

ANNUAL SERVICE PLAN

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK

May 30th, 2008

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A. Introduction

A.1 Overview and Summary

On April 1, 2007, the Champlain Local Health Integration Network (LHIN) began its role as manager of the health care system in the Champlain region. During the prior year, the LHIN developed and published its strategic priorities, in the "Blueprint toward Transformation in Health, Creating an Integrated Health Service Plan (IHSP) in the Champlain Region." Our six strategic priorities include: Access, primary health services, addictions and mental health, elderly with complex and chronic conditions and e-Health.

In 2007-08, we established our architecture for community engagement. Our geographically situated 'Communities of Care Advisory Forums' and our subject matter experts, 'Communities of Practice', are now in place to assist with health planning at the local level.

This service plan outlines the more specific projects and plans, targeted for 2008-2009, using the template prescribed by the Ministry of Health and Long Term Care. Essentially, the plan addresses two broad areas: the LHIN's organizational operations and the Champlain health system. From a resource perspective, the two are intimately entwined; our staff members lead the projects as well as provide intense facilitation for the establishment and work of Champlain's Networks and geographic advisory forums.

The projects related more directly to the Champlain health system are, of course, all aligned to the Ministry's goals, to our Vision, Mission and Values, to our IHSP priorities, and are aimed at improved system integration. Each project incorporates measures that are reported regularly through the LHIN's scorecard. We regularly present a report of activities in this format to our Board of Directors.

As an overview of how the service plan takes the higher level strategy of the IHSP to specific projects that will lead to improvements for the consumer, it may be appropriate to provide a few examples.

With the approval of this service plan, the Champlain LHIN will focus on the needs of the elderly with complex and chronic conditions. There are five objectives for this priority listed in the IHSP. In 2008-09, we are specifically addressing the following objectives:

- To work with partners, particularly the Regional Geriatric Advisory Committee, and the ALC Work Groups to identify and implement additional Alternate Level of Care (ALC) diversion initiatives with particular attention to appropriate supports for people aging at home.

These initiatives include: continuing the transitional care pilot program; expansion of the Aging in Place, the Geriatric Emergency Management, and Safe at Home programs; and efforts to reduce financial barriers and promote patient flow from hospitals to alternative settings;

- To work with partners, including the Champlain Dementia Network to develop integrated pathways for seniors living with chronic diseases, particularly dementia;
- To establish a more coordinated model for delivering services to ensure that the system is more responsive to the needs of seniors; for example, shared services supports would facilitate aging at home and ease the disability associated with chronic illnesses.

With respect to access, this service plan captures the objectives noted in the IHSP and includes several specific projects.

- Some projects such as wait times for hips, knees, cataracts, cancer services, and cardiac surgery are explicit components of the Ministry/LHIN Accountability Agreement (MLAA), with fixed performance targets; others, such as diagnostic imaging expand beyond the MRI targets to focus on studies aimed at coordinating and integrating access across the region;
- A pilot project in Prescott-Russell will provide the foundation to a more efficient and effective approach to the coordination of non-urgent transportation in the region. The pilot will build on the initial pilot which consisted of the development and implementation of a centralized access and coordination function related to non-urgent community transportation for patients discharged from hospitals to the community. The initial 6-month pilot included only hospital to hospital non-urgent transfers and hospital discharges to Long Term Care Homes in the Prescott-Russell area. A final report was submitted to the LHIN in April 2008 outlining recommendations for moving forward into Phase II.

The Phase II Non-Urgent Community Transportation pilot project objectives include developing a business case for expansion of the pilot across other geographic areas in Champlain. The Phase II project will support the Aging at Home Strategy by focussing on alleviating ALC pressures by transporting discharged seniors from hospital at no cost. The pilot will improve system integration as the model builds upon a systems approach involving emergency medical services, hospitals, community support services and the LHIN. The vans recently announced through the Aging at Home Strategy will improve access to health-related non-urgent transportation. The vans will

facilitate and expand transportation options for seniors from hospital to home at no cost to the senior.

- Other projects address the need for the regionalization of clinical services in the area of obstetrics/newborn as well as rehabilitation, including services for the physically disabled. These projects aim to move ahead with recommendations formulated through two separate planning studies.
- Other initiatives related to ongoing projects such as critical care surge capacity, services in French, planning with our First Nations, Aboriginal and Métis communities will continue;
- A Health Human Resources Council was established and a work plan for fiscal year 2008-09 is in the process of being finalized. Issues identified as requiring the Council's attention include the recruitment and retention of health professionals, the need to work closely with academic institutions in all health care fields and the need to understand the health human resource impact of integration activities.

The other strategic priorities will move ahead in similar fashion. The service plan for 2008-2009 provides the overview of individual approaches. For example, the IHSP specifically names Addictions and Mental Health as a LHIN priority due to historical stigma and chronic under-funding. While the proposal for youth addictions treatment facilities therefore fits with our strategic directions, it also responds to strong community efforts to draw attention to this important health-care need.

Together and with the full force of the community's engagement, we will build an integrated health system in the Champlain region. This Annual Service Plan provides more definition to the "Next Steps" outlined in our Blueprint, the first IHSP of November 2006.

A.2 Introduction

The first Annual Service Plan of the Champlain Local Health Integration Network (LHIN) identifies priority projects to be implemented in 2008-09.

Two documents provide the legal framework for this plan. They are the *Local Health System Integration Act, 2006* and the 2007 Accountability Agreement with the Ministry of Health and Long-Term Care (MOHLTC). We are also guided by the Champlain LHIN's vision, mission and goals and are aligned to the Minister's strategic directions (June, 2006) and strategic goals (June, 2007).

In November 2006, the Integrated Health Service Plan (IHSP) was finalized by the Champlain Local Health Integration Network (LHIN) as a blueprint to create a more effective, compassionate, equitable and responsive health system to meet the unique characteristics of the Champlain region. Six key priorities - aligned to the Ministry of Health and Long Term Care's strategic directions and health goals and grounded in the expressed needs of the community - were identified to foster system change and bring about quality improvements.

The purpose of the Annual Service Plan (ASP) is to:

- Document the implementation of the Integrated Health Service Plan (IHSP)
- Outline key directions for the Champlain LHIN and local health system
- Contribute to the MOHLTC's Results-based Planning (RbP) submission to Treasury Board/Management Board of Cabinet
- Respect reporting requirements of the Ministry/LHIN Accountability Agreement (MLAA) – Schedule 8
- Seek Board approval on a three-year plan for the Champlain LHIN

The Champlain LHIN is moving forward on several fronts:

- Consolidating the Champlain LHIN as an organization
- Implementing project plans for each of the IHSP priorities
- Putting in place an engagement architecture and processes for managing the Champlain health system, including risk identification and control
- Building relationships between the LHIN Board of Directors and the Boards of Health Service Providers
- Developing effective links with relevant organizations outside the LHIN's legislated mandate

Note: Due to the continuous nature of planning, this plan forecasts for two additional years, however, it will be amended on a year-to-year basis to remain relevant to changing realities and needs.

B. Environmental Scan of Opportunities and Risks

- **Population Distribution** - The Champlain region covers a large geographic area of almost 18,000 square kilometres with a total population of more than 1.1 million (about 10% of the Ontario population). The majority of the population is concentrated in the City of Ottawa (70%) with the balance distributed among surrounding counties. Access issues related to service distribution and transportation are important for this region; therefore projects focused on transportation, distribution &

availability of technologies (e-Health, Diagnostic Imaging Settings and Services Plan) and providing services closer to home (Intrapartum Project, Eastern Ontario Regional Laboratory Association (EORLA), and Surgical Services Modelling Project) are key to improved system access.

- **Population Growth** - The population growth in Champlain during the next five years is similar to the provincial growth estimates of about 6%. As with the rest of Canada, the Champlain region will experience growth in the aging population. This will influence demand for services and highlights the need to move forward this year with initiatives focused on chronic disease prevention and management, Appropriate Levels of Care (ALC), regional rehabilitation review, seniors with chronic and complex conditions, and diagnostic imaging projects.
- **Population Diversity** –There is a strong Francophone (20%) and multicultural presence (14% visible minority) in Champlain. Also, there are two formal First Nations communities and more than half the Aboriginal population live off-reserve (estimated 32,000 in Ottawa). The Francophone presence in Champlain is reinforced by its shared border with Quebec. Accessibility and availability of linguistically and culturally appropriate services are important considerations for all of our projects in Champlain, adding complexity and cost.
- **Socio-economic Indicators** – A composite index taking into account multiple indicators shows that residents of rural Ottawa were the most likely in Champlain to report excellent or very good health (64%). On the other hand, within Champlain, the disadvantage index is highest in parts of Renfrew County, in several areas within Ottawa, and in Cornwall and Hawkesbury. This shows the association between the determinants of health and health status that will be taken into account as planning processes develop.
- **Service Distribution, Health Care Spending and Service Utilization** - A review of service distribution, health care spending and service utilization are useful elements in analyzing the health care system's ability to meet current and future obligations. Table 1 presents the distribution of health care services by health sector and geography.

