



**A Mandate for Change  
Champlain LHIN – 2005/06 Annual Report**

August 22, 2005 to March 31, 2006

# Introducing Local Health Integration Networks

Local Health Integration Networks (LHINs) are not-for-profit organizations designed to plan, integrate and fund local health services within specific geographic areas. There are 14 LHINs across the province. They were created as recognition that a community's health needs and priorities are best understood by people familiar with the needs of that community and the people who live there, not from offices hundreds of kilometres away.

LHINs are an important part of the evolution of health care in Ontario from a collection of services that are often un-coordinated to a true health care system.

## Why Were They Created?

LHINs were created to fix the piecemeal way Ontario's health care system was organized. The goal is to create local links between health care services and health care providers, to make it easier for patients and their loved ones to find their way through a very complex health system as they move from one health service provider to another. LHINs are changing the way our health care system is managed.

## What Will LHINs Do?

LHINs will manage health services that are delivered in hospitals, long-term care homes, community health centres, community support services, community care access centres and community mental health and addictions agencies.

LHINs are based on a principle that community-based care is best planned, coordinated and funded in an integrated manner within the local community because local people are best able to determine their health service needs and priorities. LHINs will determine the health service priorities required in their local community and will work with local health providers and community members to develop an integrated health service plan for their local area. They will eventually be responsible for funding and ensuring accountability of local health service providers.



# Local Health System Integration Act 2006

The Local Health System Integration Act, 2006 was introduced on November 24, 2005 and received Royal Assent on March 28, 2006. The purpose of the Act is to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, co-ordinated health care and effective and efficient management of the health system at the local level by local health integration networks.

The Act continues 14 Local Health Integration Networks (LHINs) as Crown Agencies of the Ministry of Health and Long-Term Care. It gives LHINs the power to plan, co-ordinate and fund health care providers (hospitals, long-term care homes, community support services, community health centres, Community Care Access Centres and community mental health and addictions agencies) in their specified geographic areas. It sets out the corporate organization of the LHINs, the powers of the LHIN Boards of Directors, and requires the LHINs to have an accountability agreement with the Minister of Health and Long-Term Care.

The Act provides the legislative framework for creating a health system in Ontario that is:

- Community-based: engages the local community about needs and priorities
- Based on Partnerships: system partners are Minister, Ministry, LHINs and service providers
- Forward Looking: emphasis on planning and priority setting
- Efficient: effective allocation of funding to achieve priorities
- Accountable: clearly defined expectations and measurement of achievement; monitoring and public reporting provide checks and balances in system
- Integrated: coordinated health care with focus on client needs

The Act sets out certain requirements and authorities for the Ministry and the LHINs in the areas of: planning, community engagement, funding, accountability and integration.

A close-up photograph of a woman with dark hair and brown eyes, looking directly at the camera. She is holding a baby wrapped in a pink and white patterned blanket. The background is a solid olive green color.

## **Planning and Community Engagement:**

The Minister must develop a provincial strategic plan for the health system and make the plan public. Each LHIN is required to engage their community and Aboriginal and French Language local planning entities to develop an Integrated Health Service Plan for their local health system. Community is broadly defined in the Act and includes patients and others, health service providers, and employees. The Act identifies some of the methods LHINs would use to engage their community, including community meetings, focus groups, and advisory committees.

## **Funding and Accountability:**

The Minister determines each LHIN's funding and enters into an accountability agreement that sets out performance goals and standards, reporting requirements, a spending plan, and a performance management process.

The Act ensures that people can access care outside of the LHIN in which they live. The LHIN boundaries do not restrict people in any way.

When the LHINs have funding authority, they will enter into service accountability agreements with health care providers to deliver health services in their local communities, in accordance with the LHIN's accountability agreement with the Minister.

## **Integration:**

To enable a co-ordinated health system, LHINs may facilitate integration discussions between health care providers. (e.g., transfer services to another location or provider, start or stop providing a service or change the amount of a service). LHINs will also have the power to require integration where they believe it is in the public interest. The Act also includes mechanisms to protect employees when services are integrated.

As of June 2006 not all parts of the Act have been proclaimed in force. A full copy of the legislation is available on e-laws at [http://www.e-laws.gov.on.ca/home\\_E.asp?lang=en](http://www.e-laws.gov.on.ca/home_E.asp?lang=en)



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**Welcome to the Champlain Local Health  
Integration Network**

The Champlain LHIN is home to 1,176,600 people or 9.5 % of the population of Ontario. The region is a microcosm of Canada. It encompasses a large geographical area that includes urban clusters and rural areas, a significant Francophone population, as well as multicultural and First Nations communities. The population of the Champlain LHIN is highly educated and active, but significant disparities exist. In the Champlain region, there are

21 hospitals, 7 community health centres plus satellites, 61 long-term care homes, and dozens of community-based agencies serving seniors, residents with disabilities, and people with mental health problems and addictions. The Champlain LHIN includes Renfrew County, the City of Ottawa, Prescott & Russell, Stormont Dundas & Glengarry, North Grenville and four parts of North Lanark.



# Message from the Chair of the Board of Directors and Chief Executive Officer

## MANY VOICES were HEARD

This was a short (seven months) but busy first year for the Champlain Local Health Integration Network – appointing the Board of Directors, putting senior management and support staff in place, opening the office, waiting for the legislation to be introduced and then passed.

Because so much of this process was beyond our control, we had ample opportunity to get out into the Champlain region and engage stakeholders, consumers, and citizens in their own communities. We travelled far and wide, focusing on rural areas, meeting and greeting, but mostly listening.

## We heard and learned a lot in our travels.

We learned that folks want quality services closer to home. Community-centred agencies provide most of the care and are the unsung heroes of the health system. This sector needs to be strengthened if we are to have state of the art primary health services, to keep people out of hospitals and in their homes. Hospitals now have new opportunities, in hub and spoke collaboration, to ensure that increasingly sophisticated clinical services, such as dialysis, are provided at sites across the Champlain region. As e-Health evolves (i.e. the electronic patient record including sharing of CT scans), a de-centralized vision of health-care delivery is now more possible than ever, and has the potential to bring the skills of world-class specialists to outlying areas.

We also learned that the frail elderly and people with mental health problems are poorly served. Without a strong voice, these populations have not received the best mix of service and community care they need. We have to refocus our priorities. The cost of doing otherwise is too high both in terms of dollars and suffering.

And we learned that service providers are full of good ideas to improve the system. In many instances, Champlain providers have already created innovative programs that are serving as models of health care for the rest of Ontario. (See Success Stories, pg. 29.) We shall identify and help those who have the insight and tenacity to bring about systemic changes that will improve patient care.

**Michel Lalonde**

Chair of the Board of Directors

Appointed June 1, 2005 for a three-year term

After a successful career in healthcare management, Michel is now Executive-in-Residence at the University of Ottawa, School of Management and the Masters in Health Administration (MHA) Program. For more than thirty years he served as President and Chief Executive Officer of Hawkesbury District General Hospital and Winchester District Memorial Hospital, Vice President of Paramedical Services at the Ottawa General Hospital and Associate Executive Director at the Montfort Hospital in Ottawa.

He was also a surveyor for the Canadian Council on Health Services Accreditation, Chair of the Prescott-Russell Community Services Planning Council, Director and Vice president of La Cité Collégiale Board of Directors, Board member of the Ottawa Children's Treatment Centre and Director of the CQI Network in Ontario.

**Dr. Robert Cushman**

CEO, Champlain Local Health Integration Network

Secretary – Appointed to the Board June 1, 2005  
for a three-year term

For the past nine years, Dr. Robert Cushman held the position of Medical Officer of Health for the City of Ottawa, where he was instrumental in bringing in smoke-free legislation for workplaces and public places. Previously, he was Director of Public Health in Hull, Québec.

