.
- Champions in government and in the field who promote the OSS clinically, publicly and politically.
- Knowledge transfer focused on equipping current human resources with the skills to work better and smarter for the benefit of patients.

The Child Health Network provided the following advice:¹⁹

- It takes time to build trust and promote system thinking
- Networks are a constant balancing act between responding to competing demands from members versus achieving consensus, engaging in processes that take time versus launching initiatives that promise quick results, addressing numerous issues all at once versus concentrating on a few key issues and establishing the "right" number of committees so everyone feels involved while not making the structure itself too burdensome.
- Networks need to start with a clear focus and sense of purpose, and to develop a systematic plan of action.
- Leaders and champions are required at all levels.

¹⁶ The CCN Story. Ten Years 1990-2000. Cardiac Care Network of Ontario. April 2001

¹⁷ S M, Trypuc J, Lindsay P, O'Callaghan C, Dishaw A. HAS Ontario's Stroke System Really Made a Difference? Healthcare Quarterly Vol. 9 No. 4. 2006 Special Report

¹⁸ Black D, Lewis M, Monaghan B, Trypuc J. System Change in Healthcare: The Ontario Stroke Strategy. Hospital Quarterly Vol. 6 NO. 4. 2003.

¹⁹ Ideas, Innovation and Integration: The Story of The Child Health Network for the Greater Toronto Area. 2001.

Objectives:

To raise awareness of the Long-Term Ventilation Strategy in order to solicit informed engagement and engender support for adoption of the strategy at the local, regional and provincial levels.

Key Messages

Ontario's Critical Care Transformation Strategy launched in 2004/05 is a multifaceted initiative designed to improve access, quality and system integration in the delivery of adult critical care services as part of a broader Access to Services and Wait Times Strategy and create an efficient, integrated 1,800 bed provincial critical care resource.

As part of that strategy, a Chronic Ventilation Task Group under the leadership of Dr. Greg Downey was established to recommend how Ontario can meet the needs of medically stable, ventilator-dependent individuals who currently reside in intensive care unit (ICU) beds for months or years, while improving ICU access for critically ill individuals, a patient population that is expected to grow by 92 to 120% over the next 25 years.

Based on recommendations of the Final Report of The Chronic Ventilation Strategy Task Force, the Ministry of Health and Long-Term Care (MOH) has launched a provincial Long-Term Ventilation Strategy and is investing \$5.2 million in new services for individuals who have lung damage, neuromuscular diseases or have experienced a spinal chord injury that necessitates mechanical ventilation to support their breathing.

- The strategy will bring key stakeholders together in a collaborative process to develop an integrated service delivery plan with short, medium and long-term improvement goals.
- The plan will include a patient registry, enhanced development of hospital out-patient services, improved home care and community supports, a provincial system for transferring individuals from ICUs to more appropriate care settings and training to improve the quality of care patients receive.

The \$5.2 million investment will fund:

- the Toronto Central Local Health Integration Network to develop the strategy and create a patient registry to coordinate care for these high needs patients
- 14 new chronic assistive ventilatory care (CAVC) beds for ventilator-dependent individuals who cannot live at home
- a CAVC centre of excellence at West Park Healthcare Centre to improve CAVC services throughout the province

- a centre of excellence at Toronto East General Hospital and two additional weaning beds to provide specialized care occasionally required to help wean at-risk ICU patients

Communication Milestones

Announcement of the Strategy	June 2007
Progress report to MOH June 30th, 2007 (MOH only)	June 2007
Announcement of Strategy Secretariat	Summer 2007
Stakeholder Meeting	September 2007
Final report to MOH	Late Fall 2007

Identified Stakeholders

Toronto Central LHIN Board of Directors -

MOHLTC

Minister George Smitherman

Deputy Minister Ron Sapsford

- LHIN Liaison Branch (LLB)
 - Carrie Hayward, Kathryn Pagonis, Ted Haugen
 - Other LHIN Liaison Branch Managers
- Wait Times
 - Hugh MacLeod, ADM, Alan Hudson, Wait Times Lead, Bernard Lawless, Provincial Lead, Critical Care and Trauma
 - Robert McKay, Manager, Critical Care Secretariat
 - Joann Trypuc,
 - Sarah Kramer, Cancer Care Ontario

Other Ministries – Children & Youth Services
Community & Social Services

MPPs in affected areas

- Madeleine Meillure, MPP Ottawa Vanier
- Judy Marsales, MPP, Hamilton West
- Deb Matthews, MPP, London North Centre
- Michel Prue, MPP, Toronto
- Paul Ferreira, MPP, York South-Weston
- Elizabeth Witmer, MPP, Kitchener, Waterloo

Toronto Central LHIN Critical Care Lead – Dr. Tom Stewart

Toronto Central LHIN e-Health Lead – Mathew Anderson.

Critical Care LHIN Leads:

LHIN	CC LHIN Leader
Central	Dr. Donna McRitchie
Central East	Dr. Howard Clasky
Central West	Dr. Michael Miletin
Champlain	Dr. Redouane Bouali
Erie St. Clair	Dr. Eli Malus
South West	Dr. Michael Sharpe
Hamilton Niagara Haldimand Brant	Dr. Peter Kraus
Mississauga Halton	Dr. Laurence Chau
North Simcoe Muskoka	Dr. Giulio DiDiodato
North East	Dr. David Boyle
North West	Dr. Michael Scott
South East	Dr. John Muscedere
Toronto	Dr. Thomas Stewart
Waterloo Wellington	Dr. William Plaxton

Ontario Critical Care Steering Committee through Robert McKay, Critical Care Secretariat

Ontario Critical Care Expert Advisory Panel, through Robert McKay, Critical Care Secretariat

Ontario Chronic Vent Strategy Task Group (have contact list) through Robert McKay, Critical Care Secretariat

Ontario Ventilation Strategy Development Steering Committee (have contact list)

Other LHIN Chairs, CEOs, Sr. Directors PICE and PCA

- Those with hospitals involved first
- The rest of the group

Hospitals involved

- Grand River Hospital - Kitchener
- Sisters of Charity of Ottawa Hospital
- St. Joseph's Healthcare Hamilton
- St. Joseph's Health Care London
- Toronto East General Hospital
- University Health Network

- West Park Healthcare Centre

Ontario Hospital Association

- Referring hospitals

Referring community based physicians

- OMA District 11 & Respirology Section
- Ontario College of Family Physicians

Ontario Association of Community Care Access Centres

Faculties of Medicine, Health Sciences across the province Michener Institute

Associations, Colleges & Networks

- ALS Society
- Child Health Network
- Heart & Stroke Foundation
- March of Dimes
- Muscular Dystrophy Association
- Ontario Community Support Association
- Ontario Lung Association
- Ontario Respiratory Care Society
- Ontario Thoracic Society
- College of Respiratory Therapists of Ontario
- Ontario College of Nurses
- Registered Nurses Association of Ontario

Ventilated individuals

- Through Regina Pizzuti, Ventilator Equipment Pool
- International Ventilator Users Network

Public through Media (Toronto Comprehensive & Ethnic)

Tactics: To be developed, including

- News releases
- Email blasts
- Champion presentations
- Toronto Central LHIN and other web sites

Contact on this report;
Jan Walker
Toronto Central Local Health Integration Network
425 Bloor Street East, Suite 201
Toronto, ON M4W 3R4
Tel: 416-921-7453
Fax: 416-921-0117
www.torontocentrallhin.on.ca