Table 1: Service Distribution by Health Sector and Health Service Provider

Champlain Communities of Care	CSS	LTCH	MH	Addictio ns	Hospital	CHC Main Site	CHC Satellite	CCAC	Total
Centre	20	6	11	9		4	1		51
Eastern Counties	11	18	6	2	5	1	3		46
Central West	13	15	8	1	1	2			40
Renfrew County	12	10	3	3	5		3		36
Central East	3	7	3	3	1	1			18
N Lanark	1	3		1	2	1			8
N Grenville	2	1			1				4
Regional				1*	5**			1***	6
TOTAL	62	60	31	20	20	9	7	1	209

* Includes the Royal Ottawa Hospital Addictions Service

** Includes SCO Health Service, Children's Hospital of Eastern Ontario, Ottawa Heart Institute, Royal Ottawa Hospital and The Ottawa Hospital (3 sites)

***CCAC is a regional provider of services in all Champlain Communities of Care

- o *Service Distribution* - The table above outlines the service distribution by provider type and health service provider within the Champlain region. It is important to consider that the strongest population growth is projected for the most rural parts of Ottawa and in surrounding counties of Prescott Russell, Renfrew County and North Lanark/North Grenville. Also, as data regarding population characteristics, health status, prevalence of disease, and healthy behaviours become more available, communities will be better able to identify service needs.
- o *Health Care Spending* - In 2005, hospital spending accounted for 72% of the total MoHLTC budget in the Champlain LHIN, while community mental health and addictions programs accounted for only 3% in total. The imbalance of health care spending within the system poses both challenges and opportunities. Linkages among health providers are being encouraged through various LHIN Community of Practice networks. Integration opportunities related to chronic disease, elderly with chronic and complex conditions (e.g. ALC initiatives, Flo Collaborative) and mental health and addictions (e.g. Concurrent Disorders Project) will continue to be explored.
- o *Service Utilization* – Service utilization is influenced by several factors including the supply of health services and health professionals. The proportion of Champlain residents reporting having a regular doctor in 2005 was slightly lower than in Ontario as a whole and lower than other comparator LHINs. The lack of or inadequate supply of community services in some areas of Champlain forces consumers to use higher cost services such as emergency rooms and hospitals. For example, the proportion of non-urgent emergency department visits

that theoretically could be managed elsewhere was much higher in areas outside of Ottawa where access to and availability of community services is lower. Equitable access to services is a fundamental principle of all of our project plans. Innovative service models, expanded linkages between providers and enhanced self-management initiatives are being encouraged within our key priority areas.

➤ **Health Status Indicators and Trends** – The underlying causes of chronic diseases such as cancer, cardiovascular disease, stroke and diabetes are largely attributed to modifiable risk factors such as tobacco use, poor diet and lack of physical activity (obesity) and alcohol use (MOHLTC, 2006). Results from the 2006 Champlain Environmental Scan show variability in health behaviours and practices, prevalence of chronic conditions, and service gaps related to Chronic Disease Prevention & Management (CDPM) across sub-planning areas and populations of the Champlain region. The following provides a snapshot of selected chronic conditions and risk factors. It highlights the importance of moving ahead with projects in chronic disease prevention and management to improve quality of life for residents of our region and to contain or reduce costs.

- o *Diabetes*-- The prevalence rate of diabetes in Champlain region across all socioeconomic status groups and for Ontario overall increased between 1995 and 2004 (Institute for Clinical Evaluative Studies - ICES, 2007). This is a trend that will require attention as diabetes mellitus (DM) is reported as a leading cause of cardiac disease, end-stage renal failure leading to dialysis, blindness, and amputation (Healthcare Quarterly, 2002). Chronic disease prevention and management programs have shown to reduce the likelihood of developing diseases that may require costly treatments. For example, several large epidemiological studies, have observed that for every 1% reduction in glycosylated hemoglobin (HbA1c) e.g. from 8% to 7%, a 14% drop in the incidence of AMI (acute myocardial infarction) and a 16% drop in heart failure rates has been realized (ICES, Diabetes and Cardiac Disease). A recent Canadian study showed that if the increase in the prevalence of diabetes follows current trends, health-care costs for people with diabetes in Canada will increase by 75% between 2000 and 2016 (Canadian Journal of Diabetes, 2004; 28-2).
- o *Asthma & Chronic Obstructive Pulmonary Disease (COPD)* --Age and sex adjusted asthma prevalence rates in Champlain (6.5%) is slightly higher than the Ontario rate (6.0%) and an individual in Ontario has more than a 2 in 5 risk of developing asthma before turning 40 years of age (ICES, 2007). COPD is being recognized as a significant health problem among seniors. Current prevalence estimates for COPD are likely underrepresented as almost half of people with COPD are undiagnosed. Furthermore, the number of individuals with COPD will

likely increase in the future with an aging population. COPD is a leading cause of hospitalization with reported readmission rates as high as 40 to 50% and rising (Canadian Lung Association, 2005).

- o *Obesity*--If the prevalence of obesity continues to increase, so will the impact that obesity-related chronic conditions will have on the health status of the population and on system sustainability. The annual economic burden of obesity in Ontario is estimated at \$2.35 billion or 5.3% of the total provincial health care budget (Starky, The Obesity Epidemic in Canada. Library of Parliament Report No. PRB 05-11E, 2007). The proportion of persons reporting being overweight or obese ranged from 44.5% in Ottawa to 57.3% in Eastern Counties.
- o *Tobacco Use*--In 2005, 15.7% of Champlain Canadian Community Health Survey (CCHS) respondents reported regular smoking, exactly the same proportion as in Ontario. However, in Ontario, prevalence decreased in 2003, whereas in Champlain, it experienced a marginal increase. Eastern Counties and Renfrew County reported smoking prevalence rates of 22.7% and 22.6% respectively in 2005 (CCHS). Quitting smoking is the single most important intervention for the prevention of major chronic diseases.

The need for action in chronic disease prevention and management is clear. The Champlain Cardiovascular Prevention Network, linked to other Chronic Disease Communities of Practice, will work towards an integrated CDPM strategy in Champlain. Expected outcomes will be to improve the health status of residents of the Champlain region through coordinated initiatives targeted at modifiable chronic disease risk factors and improved management of chronic disease across the continuum of care.

➤ **Risks associated with Health Service Provider/Sectors** – Pressures affecting Champlain health sectors may impact on the ability of Health Service Providers to sustain service delivery and contribute to system improvements.

➤ **Pressures include:**

- Community Health Centre (CHC) compensation settlement
- Construction projects and operating pressures upon opening services (Post Construction Operating Plan [PCOP])
- Unresolved Health Services Restructuring Commission (HSRC) directives e.g. Royal Ottawa Health Care Group (ROHCG)
- Hospital pressures not resolved by one-time Hospital Services Accountability Agreement (HSAAPs) signing dollars (07-08),
- Community Support Services (CSS) data collection requirements and technology
- Community Care Access Centre (CCAC) restructuring costs

- Mental health services for the growing geriatric population
- Long-Term Care Home Convalescent Care physician remuneration
- Financial impact of Long-Term Care Home legislation (*Long-Term Care Homes Act, 2006*)
- Requirement for sufficient resources for adequate chronic disease prevention and management through the Champlain Cardiovascular Prevention Network
- Network facilitation requirements of Champlain LHIN staff
- Increased operational costs such as utilities, supplies, wages

In addition, wage inequities across sectors pose a serious risk to having a stable health workforce and may impact on the ability to maintain service volumes and deliver on integration plans.