Rob has worked as a primary care physician in a variety of health-care settings, including the emergency room of the Children's Hospital of Eastern Ontario, the Somerset West Community Health Centre in Ottawa, and along the James and Hudson Bay coasts serving Cree and Inuit populations. Early in his career, he worked at a large African mission hospital for three years, and has evaluated health-care programs in a number of African countries.

A pioneer in Canada for bike helmet promotion and a champion for "Success by Six," Dr. Cushman has become known for his work in injury prevention and early childhood development. He received the United Way of Ottawa's Volunteer of the Year Award in 2003, and the City of Ottawa Lifetime Achievement Award in 2005.

With the advent of the LHINs, significant organizational changes are occurring.

Historically, Ontario's health system was centrally planned from Toronto. Not surprisingly, we are convinced that the Champlain region's unique needs are better met through local input, and local remedies. The 14 LHINs in Ontario mean a devolution of the provincial system to the regional level, and therefore, we have the opportunity to build strong local services into a comprehensive regional system.

Related to this change is another important transformation - moving from a culture of 'command and control' to one of trust and collaboration. The Champlain LHIN Board will work with Boards of all the health organizations to find common solutions to common problems. Trusting relationships, transparency, accountability, and cooperation are truly the means to success.

As we develop our first Integrated Health Services Plan in the Fall of 2006, we are confident that all those involved – citizens, consumers of services, providers and institutions – will support our collective regional goals that will enable us to improve health and quality of care for the 1.1 million citizens in the Champlain LHIN.

We have the capacity to be bold and forward-looking both in terms of who we are and whom we serve. Our aspiration is to create the most compassionate, highest quality, and most accessible health care system in Ontario. We invite you all to participate.



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Michel Lalonde, Chair of the Board of Directors



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Dr. Robert Cushman, Chief Executive Officer



# Our Leadership Team

## **Dr. Robert Bourdeau**

Appointed January 5, 2006 for a one-year term

Dr. Robert Bourdeau received his medical degree from the University of Ottawa in 1968 and his M.H.A. in 1985. He completed a Masters degree in Applied Science at McGill University in 1996. Since 1985, he has been serving as Medical Officer of Health for the Eastern Ontario Health Unit. From 1973 to 1982, he was an orthopaedic surgeon and, from 1982 to 1985, a medical consultant CSST (Qc). He has served on numerous local ad hoc committees and sub-committees of the District Health Council of Eastern Ontario. Robert is a member of several professional associations including the Occupational Health Physicians of Canada, the Canadian and Ontario Public Health Associations and the Canadian and Ontario Medical Associations.

## **Linda Assad Butcher**

Appointed January 5, 2006 for a two-year term

Linda Assad Butcher has been executive director of Consortium National de Formation en Santé since 2002. From 1989 to 1990, she served as a member of the transition team for the Creation of La Cité Collégiale and subsequently held positions as director of health sciences and community services at this community college. Prior to this, she was employed as a Learning Resources Consultant and Professor of Nursing at Algonquin College. She is a member of several professional organizations, including the Ottawa-Carleton Nursing Executives, the Ontario College Administrative Staff Association and the Ontario French Nurses Association. In 2003, she received the Capital Educator's Award. Linda has served on the boards of numerous community organizations including the United Way, the Academic Operations Committee at Montfort Hospital and the Council on Aging.

## **Andrew Dickson**

Appointed May 17, 2006 for a two-year term

Andrew Dickson has enjoyed a long business career as president and owner of a printing company and publishing house based in Renfrew. A former broadcaster, he is vice-president and co-owner of a recently launched private broadcasting company serving the Upper Ottawa Valley. Andrew attained his MBA from the University of Ottawa in 2002. He is a former municipal councillor for the Corporation of the Town of Renfrew, where he served for 12 years. An active community member for 25 years, Andrew has served on the boards and committees of numerous organizations, including Renfrew and Area Physician Recruitment Committee, Equip for Care fundraising drive for Renfrew Victoria Hospital, County of Renfrew Homes for the Aged Committee, Renfrew Police Services Board, Renfrew Business Improvement Area, Renfrew County International Plowing Match, Renfrew Tourism Committee, Kinsmen Club and Opeongo Housing Corporation.



**Allison Griffith**

Appointed May 17, 2006 for a two-year term

Allison Griffith is a nursing professional with experience in rural public health nursing, case-management, program coordination, long-term care, volunteer management and teaching. Born in Stoney Creek, Allison followed her mother's footsteps to enter the nursing profession and moved to Renfrew County after completing her Bachelor of Science in nursing at the University of Western Ontario. Most recently she has been a part-time clinical professor at the University of Ottawa, focusing on community nursing, mental health, child health and long-term care. As the director of volunteer services at her local hospital, she has worked with an active auxiliary of 300 members. She has a Masters of Public Administration from Queen's University, specializing in health policy, and holds a certificate of competence and is a member of the College of Nurses of Ontario. Allison has been involved in many community boards and committees, including the Arnprior and District Memorial Hospital Board, and is a volunteer at her church and children's school.

**Gilles Lanteigne**

Appointed May 17, 2006 for a two-year term

Gilles Lanteigne of Ottawa is an experienced health professional with a strong knowledge of the province's health care system. Since 2001, he has been executive vice-president and chief operating officer of the Canadian Council on Health Services Accreditation. He has held a number of progressive positions in health care administration, including serving as executive director of two acute care hospitals in Quebec and as director of professional and rehabilitation services at Pavillon du Parc Inc., serving the Outaouais region. Gilles completed a Masters of Business Administration at University of Ottawa and a Masters in Social Work at Université de Sherbrooke, and obtained his Certified Health Executive designation in 2003. Currently he is a member of the Certified General Accountants Association of Canada and Quebec and is surveyor for the International Society for Quality in Health Care. He is a member of the Canadian College of Health Service Executives, the strategic steering committee on health care technology for the Canadian Standards Association, and a Ph.D. candidate at Université de Montréal in Public Health. He is a past member of the scientific committee of the Agence Nationale d'Accréditation et d'Évaluation en Santé in France.



**Michael LeMay**

Appointed January 5, 2006 for a two-year term

Michael LeMay is a retired educational professional. He was an educator with the Renfrew County District School Board for 28 years. From 1985 to 1997, he held the position of vice-principal at a number of secondary schools. Prior to this, he was principal of Renfrew County Summer School from 1971-74, head of guidance from 1979-85 and itinerant guidance counsellor in the Canadian Armed Forces Europe in 1979. He is past member of the Pembroke Regional Hospital Board of Directors, where he served for eight years. He has also served on the Board of Directors of Family and Children Services of Renfrew County and the Phoenix Centre for Children and Families Board of Directors. Michael is a member of the Pembroke Police Services Board, and member of the City of Pembroke Planning Advisory Committee.

**Wilmer Matthews, Vice-chair**

Appointed June 1, 2005 for a three-year term

Wilmer Matthews is a retired high school principal. During 30 years with the Renfrew District School Board, he held positions as teacher, vice-principal, and principal at a variety of high schools in the county. His community involvement has included coaching or convening duties in community sports programs such as hockey, skiing and basketball. He has also been a past member of the local Lions Club, and for a number of years worked with the student leaders of Opeongo High School in organizing the Terry Fox Run in the Cobden/Eganville area. For the past four years, Wilmer's interest in health care has seen him involved as a director of the St. Francis Memorial Hospital Foundation Board, where he has served as acting chair as well as chair of the Capital Equipment Campaign.

**Jo-Anne Poirier**

Appointed June 1, 2005 for a three-year term

Jo-Anne Poirier is currently employed by United Way/Centraide Ottawa as Vice-President, Resource Development and CEO of the Government of Canada Workplace Charitable Campaign. From November 2000 to March 2003, she was First Vice-President, Business Development for MBNA Canada Bank. From 1993 to November 2000, she worked as Deputy City Manager, Corporate Services, with the City of Gloucester. Prior to 1993, Ms. Poirier worked for 15 years in both the private sector and regional government in increasingly senior positions.

Jo-Anne's community involvement includes acting as a Special Advisor with the Nelson Mandela Children's Fund Ottawa Chapter. She also sits on the Board of Directors for the Regroupement des gens d'affaires de la capitale nationale (RGA). From 1999 to 2003, she served as a senior volunteer on the United Way/Centraide Ottawa Campaign Cabinet.

# Inside our LHIN

## Our Population

- From 1994-2004, the population of Champlain increased, on average, by 1.0 % each year.
- The proportion of residents who are Francophone, or who claim French as their mother tongue (19.2%) is substantially greater than the province as a whole.
- The unemployment rate in Champlain is slightly lower than the provincial rate, and education levels are higher than those for the province, although significant local variances occur.
- The population of Champlain is highly concentrated in the Ottawa area. Cornwall, Clarence-Rockland and Pembroke/Petawawa are also populous areas.

## Geographic Short-hand

SDG = Stormont Dundas & Glengarry

PR = Prescott & Russell

NL/NG = North Lanark/North Grenville

LG + L= Leeds Grenville and Lanark

### *Comparator LHINs*

Experts preparing the environmental scan for Champlain LHIN found it helpful to include several comparator LHIN regions, as well as Ontario as a whole. Several possibilities for comparators were considered but it was decided to use Hamilton/Niagara/Haldimand/Brant, South West and South East LHINs. The population numbers and profiles of the first two are fairly close to those of Champlain: both include academic Health Science Centres and both have fairly large geographic areas serving urban and rural areas. For South East, the population numbers and profile are not as similar but its proximity and the flow of some services across the shared boundary make comparison with the South East LHIN appropriate.

SE = South East LHIN

Hamilton = Hamilton Niagara Haldimand Brant LHIN

SW = South West LHIN

Map 1: Champlain Region

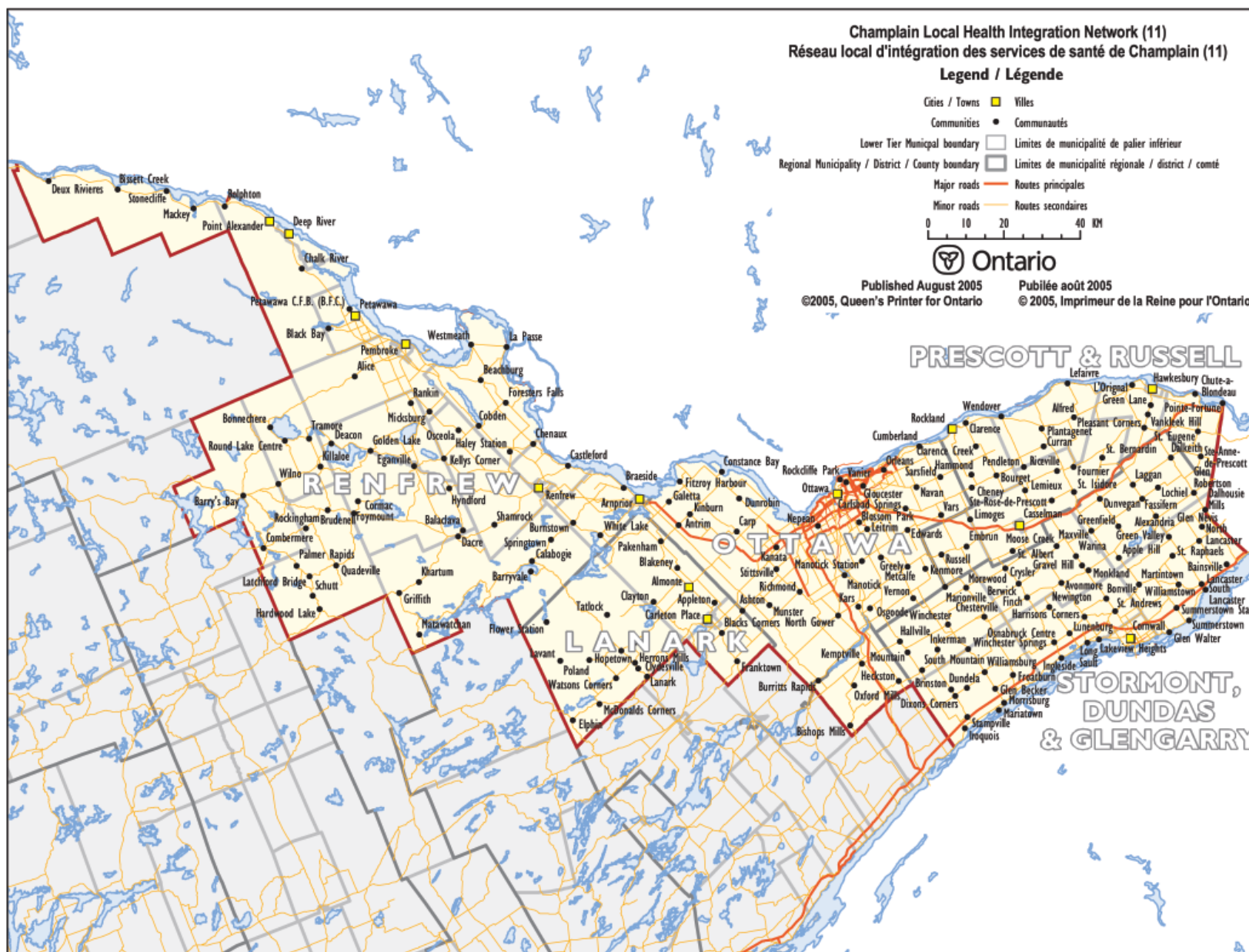
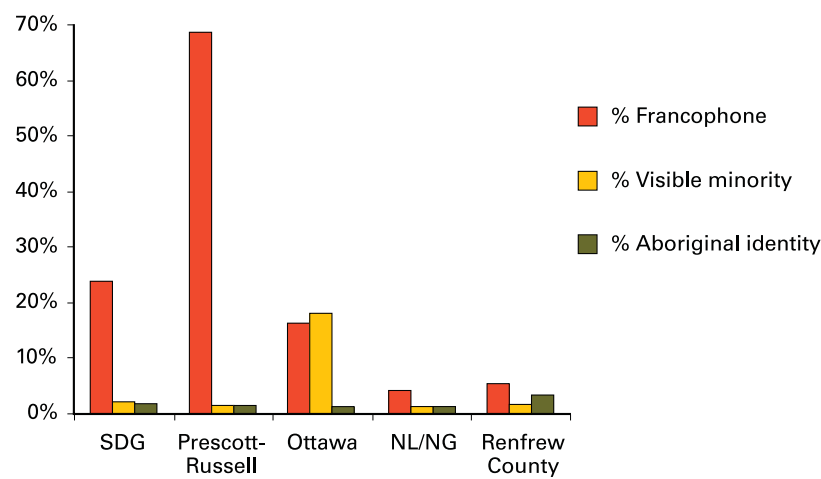