➤ **Other Cost Drivers**

- Translation costs for bilingual documents
- Normal inflation and cost of living, for instance transportation costs associated with gas prices (above normal inflation), particularly affecting Community Support Services transportation services.
- Impacts from outside the LHIN e.g. municipal decisions
- Change management issues for HSPs and for the LHIN regarding implementation of projects and the need for project management within the LHIN
- Data availability and quality
- Need for support and linkages with sectors beyond those within the LHIN purview (primary health and public health)
- Need for capital redevelopment

The Champlain LHIN has identified mitigation strategies for the majority of these areas of risk. For instance, we are currently evaluating the feasibility of reallocating budgetary increases for the 2008-2009 fiscal year between sectors to ensure equity while still allowing all sectors to meet their mandate. Funds received for Post Construction Operating Plan (PCOP) and for Hospital High Growth will decrease pressures by allowing to meeting increased service demands on the particular health service providers receiving the funds. Discussions are currently underway with the MOHLTC and various scenarios are being considered to address the financial situation of two particular hospitals. Problem solving sessions are being held with three others to identify strategies towards a balanced budget. Several projects funded through the Aging at Home strategy (described further in this document) will ensure gaps in certain sectors of care begin to be addressed. Community Support Services are being provided with support to implement MIS reporting guidelines which should ensure a smoother transition to this new system. Several initiatives are currently underway to enable organizations to participate in group purchasing activities to reduce overall costs and provide opportunities for savings. Other initiatives to support back-office integration are being explored. Collaborative initiative such as the

Eastern Ontario Regional Laboratory Association (EORLA) will help address impending health human resources shortages.

Mitigation strategies for individual initiatives are described further in each relevant section of this document.

C. Detailed Plans to Implement IHSP Priorities for the Local Health System

C.1 *The Architecture for Implementation*

The Champlain LHIN has created a specific new architecture, which pays particular attention to the mix of health care services (the 'what') and place (the 'where').

a) *Communities of Care* bring together health service providers, consumers and citizens from a geographically determined area to foster health planning and integration based on local needs. There are six communities of care in Champlain. Each Community of Care has established a 'Community of Care Advisory Forum' (CCAF) that meets regularly. The CCAFs have identified health care priorities within their region and are currently finalizing priorities for the 2008-09 year.

b) *Communities of Practice* are health networks that disseminate leading practices on specific services (i.e. stroke, mental illness) in order to ensure a level-playing field for the quality of service across Champlain. They help initiate and implement projects. Health networks are mainly comprised of health professionals, but also include members of the public. 'Statements of relationship' between the LHIN and each community of practice have been finalized. The LHIN is currently working with 15 of these networks to establish regional clinical service plans.

In addition, the Champlain LHIN has established three Council of Expertise (Health Human Resources, e-Health and Primary Care). These Councils are advisory bodies to the LHIN and a means to engage the community of health service providers.

Community engagement continues to be the cornerstone of our activities and architecture. A document entitled the "Community Engagement Guide" has been developed, has been distributed to forums and networks and has been posted on the Champlain LHIN website.

Opportunities

- The existence of Communities of Care encourages integration through information-sharing and networking.
- Communities of Care will result in tailoring of services to the needs of specific communities.

- The Champlain LHIN will make better decisions by listening to advisors from the various communities of practice as we strive to build regional clinical service models.
- Clinical areas that have historically not received the attention they deserve will gain a voice through Communities of Practice.

Risks (i.e. challenges)

- Skilled facilitation and seed money is required to help these forums and networks work effectively and initiate projects. The alignment of LHIN staff to the community engagement forums provides some support to ensure plans developed can be executed.

C.2 Elderly with Complex and Chronic Conditions

C.2.1 Alternate Level of Care (ALC)

The Alternate Level of Care (ALC) occupancy rate in acute-care beds has been rising over the past few years. The percentage of ALC days to total patient days has increased from 10.8% (2005/06) to 13.7% (2006/07) to 16.4% (2007/08 Q1). As a result, patients receive care in inappropriate settings, an overload of patients is experienced in emergency rooms, surgeries are cancelled, and the management of trauma patients is compromised. Finally, achieving wait time targets is made more difficult when beds are used inappropriately.

The Champlain LHIN has worked closely with local ALC working groups to address local patient flow challenges. In Feb. 2006 a one-time investment of \$3.9 M was announced by the LHIN and the MOHLTC to improve patient flow. Specific initiatives that were implemented in 2007-08 and are ongoing in 2008-09 include:

- **Aging in Place project:** Provides enhanced community support and professional services in five seniors' apartments in Ottawa.
- **Geriatric Emergency Management (GEM) and Going Home Project:** Supports the identification and assessment of high-risk individuals, provides quick response home supports to prevent admissions, and allows inpatients to return home with enhanced support.
- **Community Care Access Centre Case Managers in Emergency Room:** Reduces pressures on hospitals and prevents unnecessary admissions.
- **Transitional Care Program:** Supports patients for up to 90 days in a subsidized 14-bed assisted living environment in a retirement home to

improve the client's ability to live safely in the community and avoid premature placements to long-term care homes.

➤ **Enhanced Community Support and Home Care:** Improves community support services, increases provider awareness of community services, adds long-term care home capacity in Renfrew County and Winchester, subsidizes the long-term care home preferred rate.

The Champlain LHIN is also collaborating with the City of Ottawa and the United Way of Ottawa on two projects: 'Successful Aging Ottawa' and the 'Senior Agenda Steering Committee.' As well, the organization is working closely with the community of practice network, the 'Regional Geriatric Advisory Committee,' to develop long-term solutions to system-wide problems affecting this vulnerable population.

Other significant events included the addition of 85 new beds in an Ottawa long term care home in October and November 2007. Local partners worked closely to achieve the most benefit from these new beds on hospital pressures. Hospitals, the CCAC and long term care homes worked together to align patient choice, matching care needs to long term care home settings and providing a subsidy for the preferred rate of long term care home beds for ALC patients where this was a barrier to placement. This initiative will continue to alleviate ALC pressure in the hospitals within our region.

Opportunities

- Interim evaluations of several projects listed above demonstrate the potential of the initiatives to improve patient flow and assist individuals to live safely in the community. Regular monitoring of the ALC levels across the region throughout 2007/08 (through "snapshot" reports) suggests that the number of patients awaiting ALC has stabilized and has marginally reduced. The LHIN is encouraged by the results of the cumulative impact of all of these efforts. Accordingly, the LHIN is investing in the maintenance and expansion of these initiatives through the Aging at Home Strategy and the LHIN's Priority Fund.

C.2.2 Emergency Department Wait Times

The Champlain LHIN is supporting or leading several initiatives aimed at reducing emergency room congestion and improving the flow of patients through the emergency department which will ultimately result in reduced wait times. In addition to the strategies listed under the previous section of this document dealing with Alternate Level of Care, highlights of the initiatives underway in 2008-2009 are provided below.

The Champlain LHIN is supporting various hospitals that are implementing process to improve patient flow through the emergency department. In addition we are providing Adult Critical Events Simulation (ACES) training for emergency physicians.

We are also supporting the development of an emergency website to be used by physicians to obtain clinical data and to track wait times in the various emergency rooms. We are working with Health Force Ontario's wait time strategy to ensure the recruitment of physicians in hospital emergency departments.

Collaborative projects with community partners have been initiated and are ongoing to reduce pressures on emergency rooms. For example, The Ottawa Hospital initiated the Nurse Practitioner Outreach Project which involves a nurse practitioner providing outreach assessment and assistance to residents in long-term care homes to avoid emergency room visits and hospitalizations.

C.2.3 Urgent Priority Funding

The purpose of the Urgent Priority Funding process is to be responsive to the opportunities and pressures identified by health service providers in the Champlain region with the goal of furthering the Champlain LHIN's IHSP priorities for system change. Our aim is to develop a funding process that is fair and transparent in terms of awarding funding. A wide range of requests were submitted by health service providers that included cross-sector applications that foster progression along the continuum of care, system thinking and collaboration and improved service delivery. Our focus for the 2008-2009 fiscal year is to direct funding to alleviate Alternate Level of Care (ALC) and emergency room pressures.

The first round of Urgent Priority Funding saw 99 requests totaling over \$45 million with 20 applications selected to provide a more detailed business case outlining the project deliverables, outcomes and funding and other requirements. The total Urgent Priority Fund available for 2008/2009 is \$4.7M. The LHIN intends to disperse approximately \$1.8M in round one with another \$800K in August for a total of \$2.6M. This does not include an additional \$2.1M committed through last year's UPF program.

C.2.4. Aging at Home

The Champlain LHIN has budgeted 6.7 million in fiscal 2008-2009 for the Aging at Home strategy. This exciting program will allow us to truly begin transforming the health care system to meet the need of seniors with complex conditions and allow them to remain safely in their domicile of choice.

We received 120 expressions of interest from health service providers in our area for expansion of existing services for seniors or for the creation of new and innovative programs. Of these, 31 initiatives that meet the needs of elderly people with complex conditions, including strategies targeted for

Aboriginal, Francophone and immigrant communities were retained. These strategies cover a wide spectrum of activities and address significant gaps in the current services. All of the initiatives involve collaboration between health service providers and several cross sectors.