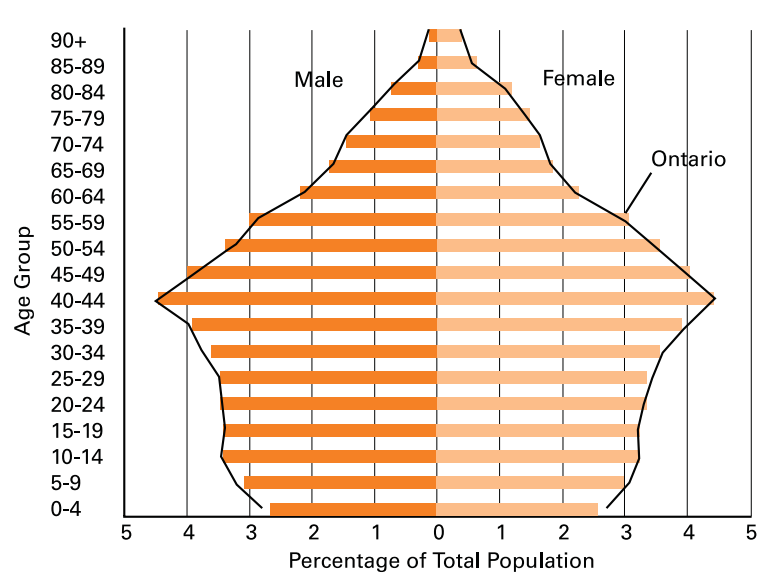
Table 1: Champlain LHIN Population

|                              | 2001 POPULATION  | COL %         | % CHANGE 1996 TO 2001 | POP/SQ. KM  |
|------------------------------|------------------|---------------|-----------------------|-------------|
| SDG                          | 109,522          | 10.0%         | -1.6%                 | 33.1        |
| Prescott Russell             | 76,446           | 6.9%          | 3.3%                  | 38.2        |
| Ottawa                       | 774,072          | 70.3%         | 7.3%                  | 278.6       |
| North Lanark/North Grenville | 45,152           | 4.1%          | 6.9%                  | 21.1        |
| Renfrew                      | 95,138           | 8.6%          | -1.1%                 | 12.6        |
| <b>Champlain</b>             | <b>1,100,330</b> | <b>100.0%</b> | <b>5.3%</b>           | <b>62.4</b> |

Graph 1: Population Groups – Champlain LHIN, 2001 Census

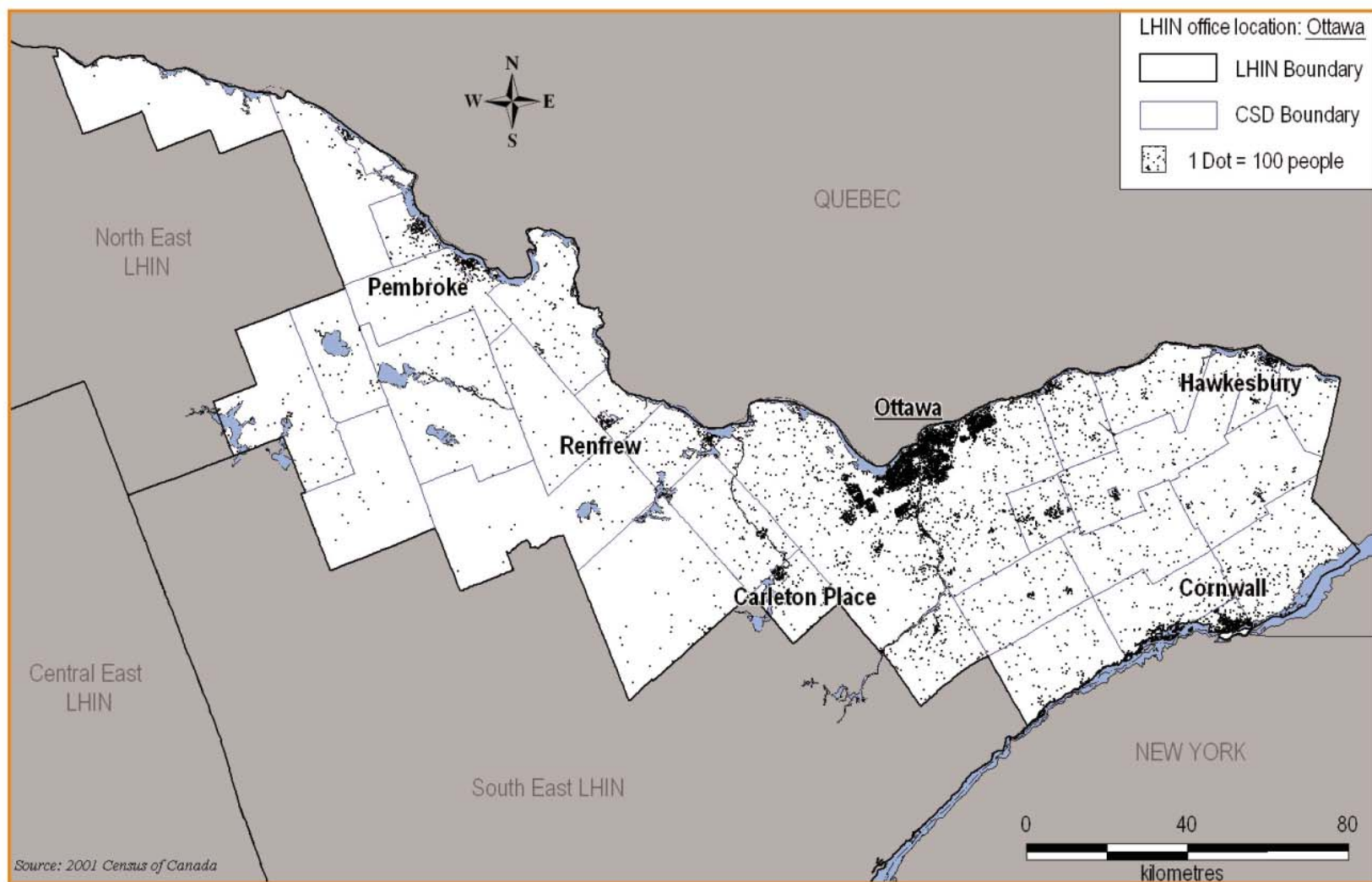


Graph 2: Age Sex Population Distribution



Data Source: 2004 Population estimates, Statistics Canada

Map 2: Population Distribution in Champlain



## Health Status

Residents of Champlain report their health as “excellent” or “very good” at rates that are slightly higher than the province as a whole. A significant proportion of residents (28.4 % compared to 24.6% provincially) report being limited in their activities because of a physical or mental condition or health problem which has lasted, or is expected to last longer than six months.

## Health Practices and Preventive Care

The use of preventive health care services can lead to early detection of disease, which ultimately results in reduced morbidity and mortality. Daily smoking rates for teenaged and adult residents in the public health units of Renfrew, Eastern Counties and Lanark Leeds Grenville are higher than in the City of Ottawa. Compared to the province as a whole, Champlain has a higher proportion of women receiving Pap tests (to screen for cervical cancer) and a higher flu shot rate. The majority of people (83.1%) in Champlain had at least one contact with a medical doctor in the past year; while this percentage is similar to the Ontario rate, more recent data (still to be fully analyzed) indicates that percentage is dropping in Champlain.

“I can assure you that we are proud of the fact that the Chair of the Champlain LHIN Board is Michel Lalonde, who is well known in Eastern Ontario for his participation on all Francophone issues.”

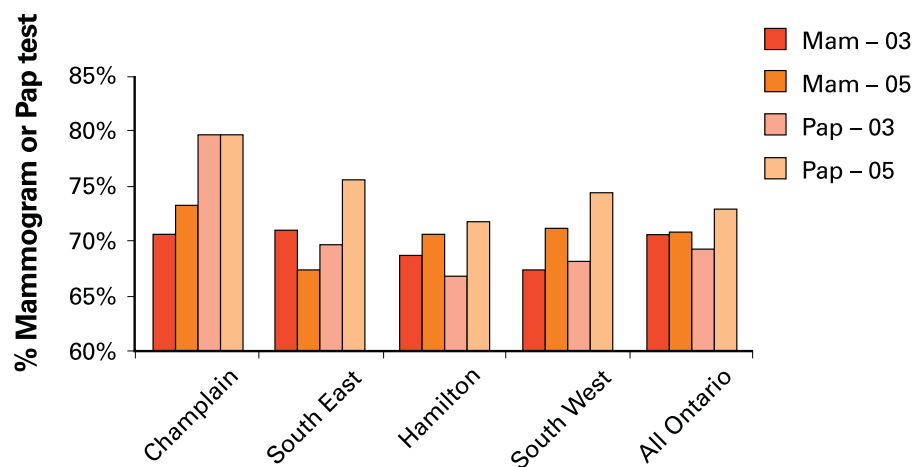
*Nicole Robert, Chair, Réseau des services de santé de l’est de l’Ontario, on a Rogers 23 panel with MPP Madeleine Meilleur.*

## Priorities

In 2004, the Ministry of Health and Long-Term Care organized community workshops across the province, as part of the creation of 14 Local Health Integration Networks.

More than 400 people participated in the Champlain region's session on December 6, 2004. At the end of that meeting, a 23-member planning group was formed to further develop priority themes and a summary report. The report provides a foundation upon which the citizens of the Champlain LHIN community can make improvements to our health system.

Graph 3: Preventive Care (Mammograms and Pap tests) 2003 & 2005 – Champlain and Comparative LHINs



*The Champlain LHIN has high rates of mammography (to screen for breast cancer) and Pap tests (to screen for cervical cancer).*

## Two themes were identified: care issues and administrative issues

### 1. Care Issues

- The development of a person-centred rural health strategy
- The organized delivery of seniors' health care
- Impact of community support services on acute and primary care
- Mental health and addiction services as core components of health care
- Coordinated service and planning links between health and other sectors
- Accessibility to the continuum of care that is close to home

### 2. Administrative Issues

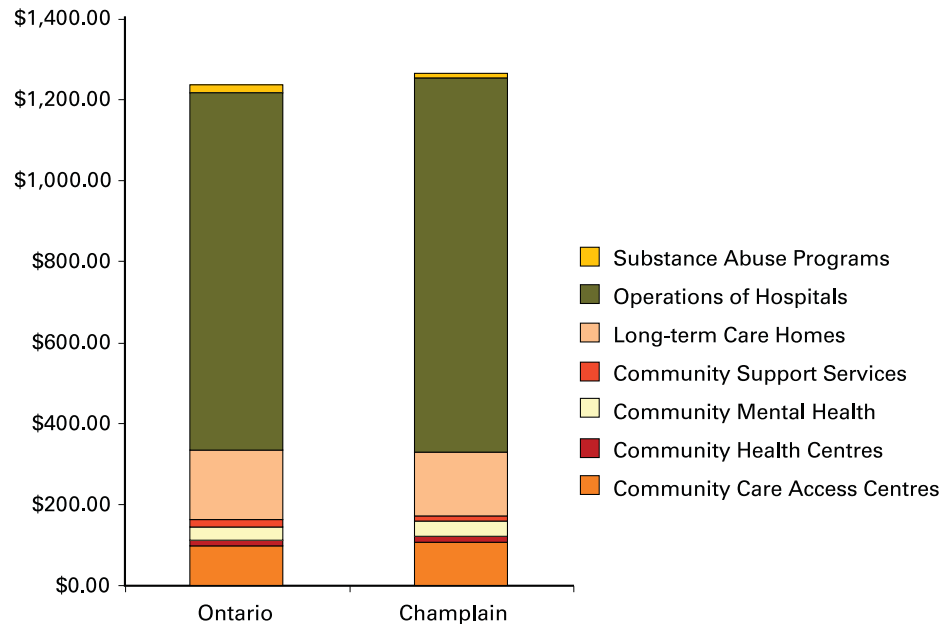
- eHealth – sharing information and building linkages among providers and organizations
- The Champlain LHIN's accountability to the community and consumer and an accountability framework that aligns health investments with health outcomes
- Navigating the system
- Human resources planning

Table 2: Health Expenditures for 7 Health Programs – 2003/04

| ONTARIO                       |                  |            |       | CHAMPLAIN       |            |       |
|-------------------------------|------------------|------------|-------|-----------------|------------|-------|
| Program                       | Expenditures     | Per capita | Col % | Expenditures    | Per capita | Col % |
| Community Care Access Centres | \$1,215,452,698  | \$98.08    | 8%    | \$123,253,643   | \$104.76   | 8%    |
| Community Health Centres      | \$142,539,808    | \$11.50    | 1%    | \$25,476,935    | \$21.65    | 2%    |
| Community Mental Health       | \$419,397,133    | \$33.84    | 3%    | \$36,677,147    | \$31.17    | 2%    |
| Community Support Services    | \$256,328,921    | \$20.68    | 2%    | \$16,137,404    | \$13.72    | 1%    |
| Long-term Care Homes          | \$2,127,854,431  | \$171.70   | 14%   | \$188,145,333   | \$159.91   | 13%   |
| Operation of Hospitals        | \$10,973,309,940 | \$885.46   | 72%   | \$1,085,869,071 | \$922.90   | 73%   |
| Substance Abuse Programs      | \$127,990,164    | \$10.33    | 1%    | \$12,853,264    | \$10.92    | 1%    |
| Total                         | \$15,262,873,095 | \$1,231.60 | 100%  | \$1,488,412,797 | \$1,265.03 | 100%  |

These are the seven programs for which the LHINs are responsible. Note the LHINs are not responsible for physicians, laboratories, drugs and public health units.

Graph 4: \$ per capita for LHIN programs 2003/2004





# Building on Local Success

There are already healthcare service integration success stories in the areas served by the Champlain LHIN. Following are a few examples of programs developed by groups, organizations or agencies who are working together to better serve the residents of the Champlain Local Health Integration Network.

## Going home for treatment

### Chemo Home Infusion Pump Program (CHIPP)

This project allows patients with cancer to receive chemotherapy at home, instead of in a hospital. Since some chemo regimens can last for days and are repeated every two weeks, the program makes life easier for patients. CHIPP is a joint effort involving health professionals at The Ottawa Hospital Regional Cancer Centre, community care access centres, agencies providing care in the home, and community pharmacists. This is how it works:

patients start their therapy at The Ottawa Hospital and return home while the medication is still infusing. A nurse visits every day to monitor the treatment, change the medication and disconnect the pump. The future aim is to expand the Chemo Home Infusion Pump Program so that patients can initiate therapy at smaller hospitals in the Champlain region – the first to participate is Renfrew Victoria Hospital.

**Left to right:** Nurse Eric Lee with Anthony Larmond, monitoring his chemo home infusion pump



# Building on Local Success

## A partnership of mental health workers and police

### The L.E.A.D. Team of Lanark County

In this project, Lanark County Mental Health Services work together with local police officers to better serve emotionally disturbed people in crisis. Police involved in the partnership receive intensive training on mental illness, and use this training to de-escalate volatile situations. (Sgt. Dave MacDonald, a coordinator of the project with Lanark County O.P.P., is a key police champion on this issue and was instrumental in the training). The team has developed a crisis response system so that emotionally disturbed people in police custody can receive the services

they need at any hour. Because people with mental illnesses are increasingly living in the community instead of in institutions, this is a much-needed program. Not only does it offer more caring treatment for emotionally disturbed people, it also results in fewer injuries to clients and police. This is a good example of how to co-ordinate services between health and other sectors.

L.E.A.D. stands for Lanark County Police & Mental Health, Emergency Department, Ambulance Service & Diversion

**Left to right:** Diana McDonnell, a registered nurse and L.E.A.D. Team Coordinator and Supervisor with Lanark County Mental Health; and Constable Angie Atkinson, a Community Officer with Carleton Place Ontario Provincial Police



# Building on Local Success

## A compassionate approach

### Resource Integration for Seniors in the Community (RISC)

The RISC program helps frail, elderly people get the care they need at home so they don't repeatedly end up in the emergency department. Often, vulnerable seniors endure crisis after crisis following different medical events that are both predictable and preventable. The RISC program tries to stop this cycle by organizing and providing health services through Community Care Access centres, community support agencies and family physicians.

The benefits are two-fold; clients get quick access to a range of medical services, and their families receive the support they need and have earned. Not only is RISC a compassionate approach, it also saves the health system money because of fewer hospitalizations. After a successful pilot project, there are now six new RISC programs across the Eastern Counties and the City of Ottawa.