An evaluation framework is currently being developed to ensure consistent measurement of the initiatives and to assist the LHIN staff in determining which of the initiatives meeting their stated aims and targets should be carried forward in the 2009-2010 year.

Planning for the second year of the Aging at Home strategy is currently underway. A study of existing long-term and “transitional” care bed capacity in the Champlain region is currently underway to inform the decision regarding the use a portion of Aging at Home funds to increase the volume of long-term care beds. Although institutional placement is not the preferred option in the context of a strategy designed to maintain seniors in their own homes, it is prudent to conduct a thorough evaluation to ensure an appropriate spectrum of services in the context of demographic shifts.

C.3 Access: Regional Clinical Service Plans

Clinical services in the Champlain LHIN, not unlike other centres in Ontario, tend to be concentrated in university tertiary care hospitals close to or in the downtown core. The MOHLTC has recognized that these institutions are currently providing too high a percentage of primary and secondary services in their case mix, and that corrective action is required. The situation is accentuated in the Champlain region because The Ottawa Hospital, a tertiary care centre, is also the largest provider of primary and secondary services.

The result is a triangle of opportunities and challenges for the Champlain LHIN. First, there is pressure to reduce the number of primary and secondary cases in the tertiary care centre, The Ottawa Hospital. Second, there is the effort to ‘repatriate’ these cases to hospitals ‘closer to home’ to reduce distances and associated barriers to access. Unfortunately, the major restriction for this strategy is that most people live in Ottawa, and the city centre does not have a community hospital. Finally, there is a keen interest and growing commitment to build Champlain communities of Practice with regional clinical service distribution plans. More specifically, the goal is to build a seamless integrated system where services are strengthened in the community and in the peripheral hospitals, and where timely decisions can be made in a fluid system without barriers to accessing the next immediate and appropriate level of care. Examples include dialysis and ambulatory care follow-up closer to home, elective day surgeries in community hospitals, and immediate referrals to tertiary care services for critically ill patients.

To further these goals, the Champlain LHIN has a number of 'regional clinical service' initiatives underway which are addressed in detail in this section of the plan.

C.3.1 Regional Clinical Rehabilitation Review Project

The Champlain region conducted a review of clinical rehabilitation services in April, 2007 due to access problems and fragmented continuity of care. The review focused on transition from children's to adult services, adult rehabilitation services, and geriatric rehabilitation services.

A steering committee comprised of providers and chaired by an independent volunteer reviewed preliminary recommendations in June, 2007. The final report was tabled in February 2008. The Rehabilitation Network of Champlain (RNOC), is currently finalizing the work plan to address the report's key findings and will work collaboratively with the Champlain LHIN to implement the recommendations in the areas of data quality, communication channels and organization of services. As an example, a recommendation to address data quality might include the development of a standardized assessment tool, of uniform admission and discharge criteria and processes as well as communication of these standards to the public and health care providers. With respect to the organization of services, RNOC may choose to review existing operational models of ambulatory and outreach services with a focus on consolidation of service and associated cost savings.

Opportunities

- Better understanding of community/system needs in the rehabilitation sector
- Ability to better match services (inpatient/outpatient, diagnostic category) with population needs.

Risks (i.e. challenges)

- Project management human and financial resources are required to implement the recommendations of the review. Hiring a project manager to facilitate the next planning phase will mitigate the risks ensuring that work group priorities are finalized with a timeframe for completion.
- Some health service providers may feel reluctant to investigate potential change to the status quo. The membership of RNOC is currently being revised to ensure appropriate membership to facilitate strategic discussions and planning.

C.3.2 Regional Obstetrics and Neonatal Services

A number of independent initiatives were underway region-wide in this area, and consequently the LHIN has coordinated and facilitated a regional approach to comprehensive planning.

An extensive inventory of Champlain wide services, gaps, and outcomes, as well as nationwide comparisons of service delivery models and reviews of consumer preference studies have been completed. While at first glance the services are of high quality, concerns include the concentration of deliveries in tertiary care settings, a fragmented system with wide practice variations, gaps in paediatric coverage for newborns in hospital, and inadequate organization and resources for primary care maternal/infant services.

The Champlain LHIN is working with the Perinatal Partnership Program of Eastern and South-eastern Ontario (PPESO) to develop a regional clinical services plan for obstetrics and neonatal services.

Opportunities

- Building a regional system to provide, monitor and evaluate obstetric/newborn services in the Champlain LHIN
- More cost effective resource use and improvement in health status indicators (low birth weight, pre-term deliveries, breast feeding, neonatal jaundice)
- Smoother transitions from one provider to another, particularly in urgent situations
- Shorter travel times and more consumer preference

Risks (i.e. challenges)

- Human Resources: number and distribution of skilled practitioners; for example, mismatches between obstetric and paediatric capacity at specific sites.
- Continued fragmentation and siloed approach; inconsistent practice patterns; lack of collective commitment necessary to monitor and address important health status indicators.

These risks are being mitigated by involving all key stakeholders in the development of the regional plan.

C.3.3 Diagnostic Imaging (MRI / CT)

The Champlain LHIN is working closely with the Champlain Diagnostic Imaging Working Network to reduce wait times and provide CT and MRI services 'closer to home.'

In 2008/09, the Network will complete the development of a five year sittings and services plan for CT. This plan will be similar to the MRI plan endorsed by the Champlain LHIN and submitted to the MOHLTC in 2007/08. The Network will also review human resource needs with respect to technologists and review opportunities for group equipment procurement.

The Champlain LHIN is also working closely with the Champlain Picture Archiving and Communication Systems (PACS) Repository and Central Intake Steering Committee. The Committee is currently overseeing two parallel projects. The Champlain Diagnostic Imaging Repository (DI-r) initiative is helping to fulfill the vision of a provincial electronic health record (EHR) by creating a shared digital imaging network that allows hospitals across the region to share digital diagnostic images and reports. The Committee has also been mandated to undertake a study to find a solution for the development of a central Intake system (CIS) for diagnostic imaging, focusing on CT and MR exams in the Champlain Region. The study intends to verify the benefits and challenges of a CIS and investigate the infrastructure, integration requirements, process change, support and security requirements, funding model, high level costs and determine and implementation timeline. Together, these projects are currently funded through Canada Health Infoway, MOHLTC E-Health Program and the Champlain LHIN. The plans for these projects are expected to be completed by the second quarter of 2008/09.

The Champlain LHIN utilized the one-time funding of \$700,000 received in 2008-2009 to increase the volume of MRI procedures back to 2007-2008 level.

Opportunities:

- Disparate Picture Archiving and Communication Systems (PACS) do not allow for the sharing of diagnostic images among hospitals. The Champlain LHIN is pursuing the development of a regional repository for these images and reports. Approximately 1.2 million patient images are scanned each year in Champlain hospitals with an additional 600,000 scanned within the Independent Healthcare Facilities – Radiology Clinics.
- Multiple wait lists for similar diagnostic imaging services result in duplicate referrals, duplicate administrative efforts and wait time data

quality issues. To address this, the Champlain LHIN is conducting a regional clinical central intake study for CT and MRI services.

Risks (i.e. challenges)

- Achieving the MRI wait time annual performance goal is threatened by increasing service demands. Achieving the CT wait time annual performance goal is threatened by the 2008/09 reduction in CT funded volumes. To mitigate this risk, we are currently re-negotiating our targets to ensure they reflect our current reality.

C.3.4 EORLA

The Eastern Ontario Regional Laboratory Association (EORLA) is the most advanced hospital laboratory transformation project in the province of Ontario. EORLA is a corporation without shared capital, established in 2003 by the 16 hospitals of the Champlain region. EORLA consists of an integrated system of 19 licensed hospital based laboratories, governed and managed by the EORLA Board of Directors.

The member hospitals are working closely with the Champlain LHIN and the MOHLTC to implement the EORLA workplan developed in 2007 through the EORLA/ MOHLTC/LHIN joint steering committee. The joint steering committee's three subcommittees ((i) EORLA, LHIN, Ministry Relations (ii) Medical and Scientific Affairs (iii) EORLA/Hospital Relations) which are comprised of senior administrative representatives of the member hospitals, MOHLTC and the Champlain LHIN are all active.

The implementation of EORLA will lead to improved quality and efficiency of laboratory services. EORLA is expected to become a functional corporate entity before the end of fiscal 08-09. The business plan for this fiscal year includes a number of activities including:

- Signed Service Level and Site Use Agreements
- Signed EORLA Member Agreements
- Recruitment of a CEO
- Development of the Funding Model
- Establishment of the Leadership and management structure
- Movement to the Single Employer Model
- Movement toward a Single Medical and Scientific Model
- Development of 5 more LIS to LIS connections
- Procurement and implementation of a few remote printers for the non-integrated LISs.