**Left to right:** Jack and Hazel Carmichael at their home  
with RISC Care Manager Lauda Cabral



# Building on Local Success

## A great example of cooperation

### Newborns – Transfer of low-risk obstetrical cases from The Ottawa Hospital to the Montfort Hospital

After a study found The Ottawa Hospital was handling too many low-risk births, officials allocated a portion of their obstetrical care to the Montfort Hospital. A benefit of the switch was greater safety for mother and baby – The Ottawa Hospital simply had to cope with too many births at once. Now both hospitals are doing what they do best; The Ottawa Hospital concentrates on higher-risk cases, and the Montfort provides women with a community-

hospital atmosphere in which to deliver their babies. Due to the Montfort's expanded obstetrics department, the transfer has also improved training for francophone medical students at the University of Ottawa. This example of cooperation, spearheaded by the late Dr. Carl Nimrod at The Ottawa Hospital, could not have happened without superb leadership shown at both hospitals.

**Left to right:** Eric Desnoyers, Stéphanie Farmer and their newborn Abigaëlle Desnoyers at the Montfort Hospital Family Birthing Centre with Dr. Guy d'Anjou, Departmental Chief; Ann Salvador, Director; and Helene Langlois, Interim Manager



# Building on Local Success

## The Pillow Talk Team

### Recovering from knee and hip surgery

What's the best way to position the pillow for patients recovering from hip and knee replacements? There were conflicting opinions at The Ottawa Hospital about which method was ideal for making patients feel comfortable and preventing pressure wounds. So a team of surgeons, occupational therapists, physiotherapists and nurses – the so-called Pillow Talk Team – conducted a study over a four-month period, determined the best standard

of practice, and taught the technique to other staff and students. This success story demonstrates the importance of “evidence-based” practices, and illustrates how patient care can improve when a number of health disciplines work together to solve a problem. The team's work was presented at the Celebrating Innovations in Health Care Expo, hosted by the Ministry of Health and Long-Term Care and the LHINs in 2006.

**Left to right:** Barbara Hahn, Physiotherapist; Jackie Mace, Clinical Manager; Margaret Dumoulin, Nurse Educator; and Brenda Ashe, Occupational Therapist at The Ottawa Hospital



# Building on Local Success

## Timely access to treatment

### Redesigning care for heart attack patients

For people suffering from a certain type of heart attack, timely access to a treatment called angioplasty is crucial. However, experts in the Champlain LHIN noted that some of these patients were not receiving the artery-widening treatment quickly enough. Therefore, staff from the Ottawa Paramedic Services, The Ottawa Hospital/University of Ottawa Heart Institute, and referring facilities embarked on a project to redesign care for these patients. The result: paramedics responding to a 911 call can now assess

whether patients need angioplasty and, if they do, skip local emergency departments and take the patient directly to the Heart Institute. This rapid transfer of patients has reduced death rates. The project, which shows how patient care can improve through a thoughtful reorganization of the health system, was presented at the Celebrating Innovations in Health Care Expo hosted by the Ministry of Health and Long-Term Care and the LHINs in 2006.

**Left to right:** Paramedics Natalie Charlebois and  
France Lavergne



# Building on Local Success

## Improving efficiency through sharing

### The Ottawa Community Support Coalition

Historically, home-based community support services were delivered in a traditional “silo” approach. The community support sector, which serves seniors and adults with physical disabilities, was plagued by poor communication, turfism, and conflict. To fix the problem, 18 organizations in Ottawa (including such services as Meals on Wheels) decided to form a coalition. With each organization maintaining its unique identity, the coalition

worked together on client transportation, volunteer development, and purchasing. The results: fewer costs, less unnecessary duplication, more sharing of expertise, and better care for clients. The work of this coalition – presented at the Celebrating Innovations in Health Care Expo, hosted by the Ministry of Long-Term Care and the LHINs – shows that the health system can be transformed simply by adopting a more sharing approach.

**Left to right:** Sharon Oatwary, Joan West and Day Centre Coordinator, Penny Durocher at The Good Companions

# The Champlain Local Health Integration Network: *The Year in Review*

The Champlain LHIN made substantial progress in its gestational year, working toward its upcoming mandate to fund, plan and coordinate health-care services for the people of this region. The main aim has been to cultivate a strong foundation of strategic partnerships that will help achieve future goals.

The CEO, Board chair, and Board members conducted more than 130 in-depth site visits, presentations, and discussions with representatives of service providers, service provider Boards, health professionals, health associations, strategic partner groups, consumers, academic institutions, the regional office of the Ministry of Health and Long-Term Care, as well as elected officials. A first step, prior to passage of the legislation and development of the planning framework, was to engage stakeholders in their own communities, to understand their core business, pressing concerns, challenges, and potential for future initiatives. To foster results-oriented dialogue, agencies were encouraged to bring their partners to the table for discussion. Efforts were concentrated on the western and

southern parts of the region – Renfrew County and Lanark and Grenville. This strategy was deliberate, as there were legitimate concerns outside the City of Ottawa that the LHIN would replace the current Toronto-centric system with an Ottawa-centric one. A key learning was the need to identify a number of smaller Champlain communities (beyond the traditional four county-municipal divisions) for the provision of primary health services. An important next step is to focus site visits in the Eastern Counties of the Champlain region.

## Additional Highlights:

- Recruitment of senior management and administrative staff
- Identification of three community representatives of the Board
- Commitment to develop an educational strategy for the orientation of the 14 LHIN Boards
- Creation of a community engagement framework involving public meetings, meetings with First Nations communities, Board-to-Board gatherings, and conversations with existing and new provider networks, including the Réseau des services de santé en français
- Engagement of the physician community at hospital and specialist meetings, the University of Ottawa, the Academy of Medicine and community clinics
- Collection of data/environmental scan for the Integrated Health Services Plan
- Participation in and support to important initiatives such as the Champlain e-Health planning group and the Champlain Regional Cancer Program's proposed model to improve access to quality cancer surgery in smaller centres
- Establishment of the Champlain LHIN office

"We found your candour, openness, and eagerness to respond to our questions and concerns very refreshing and we feel secure in the knowledge that our regional health care delivery is under such responsible leadership. We have taken your suggestions to heart and will be making plans to challenge the board of directors and staff with specific goals to follow up on the matters discussed at our meeting."

*Brian Turner, Board Chair,  
Alwood Treatment Centre Inc., Carleton Place*

# Operational Start-Up

Once the policy framework was established by the Ontario government, and the Local Health Integration Networks were chosen as the model for integration in this province, it was time to launch LHINs as 14 corporations. In June, 2005, 14 news conferences were held across Ontario to announce the 14 LHIN chairs, 42 founding board members, and 14 CEOs.

Starting in the summer of 2005, extensive orientation sessions were held for the founding LHIN Board members and staff. As part of their professional development, LHINs and the Ministry hosted several “think tanks” on topics such as funding models, planning, corporate governance and ethics. Discussion forums were also held to discuss physician and LHINs, and LHIN cross-boundary issues

“I personally appreciate and value the efforts you are making to engage with the multiple stakeholders in our community. I also appreciate how much time you have taken to connect with the Academy of Medicine, both as an active listener and as an invited speaker. I do hope this is the foundation of a long and productive relationship between AMO and the Champlain LHIN.”

*Dr. Derek Puddester, President,  
Academy of Medicine of Ottawa.*

in the community sector. Accountability agreements between each LHIN and the Ministry were developed for 2005/06 and 2006/07.

The Champlain LHIN office at 1900 City Park Drive in Ottawa opened in December, 2005.

A senior team of staff was recruited including the CEO, two senior directors, office manager, and executive assistant. Support staff members were hired in 2006 through a contract agency. Project team members were also hired on contract to conduct an environmental scan and collect data for the development of the Integrated Health Services Plan. The office manager oversaw the establishment of business processes such as equipment, supplies and IT procurement and installation; pay, pension, and benefit coordination; policies and guidelines; security; and liaison with property management.

Back office and shared services included support from the Ministry of Health and Long-Term Care and CGI in the areas of legal, finance, IT, communications, translation and payroll.

The Champlain LHIN finished the 2005/06 fiscal year on budget. The organization will continue to work with the Ministry to develop appropriate financial reporting mechanisms for the transfer of funding role to be taken on in fiscal year 2007/08.

# Community Engagement

## Summary

Champlain LHIN staff and Board members reached more than 130 service providers in official “meet and greets”, began discussions with a number of service provider networks, and organized general public meetings. To develop the Champlain LHIN Integrated Health Services Plan, the vision is not only to hear from providers, but also

from residents of the Champlain region and consumers of health services. Next steps include focusing on consumer groups, organizing more public meetings in additional geographical areas, and summarizing priorities of each service provider network and other associations.

## Achieving an integrated system



### Integration outcomes:

- **Seamless experience** for user, where boundaries between organizations minimized
- **Improved match** between single services provided and the multiple needs of clients and families
- **Effective and efficient** use of system resources and capacity

## Public Meetings

With help from Avant Communications, eight public meetings were planned for May and June, 2006, with that process continuing in the fall of 2006. Initial meetings were to be held in Barry's Bay, Kanata, Carleton Place, Metcalfe, Cornwall, Casselman, Ottawa Centre, and Hawkesbury. The 10 priority themes identified in the 2005 Champlain Integration Priority Report would form the basis of community discussions. A participant workbook was to be provided to all attendees, including an outline of the themes in the local priority report submitted in 2005, examples of integration success stories in the region, and four questions for discussion. The feedback will be integral to the development of Champlain's Integrated Health Services Plan.



*Residents had their say at a recent public meeting held in Cornwall.*

## Service Provider Networks

In-depth meetings are also taking place with more than 20 service provider networks and other interested parties such as home-care providers. An Integrated Health Services Plan Advisory Task Force includes individuals identified by each of the networks, and representatives from two First Nations communities and the Réseau des services de santé en français.

### *Champlain-Wide LHIN Service Provider Networks*

- CareConnect
- Champlain Addiction Coordinating Body
- Champlain Dementia Network

- Champlain District Regional Stroke Steering Committee
- Champlain Mental Health Network
- Child and Youth Network of Eastern Ontario
- Community Advisory Committee – CCAC for Renfrew County
- Community Advisory Committee – The Ottawa Hospital
- Community Advisory Committee – Queensway-Carleton Hospital
- Eastern Counties Community Support Services

- End-of-Life Network
- Health Alliance of Eastern Ontario
- North Lanark & North Grenville Group\*
- Ottawa Community Support Coalition
- Perinatal Partnership Program of Eastern and South-eastern Ontario
- Regional Geriatric Services Advisory Committee
- Rehabilitation Network of Champlain
- Renfrew County Community Support Network
- Réseau des services de santé en français
- Seniors' Health Research Transfer Network

*\*This is a temporary group, not a network, organized to better understand services in the area and address cross-LHIN boundary issues.*

## Board-to-Board Meetings

The Champlain LHIN Board of Directors began meeting with representatives of other service provider Boards covering the geography of the Champlain LHIN. It also planned discussions with the Réseau des services de santé en français. These meetings are complementary and additional to the large number of CEO and Board exchanges described on page 42.

## First Nations and Aboriginal Communities

There are two First Nations communities in the Champlain LHIN; the Mohawk Nation of Akwesasne and the Algonquins of Pikwàkanagàn First Nation. In 2005, Champlain LHIN CEO Dr. Robert Cushman and Board vice-chair Wilmer Matthews met with the Band Council of Pikwàkanagàn for a general presentation and discussion. A meeting with Akwesasne representatives that includes the Champlain LHIN Board, CEO, and a Senior Director is scheduled for July, 2006, and a further meeting with Pikwàkanagàn is also being planned. Service managers from both Akwesasne and Pikwàkanagàn participate in the Integrated Health Services Plan Advisory Task Force, and representatives from those communities are members of many of the service provider networks. A next step is to contact other groups such as the Métis of Bonnechère. In addition, the Champlain LHIN Senior Directors have met with a representative of the Noojimawin Health Authority, which is mandated to articulate the health priorities of Aboriginal people living in urban and rural communities; it is funded by the Aboriginal Healing and Wellness Strategy.

# Governance

Members of the Board of Directors met with numerous community partners and attended a number of agency Board meetings. Consistent with bylaws, the Board members also held four meetings. However, because only six of nine members had been officially appointed between August, 2005 and March, 2006, and since a fundamental governance principle states, “The Board will speak as one voice at all times,” Board members decided not to make decisions until a full Board was in place.

Nevertheless, a great deal of planning took place – for example, a four-day orientation for Board members planned for June through August 2006, in addition to an on going Board development and education program.

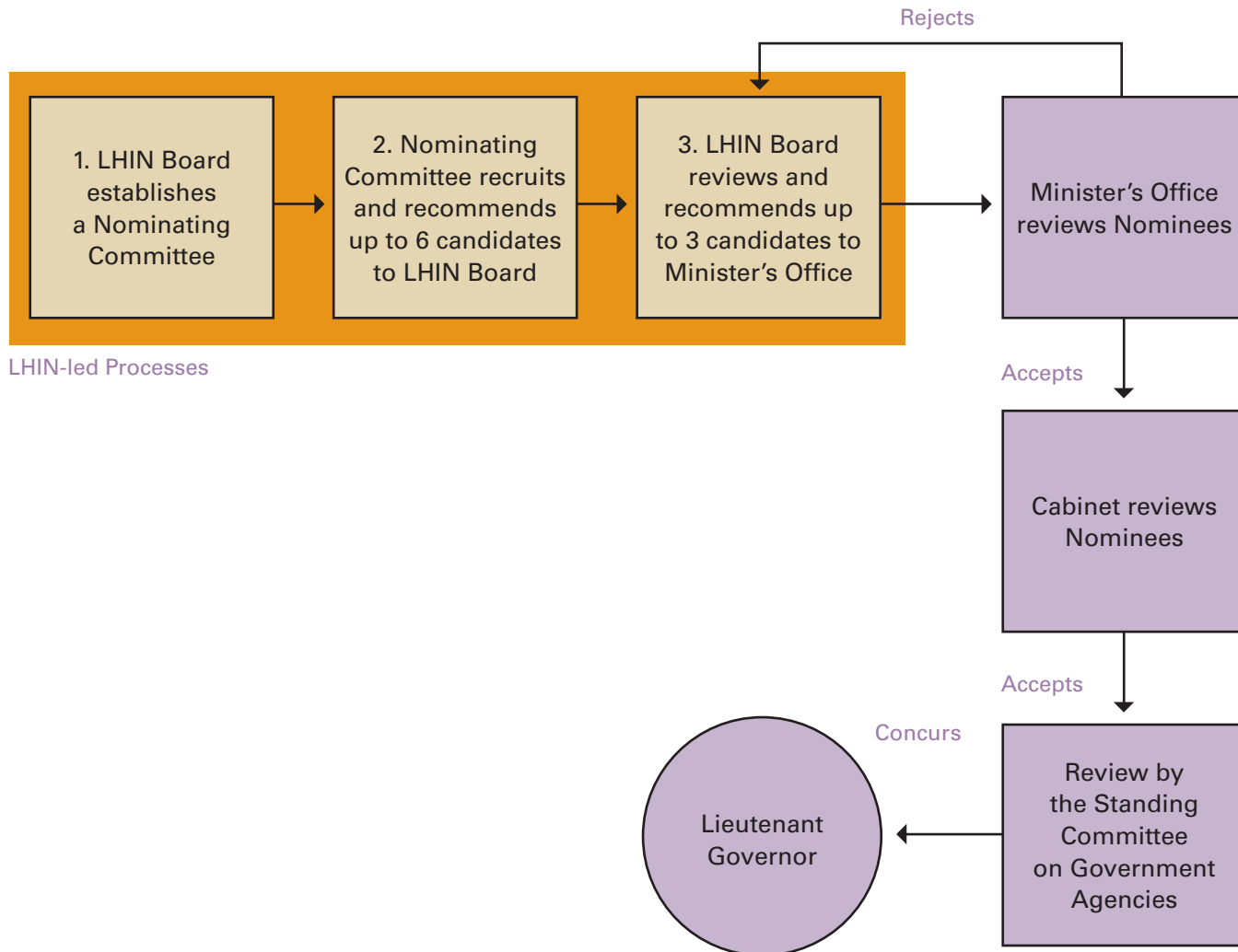
The community-based recruitment and nomination process was transparent and successful. In September, 2005, the Champlain LHIN formed a nominating committee that included the Chair and Vice-Chair of the LHIN Board and three community members. The committee compiled a shortlist of nine candidates from more than 60 applications. After interviews, the names of five candidates were submitted to the Board, of which three were selected for submission to the Minister of Health and Long-Term Care. The three community members, Andrew Dickson, Allison Griffith and Gilles Lanteigne, were appointed in May 2006.