Opportunities

- EORLA, a significant integration initiative, can be used as a model for other complex coordination efforts in Champlain LHIN.

- Increased efficiency and integration of lab services is needed now due to increasing laboratory service volumes and disparity of standardization and access to lab services/expertise across the region.

Risks (i.e. challenges)

- EORLA has developed a Risk Assessment and Mitigation Strategy, which includes human resource challenges, that is shared quarterly with the Ministry of Finance and MOHLTC. These risks require dedicated attention to resolve.

C.3.5 Cancer Care – Hub and Spoke Model for Cancer Surgery

As part of efforts to reduce the caseload of the tertiary care hospital and to strengthen the role of community hospitals, the Cancer Centre at The Ottawa Hospital has a unique project underway which is designed to reduce wait times for cancer surgery.

A diagnosis of cancer is an emotional hurricane for any patient. Many cancers are now chronic diseases, and cancer survivors are increasing in number not unlike heart attack victims a generation ago. Yet the initial diagnosis remains a death sentence in the minds of many, and as a result there is panic, and a determination to get the best care as soon as possible.

Interestingly, most of the surgery required is routine and can be done by competent surgeons in most hospital settings, not exclusively in university teaching hospitals. What is of far greater importance is to stage the severity of the disease precisely, and then to determine from the world medical literature, what the most up to date and best options are for therapy (the mix of radiation, chemotherapy, and possibly further surgery).

The Hub and Spoke project aims to do just this by linking most of the Champlain hospitals and their medical staff into a system where their surgeons and pathologists will have the support and participation of the Cancer Centre expertise to outline and identify the best treatment modalities.

Cancer service teams have been established in community hospitals, through the Champlain Cancer Surgery Program. The focus for 2008-2009 will be the implementation of regional standards/guidelines and the initiation of quality improvement initiatives to provide services closer to home.

Opportunities

- Reduced wait times and services closer to home
- Increased capacity of community hospitals
- Lessened primary/secondary caseload of the tertiary care hospital

Risks (i.e. challenges)

- The project necessitates resource availability at local level – financing, operating room time, and staff.
- Buy-in from providers and patients into a seamless regional program is crucial.

The development of commonly endorsed best practice standards for cancer treatment will facilitate buy-in from key partners and patients.

C.3.6 Regional Surgical Specialty Clinical Distribution Models

The goal of this project is to evolve a regional system for general surgery, orthopaedics, obstetrics and gynaecology, and other specialties so that timely access to surgical services is, from a client perspective, closer to home, in the right setting while ensuring sustainability of surgical services in each hospital. For example, patients with fractured hips could be serviced within narrow timelines at a subset of LHIN hospitals, and smaller community hospitals could specialize in specific day surgeries such as arthroscopy.

Epidemiologists at the Champlain LHIN have already completed extensive mapping of surgical procedures by specialty and postal code, and the LHIN is now initiating discussions about which hospitals could do what procedures, and how to plan human health resources in building a system approach.

Opportunities

- The initiative will result in reduced barriers to patient flow from provider to provider.
- Human health resources will be planned regionally, and expertise shared.
- Standardized practices will be promoted.
- The project fosters system planning, management and evaluation rather than institutional competition.

Risks (i.e. challenges)

- Resistance to change and capacity challenges in moving surgical services from tertiary care hospitals to community hospitals and from

community hospitals to tertiary care hospitals. This challenge will be mitigated by involving key stakeholders in the planning, implementation and evaluation phases of this initiative.

C.4 Access: Non-Urgent Community Transportation Coordination

The Phase I Non-Urgent Community Transportation pilot project completed in early 2008 consisted of the development and implementation of a centralized access and coordination function. Initially, the 6-month pilot focused on the small rural area of Prescott-Russell Counties. The pilot project included only hospital to hospital non-urgent transfers and hospital discharges to Long Term Care Homes in the Prescott-Russell area. A final report was submitted to the LHIN in April 2008 with recommendations for moving forward.

In 2008/09 the goal of Phase II Non-Urgent Community Transportation is the continuation and expansion of the pilot project to improve access to a broader geographic area and across other health sectors. This goal will be achieved by transporting discharged ALC patients from hospitals in a timely manner as a result of local, coordinated and affordable non-urgent transportation provided by the vans funded through the Aging at Home Strategy. This initiative will result in reduced wait times thereby alleviating ALC pressures in hospitals and providing the safe return of discharged seniors to their homes in the community setting. This pilot will also evaluate the potential for the creation of flexible human resource career options for paramedics and other professionals which may further support the human resource recruitment and retention issues in the region. By developing a coordinated approach for all Champlain, this one-stop, centralized coordination centre will ensure the most appropriate and cost effective transportation service is utilized.

Opportunities

- Following an evaluation of the pilot project and incorporation of necessary changes, the LHIN may introduce similar transportation mechanisms elsewhere in the region.
- LHIN integration projects in other health sectors will benefit from lessons learned from this initiative: Centralizing coordination and access, developing standardized practices and training of volunteers.

Risks (i.e. challenges)

- It is possible the pilot project may not result in demonstrable improvements without a paid driver and a fully accessible vehicle which allows for transfers by stretcher and/or electric wheelchair users

- Involving non-LHIN funded providers (i.e. Emergency Medical Services (EMS))
- The identified risks may be mitigated by expanding the target population to include all discharged patients without means of transport home, and/or to expand the use of the vans for other uses (other than priority of discharge to home).

C.5 Access: Wait Times – Hip/Knees Replacement and Cataracts

Regional multidisciplinary steering committees have been created for all wait time programs. A number of initiatives are currently under way to improve access to total joint replacement and cataract surgery, as these areas are suffering from the longest waits. For instance, the Queensway Carleton Hospital has successfully implemented a program to assess all patients referred for hip and knee surgery by an interprofessional team which includes an advanced practice physiotherapist. As a result of this assessment, a proportion of patients is found not to require surgery and is referred for therapy. Several patients identified as needing surgery are provided with prehab to enhance their post-surgical recovery. Finally, all patients are given the option of booking their surgery with the next available surgeon or of waiting for their preferred surgeon. Most patients select the first option. The program has been incredibly successful and the feasibility of disseminating it to other hospitals within the region is currently being examined.

Several hospitals have implemented protocols where patients on long waiting lists are being reassessed at regular intervals to ensure they still require surgery and whether their priority status has changed. During this reassessment, patients are given the option of having their surgery with the next available surgeon rather than continuing to remain on the waiting list.

Building on a review conducted by the Courtyard Group in late 2007, several strategies are currently being implemented to enhance the quality of wait times data. For instance, surgeons with wait times significantly higher than average are being contacted to explain the variation. Coding issues can then be rectified to ensure consistency in reporting.

Finally, the Champlain LHIN has utilised Wait Times funding to increase the volume of hip and knee surgeries by 563 cases and 1676 cases for cataract surgery. Increasing the volume of surgeries will have an impact on the wait times in these areas.

Opportunities

- The Champlain LHIN aims to improve management of the wait lists by providing comprehensive information to patients and referring providers of opportunities to shorten waits.
- To improve efficiency of these surgical procedures, the LHIN plans to review service delivery models.

Risks (i.e. challenges)

- Some physicians may feel overburdened by new wait time reporting requirements. The Champlain LHIN is currently working with individual hospitals having raised this concern to identify viable solutions.
- The high ALC occupancy rates result in cancelled surgeries and reduced access to inpatient beds. To this end, the Champlain LHIN is implementing a number of strategies to ensure patients are cared for in the most appropriate setting (refer to section D.2.1)
- Demands for joint and cataract surgery may increase in light of changing population demographics. For instance, higher rates of obesity may have an impact on the requirements for joint surgery and the aging of the population may impact of requests for cataract surgery. Some of the initiatives in the chronic disease prevention and management strategy may assist in alleviating some of these risks.

C.6 Access: Surge Capacity

The Champlain LHIN has been a demonstration site for the province this year in surge capacity planning (i.e. the ability to manage sudden increased in volume) for critical care. The surge capacity planning project has proven to be a real success story. This project has highlighted the need for being prepared to face surge situations, it has also allowed the hospitals to set a common language on defining surge situations (minor, moderate and major), a common decision process (communication, flow mapping), and allowed the Champlain hospitals to set common policies such as transfers and repatriation agreement. It has also been an opportunity, for community hospitals (level ones and twos), to share their reality in the management of difficult situations due to the lack of human and technical resources. It has showed the need to have efficient communication channels between hospitals, and a fast and efficient transport system.