The Performance Agreement and Conflict of Interest Guidelines were developed and are being implemented.

The LHIN Chairs proposed creating a task force of Chairs and CEOs to outline performance objectives and evaluation process for CEOs. A document was produced for review by all concerned parties.

The aggregate remuneration for members of the Board of Directors for Fiscal Year 2005/06 was \$8750.

## Overview of the Community-Based Board Nomination Process



# Integrated Health Services Plan (IHSP)

The Champlain LHIN will create, by October, 2006, a three-year Integrated Health Services Plan for implementation beginning 2007/08.

The road map for the plan is as follows:

- Completing an environmental scan to provide a knowledge base for planning and decision making. The scan focuses on developing an understanding of the people served by the Champlain LHIN and the health measures available for doing so.
- Constituting an IHSP steering committee, chaired by the Chief Executive Officer and including the Board Chair, Vice-Chair and an additional Board Member
- Establishing an IHSP advisory task force, chaired by the Senior Director (Planning, Integration & Community Engagement)
- Undertaking a community engagement process (see community engagement section pg. 45)
- Producing a synthesis report including analysis of the environmental scan and needs, gaps and opportunities as identified by service provider networks, consumers, and residents
- Determining short, medium and long-term priorities for the Champlain LHIN, noting that needs constantly evolve and may change over time. Priorities will be based on a number of emerging themes and principles, including: promoting service innovation and diffusion of evidence-based practices; improving

effectiveness and efficiency of health-care services; cultivating integration and coordination of services within the regional health system; enhancing access to appropriate care closer to home; boosting patient-centred care, patient safety, clinical outcomes and quality of care ; fostering healthy behaviours; and ensuring sustainability and equity of the regional health system.

- Producing a draft IHSP to be distributed first to the Champlain LHIN Board of Directors for approval, then to be circulated for feedback from our community, then presented to the Board for final approval

“The new Local Health Integration Networks are a key component of the provincial health system transformation. It was indeed gratifying to witness the groundswell of support for, and recognition of, the needs of older persons in local and provincial LHIN consultations...The initial understanding and receptivity expressed by Dr. Robert Cushman, CEO of the LHIN, has been most encouraging.”

*From Encore! a newsletter of the Regional Geriatric Assessment Program of Ottawa.*

## Environmental Scan Components

### **1. Introduction**

### **2. Champlain region**

### **3. Characteristics of the residents of Champlain Region**

3.1 Social & demographic

3.2 Health status

3.3 Preventative care

3.4 Health practices/behaviours

3.5 Prevalence of chronic conditions

3.6 Morbidity/mortality

### **4. Health System Utilization**

4.1 Acute inpatient hospital

4.2 Day procedures and emergency visits

4.3 Mental health hospital

4.4 Complex continuing care

4.5 Inpatient rehabilitation

4.6 Alternate level of care

### **5. Champlain Region Health System Resources**

5.1 Financial resources

5.2 Services and distribution

5.3 Accountability agreements

5.4 Hospital reports

5.5 Physician services

5.6 Health human resources

5.7 Information readiness

### **6. Local System Performance**

6.1 System scorecard

6.2 Wait times

### **7. Regional Priorities**

# Statement of Financial Position

March 31, 2006

## Assets

|                         |          |
|-------------------------|----------|
| Cash                    | \$31,705 |
| Capital assets (Note 3) | 1        |

\$31,706

## Liabilities and Net Assets

|                                                   |          |
|---------------------------------------------------|----------|
| Accounts payable and accrued liabilities (Note 4) | –        |
| Net assets                                        | \$31,706 |
|                                                   | \$31,706 |

APPROVED BY THE BOARD

# Statement of Operations and Changes in Net Assets

Period from the date of incorporation, July 9, 2005 to March 31, 2006

## Revenue

|                                                        |         |
|--------------------------------------------------------|---------|
| Ministry of Health and Long Term Care (MOHLTC) Funding | \$4,000 |
| MOHLTC payroll reimbursement                           | 181,923 |
|                                                        | 185,923 |

## Expenses (Note 5)

|                       |         |
|-----------------------|---------|
| Salaries and benefits | 153,158 |
| Office supplies       | 621     |
| Catering              | 78      |
| Other                 | 360     |
|                       | 154,217 |

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Excess of Revenue Over Expenses</b> | <b>31,706</b>   |
| <b>Net Assets, Beginning of Period</b> | <b>–</b>        |
| <b>Net Assets, End of Period</b>       | <b>\$31,706</b> |

# Notes to the Financial Statements March 31, 2006

## 1. DESCRIPTION OF BUSINESS

### Formation and status

The Local Health Integration Network of Champlain was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Champlain Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in both the Act and the Memorandum of Understanding between the LHIN and the Ministry of Health and Long-Term Care ("MOHLTC"). Funding of the LHIN by the MOHLTC in the fiscal year ended March 31, 2006 was made pursuant to the terms of a Performance Agreement.

### LHIN operations

The objects of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The Champlain Local Health Integration Network boundaries include all of Renfrew County, the City of Ottawa, the counties of Prescott and Stormont, Dundas and Glengarry as well as some municipalities of Lanark County and parts of Leeds and Grenville

### Fiscal period

These financial statements represent the activities of the LHIN from July 9, 2005, the date of incorporation, to March 31, 2006.

## 2. SIGNIFICANT ACCOUNTING POLICIES

### Financial statement presentation

The financial statements have been prepared in accordance with the accounting standards for not-for-profit organizations published by the Canadian Institute of Chartered Accountants using the deferral method of reporting restricted contributions.

### Revenue recognition

Ministry of Health and Long-Term Care funding is recognized as revenue in the year in which the related expenses are incurred. Any designated funds for which the expenses have not been incurred are recorded as deferred revenue.

### Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

## 3. CAPITAL ASSETS

The LHIN office maintains a record of assets purchased on its behalf by the MOHLTC. The nature of these assets includes:

- Leaseholds (arranged by Ontario Realty Corporation)
- Furniture and equipment
- Computer software and equipment

These assets have been reflected at a nominal dollar value of \$1, as the payment for these assets has been included in the expenditures of the MOHLTC

## 4. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

The MOHLTC has included accounts payable and accrued liabilities totaling \$59,393 in its records on behalf of the LHIN as at March 31, 2006. These expenses are included in amounts disclosed in Note 5.

## 5. EXPENSES

All other operating expenses, other than those disclosed on the statement of operations, were approved and paid for on behalf of the LHIN by the MOHLTC. These expenses for the period ended March 31, 2006 are as follows:

|                        |             |
|------------------------|-------------|
| Salaries and benefits  | \$81,100    |
| Office occupancy       | 1,109,307   |
| Common services        | 42,126      |
| Information technology | 98,648      |
| Other expenditures     | 175,328     |
|                        | \$1,506,509 |

## 6. GUARANTEES

(i) The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

(ii) An indemnity for the Chief Executive Officer was provided directly by the LHIN. Between March 28, 2006 and March 31, 2006, the directors, officers and employees of the LHIN received the benefit of Section 35 of the Act.

## 7. STATEMENT OF CASH FLOWS

A statement of cash flows has not been provided, as the information it would contain is readily determinable from the accompanying statements.

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