Opportunities

- The Champlain region will be a provincial leader in surge capacity planning by participating as a demonstration site.

- Investments made to improve surge capacity will also lead to the development of a more integrated and regional approach to critical care through Champlain.

Risks (i.e. challenges)

There is still a need to have a strong information system to measure the metrics of patient care. Examples include measuring the time to transfer a patient from a community hospital to a tertiary care centre, time from the initial call and the arrival time at the sending hospital on repatriations. There is also a need to have a unified system capable of informing all decision makers about trends, or early outbreak situations, including an automatic calling system to the patient flow coordinators. Finally reviewing at the region level some situations has convinced all hospitals leaders to agree to form a LHIN-wide executive group for coordination and for follow up on situations for continuous improvement of the surge planning

C.7 Access - Paediatric Surgery

In 2007-2008, the Champlain LHIN received one-time funding to perform 100 additional paediatric surgical procedures at the Children's Hospital of Eastern Ontario. This funding has improved access to children's health services by reducing wait times for paediatric dental, ophthalmology and otolaryngology surgeries. We are anticipating additional funding in fiscal year 2008-2009 to address pediatric wait time issues and expect that this funding will be directed to increasing surgical volumes within our region.

C.8 Access: Health Human Resources (HHR)

The labour force is rapidly aging and there will be a dramatic increase in retirements as the baby boomers move into their senior years. Consequently, there is widespread concern that supply side limitations will soon add to the challenges of treating an increasingly aging population.

To this end, the Champlain LHIN has established a Health Human Resources Council (in addition to the provincially mandated Health Professionals Advisory Council). We have worked in conjunction with the local Academic Health Council, and have participated in a number of provincial initiatives to explore solutions to upcoming challenges.

The need to co-ordinate recruitment activities among Health Service Providers, Health Force Ontario (HFO) and others is a priority. We are

working on understanding our strengths as a region and how to ensure they are highlighted in our communications plans.

For example, the Ontario Telemedicine Network is used extensively in this region and we will be including its advanced e-health capabilities in our recruitment strategies. Linkages have been made with the Ontario Hospital Association Provincial Health HR Strategic Advisory Group.

In order to increase the pool of potential candidates, we are working to strengthen linkages with educational institutes especially with respect to interprofessional care.

We have identified the need to understand the human resource issues associated with integration activities. There are organizations in our LHIN that have experienced restructuring and are willing to share their knowledge of personnel issues that can arise. This will assist us in working together to develop innovative solutions.

Opportunities

- Ability to investigate educational, training, collaborative and expanded scope initiatives to reduce health human resource pressures.

Risks (i.e. challenges)

- Most inputs/controls are well out of the LHIN mandate (universities, colleges, unions etc.) however, involving these sectors in planning will mitigate this risk.

C.9 Chronic Disease Prevention and Management (CDPM)

Health services planners are increasingly recognizing the importance of focusing on more cost-effective, outcome-oriented chronic disease prevention and management strategies.

The Champlain LHIN is fortunate to have one of the better models of CDPM in the country – the Champlain Cardiovascular Prevention Network. The result of some five years of extensive planning and broad health and community stakeholder engagement, it is already in the early implementation stages.

While focused on cardiovascular disease, the common risk factors and related diseases are such that this initiative addresses the lion's share of the chronic disease burden of illness. The network provides the structure and momentum necessary to make an impact and to later broaden the mandate to other risk factors and diseases.

The CCPN has six key implementation initiatives in various stages funded through the Ministry of Health Promotion, in-kind contributions for the main partners, and private sponsorship. An example of an ongoing initiative is the inpatient hospital smoking cessation project, which is now being imitated in regions across Canada. A detailed five-year business plan was submitted to the MOHLTC in early 2007. Discussions between the CCPN, the Champlain LHIN and the ministry have been ongoing to obtain sustainable funding to support these initiatives. Recognizing the importance of primary health to chronic disease prevention and management, the Champlain LHIN is providing some financial support to the CCPN specifically to the IDOCC (Improved Delivery of Cardiovascular Care in primary health) project through our Urgent Priority Fund.

Other chronic disease networks are becoming increasingly active with defined projects in lung health, diabetes, chronic kidney disease, stroke and cancer. The Champlain LHIN has established a Champlain Chronic Disease Prevention and Management Collaborative which brings together representatives from chronic disease networks in our region for the purpose of knowledge exchange and innovation and to leverage opportunities for coordination and integration in common areas of focus.

Opportunities

- Because many chronic diseases share the same risk factors, the Champlain collaborative will give networks an opportunity to share information and work together on projects they could not accomplish on their own.
- The LHIN is pursuing a new focus on chronic disease self-management, meaning patients would become more involved in their own care.

Risks (i.e. challenges)

- The prevalence of chronic disease will rise with the aging population; health care expenditures will also increase unless prevention efforts and more efficient management of chronic disease occur. The Champlain LHIN is providing planning and financial support to chronic disease efforts in our region. A performance measurement framework will be developed in 2008-09 to monitor outcomes of these efforts.
- Lack of electronic health records, disease registries and surveillance capability will be a barrier in moving forward on chronic disease initiatives. The e-Health strategy for the Champlain LHIN will incorporate plans to address CDPM needs and will use expertise from our networks.

- Need to link with other jurisdictions such as primary health, public health, and social sectors (more complex to work cross-sector). Mitigating strategies will continue to include ensuring public health and primary health representation on chronic disease networks and the CDPM Collaborative as well as linking to the LHIN Primary Health Council.

C.10 Addictions and Mental Health

The LHIN recognizes the historical under-funding of the Mental Health and Addictions sector. Current programs require stabilization and sustained investment targeted primarily at increased community services. The Champlain LHIN is currently working with several health service providers to enhance capacity in this sector. The following are highlight of some initiatives underway in 2008-2009.

The Concurrent Disorder Workgroup has developed a work plan and \$12,000 was invested for the development and implementation of the activities. The activities include the creation of a Charter Document to Health Service Provider boards and executive directors and a system-wide concurrent disorder screening tool.

The Champlain LHIN and the South-East LHIN are currently working on a concurrent disorder system capacity document.

The Integrated Access to Mental Health Services Task Group has developed a work plan and integrated access to psychiatric inpatient services and community mental health services planning documents are underway.

A proposal for Residential Youth Drug Addiction Treatment Centres (one Francophone and one Anglophone facility) has received strong support from the public, addictions network le Réseau des services de santé en français de l'est de l'Ontario and endorsement by the Champlain LHIN Board of Directors. The proposal will proceed with next steps for planning and implementation throughout the 2008-2009 year.

We are currently working to resolve issues of access and funding of cross-LHIN services with the South-East LHIN.

The Ottawa Withdrawal Management Services (OWMS), run by Montfort Renaissance Inc. has increased their level of service for withdrawal management from a level 1 to a level 2 and staff can currently manage clients on methadone and those being tapered from benzodiazepines or narcotics. The relocation of the program to the campus of the Royal Ottawa Health Care Group was not successful therefore Montfort Renaissance Inc. has put a conditional offer on a property (conditional to

rezoning and funding approval from the Ministry of Health and Long-Term Care). A dialogue between the Ministry, the LHIN and Montfort Hospital regarding this issue is ongoing.

C.11 E-Health

Champlain is well positioned to implement the core components of an Electronic Health Record (EHR) within four years for its population of 1.1 million. By using the province's secure network - Smart Systems for Health Network - the LHIN aims to create a 'regional repository' which can be viewed by clinicians through a provider portal. This will give clinicians a longitudinal view of a patient's medical history and act as a single reference of care. The creation of an e-Health Council provides us with the vehicle for engaging our community in the planning, implementation and evaluation of the many facets of our comprehensive strategy.

As a first step in building the electronic health record, all of the hospitals in the Champlain region will be linked via the Enterprise Master Patient Index (EMPI) system, a unique identifier that allows all providers to attach health care information to an individual patient regardless of the setting. Plans are currently underway to include other sectors.

The Champlain LHIN is currently working to build the four foundational pillars of the EHR: 1) Drug profile, 2) laboratory test results repository, 3) diagnostic imaging repository, and 4) provider portal.

It is anticipated that by the end of the 2008-2009 fiscal year, all hospitals within the Champlain LHIN will have the capacity to view drug information which would include medications prescribed at time of discharge from acute care. In addition, we are hopeful that we will be selected to act as a pilot site for an ePrescribing function. As well, we will focus our efforts this year on engaging the primary care sector in this initiative.

The creation of repositories for laboratory and diagnostic imaging test results are well underway. Activities for the 2008-2009 year have been described in other sections of this document (refer to sections D.3.3. and D.3.4).

We will be working this year on the implementation of a Champlain-wide provider registry and portal. We will be building on the success of The Ottawa Hospital's portal as a starting template. An initial step will involve the development of an identity management strategy and project.

Finally, other initiatives related to our e-Health strategy include building a platform for clinical and operational decision support, developing LHIN-side standards for managing the integrity of the electronic health record,

establishing a project management office to support new initiatives, and implementing strategies to ensure cost effective capability.

Opportunities

- Due to the technical complexities of this initiative, the Champlain LHIN has hired a Chief Information Officer that is responsible for moving the e-Health agenda forward.
- The e-Health strategy will enable other LHIN projects (for example, chronic disease management), will have numerous benefits to patients (for instance, reduce duplicate tests), and create system savings (such as managing the physical movements of charts and film).
- A regional network upgrade by the Smart Systems network will give the region a capability to move very large data files such as X-rays between facilities and further deployment of secure e-mail.

Risks (i.e. challenges)

- The technical complexities of integrating provincial repositories with local applications and data. To mitigate this risk, we are focussing our efforts on bringing strong technical skills forward and conducting a thorough analysis of the technical requirements.

C.12 Primary Health Services for Healthy Communities

While the majority of primary health care services reside outside the LHIN mandate, there is broad recognition that a cost-effective health system must have a strong foundation at the primary care level. The Champlain LHIN's approach is to ensure engagement and inclusion of primary care providers into concrete projects in line with other strategies such as chronic disease prevention and management, e-Health, and access to regional critical care.

In addition, the LHIN has held multiple sessions with stakeholders in the primary care sector, and has established a Primary Care/Public Health Council to serve as a forum for further planning and project identification. The Council is currently establishing its priorities however a focus on human resource issues and access for the physically disabled are areas that have been identified as requiring attention.

The Champlain LHIN is also working with health service partners to support the establishment of new service delivery models that support Family Health Care. For instance, the urgent care clinic is one such model that is being explored and the LHIN is supporting the planning and subsequent implementation of such a clinic in Orleans. In 2008-2009, we

will continue to identify similar opportunities and will work with primary care partners to support projects such as expanding and establishing new family health teams, community health centres and nurse-led clinics.

Opportunities

- Primary care participation in specific LHIN projects is assumed and will strengthen the role of this sector.

Risks (i.e. challenges)

- While community health centres are under the purview of the LHIN, family health teams and community-based family physicians are not.
- There is a lack of financial incentives for integration projects among primary care providers.
- Primary care providers are a dispersed, poorly coordinated group.

Establishing relationships with local physicians and the Ontario Medical Association through their Outreach Representatives, and arranging such initiatives as sharing the Champlain LHIN newsletter with the OMA and organizing a LHIN workshop for physicians will mitigate some of these risks,

C.13 First Nations, Inuit and Métis Communities

The Champlain LHIN is currently working with First Nations, Inuit and Métis communities to build relationships that will lead to information sharing, joint planning, and the identification of innovative strategies that are responsive to the needs of these communities. The following are examples of initial strategies that have been undertaken and that will continue throughout the course of 2008-09.

The Champlain LHIN has conducted an information sharing and brainstorming session with the 11 Aboriginal organizations comprising the Local Aboriginal Health Planning Entity (LAHPE) in the Fall 2007. This was a historic event, marking the first time these organizations met group to work on common issues. As a result of the session, the Aboriginal organizations have jointly submitted a proposal for the Aging at Home strategy. The LAHPE group will continue to meet in 2008-09 to further identify areas of common interest strategies for resolution.

The Champlain LHIN provided the "LAHPE" with one-time funding to conduct a preliminary assessment of Aboriginal service providers' ability to collect and access data (data capability) and identify the requirements of an adequate data collection strategy. This study will greatly assist us in planning and monitoring health services responsive to the needs of

Aboriginal communities. In partnership with the Aboriginal Working Committee for the city of Ottawa, we organized a "Listening Circles" event. The event attracted over 180 participants that included representation from all the Aboriginal service organizations in Ottawa and a wide range of non-Aboriginal organizations. Similar events are planned for 2008-2009.

C.14 French Language Health Services

The Champlain LHIN is working closely with the Réseau des services de santé en français de l'est de l'Ontario, which has designed a complementary engagement architecture to the LHIN's. Joint meetings of senior management and staff have been held. When provincial regulations are in place to define the local entities for francophone matters, we will work with the Réseau to put in place appropriate mechanisms.

D. Financial Summary – By Sector

A summary of funding per sector is provided in Section D.1 (Attachment A). In 2008-09, the Champlain LHIN is examining the feasibility of reallocating funds across sectors to ensure equity and the ability of all sectors to meet their mandates.

D.1 Financial Summary Templates (Attachment A)

Attachment A: Statement of Champlain LHIN 2008/09 Funding Allocation and Multi-Year Funding Target

As of May 2008

	2008/09 Funding Allocation (000's) ⁽¹⁾	2009/10 Funding Target (000's) ⁽¹⁾	2010/11 Funding Target (000's) ⁽¹⁾
Total LHIN Budget	2,083,031.7	2,111,637.2	2,135,758.4
Total Health Service Provider (HSP) Transfer Payments	2,077,788.6	2,111,602.2	2,135,723.4
Operation of LHIN ⁽²⁾	5,088.1	TBD	TBD
Initiatives ⁽³⁾	35.0	35.0	35.0
E-Health	120.0	TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector:			
Operation of Hospitals ⁽⁴⁾	1,415,135.4	1,427,742.9	1,427,742.9
Grants to compensate for Municipal Taxation – public hospitals	352.1	352.1	352.1
Long Term Care Homes	241,463.2	241,463.2	241,463.2
Community Care Access Centres	164,747.4	171,337.3	179,904.1
Community Support Services	22,327.1	22,829.5	23,343.2
Acquired Brain Injury	1,477.8	1,511.1	1,545.1
Assisted Living Services in Supportive Housing	5,969.8	6,104.1	6,241.4
Community Health Centres	39,332.9	39,332.9	39,332.9
Community Mental Health	58,233.2	59,543.5	60,883.2
Addictions Program	14,655.9	14,985.6	15,322.8
Specialty Psych Hospitals	102,323.0	104,413.0	104,413.0
Grants to compensate for Municipal Taxation - psychiatric hospitals	28.4	28.4	28.4
Initiatives ⁽⁵⁾	11,742.4	21,958.6	35,151.1

Note:

- 1) The 2008/09 funding allocation and the 2009/10 and 2010/11 funding targets are updated as of April 15, 2008 from the approved 2008/09 multi-year Results Based Plan and the 2008-09 Printed Estimates. The update is based on realignments within and between the LHIN programs vote 1411 and the Ministry programs vote 1412 which correspond with decisions about programs and services that will remain with the Ministry or transfer to the LHINs. They include base and one-time realignments for 2008/09 and base only realignments for 2009/10 and 2010/11 (except for the Operations of Hospitals which includes some one-time funding agreements). The realignment occurs within the Ministry's total approved appropriation. Additional details and formal adjustment for these programs will be sought as part of the 2008/09 Results Base Plan and is subject to Cabinet approval.

The 2008/09 funding allocation includes additional funding (base and one-time only). If further additional funding is designated throughout 2008/09, the table and schedule may be amended or updated allocation letters appended to the agreement to reflect the LHIN allocation. Any additional funding provided would be within the Ministry's total approved appropriation.

The 2009/10 and 2010/11 funding targets are for planning purposes and are base funding targets only (except for the Operations of Hospitals which includes some one-time funding agreements). They are subject to the annual Results Based Plan, Printed Estimates and Provincial Budget approvals.

- 2) The LHIN Operation funding targets for 2009/10 and 2010/11 are to be determined as they are subject to further review.
- 3) LHIN Operations initiatives.
- 4) Operation of Hospitals allocations and funding targets include private and public hospitals. It may also include, as appropriate, any approved PCOP funding.
- 5) Transfer payment Initiatives by LHIN will be allocated by sector by the LHIN at a later date. It should be noted that as the LHIN allocates by sector, the allocation will be distribute

E. Planning for LHIN Operations

E.1 *Planned Operations Expenses*

Attachment B shows the LHIN operations spending for the years ended March 31, 2007 and 2008, as well as the spending plan for the current fiscal year 2008–2009, and the two subsequent years. Actual results could differ from these estimates.

It is important to note that the 2006–2007 and 2007–2008 amounts reflect the results solely for the LHIN operations. The spending plan for the next three years also includes the salary and benefits for the Chief Information Officer (CIO) and his Executive Assistant. As of the date of this ASP, \$120K had been announced for 2008–2009 e-Health funding; this amount is not included in the spending plan.

The 2008–2009 preliminary plan reflects the LHIN's best estimate of its business activities. The significant assumptions used in the creation of the 2008–2009 plan were:

- An increase of three FTE effective April 30, 2008. The CIO and his Executive Assistant account for two of this increase.
- The starting salary of many employees was significantly lower than the market rate. Based on a review in 2007–2008 by the LHIN Shared Services Office and the subsequent approval by the LHIN CEOs, the LHIN will implement revised salary grades and the associated new salary ranges for most employees. The weighted average increase is estimated to be 7%, which includes a portion for COLA and performance. All employees will move to an April 1 review date; no additional performance increases are planned for this fiscal year.

These changes are expected to bring the salaries to a more competitive range.

- The accommodation costs reflect the new lease for Suite L101 (see section E.3. Facilities).
- Staff development is a priority and funds have been allocated for training and conference attendance to ensure staff has the appropriate level of skills. The 2007–2008 amount includes significant recruiting fees which are not anticipated in 2008–2009.
- The Governance Per Diems are based on all Board members claiming in 2008–2009. In 2007–2008, not all members had claimed.
- The estimate for the purchased Capital Assets relates to the residual activity from the renovations and expansion begun in February 2008.

E.1.1 LHIN Operations Spending Plan (Attachment B)

Table 5: LHIN Operations Spending Plan					
LHIN Operations Sub-Category (\$)	2006/07 Actuals	2007/08 Actuals	2008/09 Planned Expenses ¹	2009/10 Planned Expenses ²	2010/11 Planned Expenses ²
Salaries and Wages	1,310,771	2,213,886	2,940,400	3,146,200	3,366,450
Employee Benefits					
HOOPP	92,059	201,162	277,800	298,890	319,815
Other Benefits	183,954	254,045	359,000	377,550	403,970
Total Employee Benefits	276,013	455,207	636,800	676,440	723,785
Transportation and Communication					
Staff Travel	64,313	83,257	91,600	93,900	96,220
Governance Travel	44,464	23,758	30,000	30,750	31,520
Communications	42,026	53,861	59,250	60,725	62,250
Other Benefits	0	0		0	0
Total Transportation and Communication	150,803	160,876	180,850	185,375	189,990
Services					
Accommodation	211,459	201,080	241,600	247,600	253,830
Advertising	41,413	17,711	19,500	19,970	20,465
Banking	1,396	832	915	935	950
Community Engagement	0	0	0	0	0
Consulting Fees	424,551	271,603	297,622	305,150	312,785
Equipment Rentals	7,523	6,514	7,200	7,350	7,530
Governance Per Diems	110,050	83,625	121,000	124,020	127,120
Insurance	0	16,227	16,400	16,800	17,230
LSSO Shared Costs	290,201	300,000	300,000	307,500	315,190
Other Meeting Expenses	34,013	27,005	29,700	30,500	31,210
Other Governance Costs	99,179	30,749	42,540	43,610	44,700
Printing & Translation	79,582	41,913	46,100	47,260	48,435
Staff Development	33,334	47,525	44,050	45,130	46,260
Total Services	1,332,701	1,044,784	1,166,627	1,195,825	1,225,705
Supplies and Equipment					
IT Equipment	72,029	20,962	23,050	23,630	24,230
Office Supplies & Purchased Equipment	106,730	59,746	65,400	67,030	68,700
Total Supplies and Equipment	178,759	80,708	88,450	90,660	92,930
Capital Assets Purchased	123,774	201,996	75,000	0	0
LHIN Operations: Total Planned Expense	3,372,821	4,157,457	5,088,127	5,294,500	5,598,860
Annual Funding Target			5,088,127	n/a	n/a
Variance			0		

Planned Expense Assumptions

Some comparative figures have been reclassified to conform to the 2007/08 presentation

- 2008-2009 Planned Expenses is a preliminary allocation; the final budget allocation may differ
 - The salary line is based on an assumption of headcount in Staffing Plan (Attachment C)
 - Some costs are based on predetermined amounts (e.g. accommodation)
 - All other costs are based on a 10% increase
- Annual Funding Targets have not been received
 - The salary line is based on an assumption of headcount in Staffing Plan (Attachment C)
 - Total costs in each year have increased by an average of 5% from the previous year

E.2 Human Resources

Attachment C provides the LHIN Staffing Plan for the Champlain LHIN. The staffing levels for 2008–2009, 2009–2010, and 2010–2011 were used to create the salary and benefit, and other staff-dependent expense plans (e.g., staff travel, development).

E.2.1 LHIN Staffing Plan (Attachment C)

Table 6: LHIN Staffing Plan					
	2006/07 Actuals as of March 31	2007/08 Actuals as of March 31	2008/09 Plan	2009/10 Plan	2010/11 Plan
Number of FTE *	26	28	31	31	31

Position Title:

Chief Executive Officer	1	1	1	1	1
Senior Director, Performance, Contract and Allocation	1	1	1	1	1
Senior Funding Consultant	0	1	1	1	1
Senior Consultant, Performance & Contracts	1	1	1	1	1
Funding and Performance Consultant	4	4	4	4	4
Senior Director, Planning, Integration, and Community Engagement	1	0	1	1	1
Senior Planner, Community Engagement	1	1	1	1	1
Senior Planner	5	5	5	5	5
Senior Epidemiology & Decision Support Consultant	1	1	1	1	1
Epidemiology & Decision Support Consultant	1	1	1	1	1
Special Projects	1	1	1	1	1
Communications Officer	1	1	1	1	1
Controller & Business Support Manager	1	1	1	1	1
Executive Assistant	1	1	1	1	1
Administrative Assistant	4	5	5	5	5
Program Assistant	1	1	1	1	1
Receptionist	1	1	1	1	1
Executive Assistant (Board of Directors)	0	1	1	1	1
TOTAL LHIN OPERATIONS	26	28	29	29	29
Chief Information Officer	0	1	1	1	1
Executive Assistant	0	0	1	1	1
LHIN OPERATIONS and e-HEALTH	26	29	31	31	31

* these amounts are consistent with LHIN Operations Spending Plan

E.3 Facilities

The LHIN fully utilizes the 7,276 square feet that has been occupied since September 1, 2005. This space is used by the LHIN staff, the Board Chair, the Chief Information Officer and his Executive Assistant. In addition, there are two meeting rooms, a kitchen, and 4 work surfaces for temporary staff / contractors. Toward the end of fiscal 2008, the LHIN secured a lease for an additional 1,153 square feet in the same building (Suite L101) that provides two meeting rooms, two work surfaces for casual use, and storage space.

E.4 Technology

The LHIN relies primarily on the LSSO for all its technical needs (computers, phone system, network, etc). Already many of the systems are at capacity. The LSSO had a significant portion of their fiscal 2008 project budget allocated to technology-based initiatives. It is essential that these are successful (e.g. email server, network capacity, document and record management tool, contact management) to ensure the LHIN is able to operate effectively and efficiently.

E.5 Specific Initiatives

The LHIN has identified the following initiatives for fiscal 2008-09.

E.5.1 Policies and Procedures

In 2007–2008, the LHIN identified and created many internal policies and procedures that are necessary to ensure its efficient and effective operation. The review and approval process includes Senior Management and the Audit Committee before they are submitted to the Board for final approval. The LHIN will continue to identify and create new policies and procedures in 2008–2009.

E.5.2 Interaction with Ministry of Health and Long Term Care

During the past year, Champlain LHIN staff has attended numerous knowledge transfer sessions hosted by various branches of the MOHLTC. A number of information systems have also been made available to the LHIN in order to support the communication of financial transactions between the Ministry and the LHIN, the monitoring of HSP budgets, and the monitoring of LHIN performance.

The LHIN Liaison Branch has been instrumental in helping the Champlain LHIN understand the processes and access information at the Ministry of

Health. However, the system is highly complex so further work will be required to streamline processes, develop key contacts, and support timely access to information.

E.5.3 Board of Directors

The Board of Directors has spent the past year gaining an understanding of the specific functions of the LHIN Board, the legal environment of the LHINs, the Memorandum of Understanding and the Ministry-LHIN Accountability Agreement. Processes have been developed to ensure that all commitments associated with MLAA are monitored and performance objectives are achieved.

In addition to the open Board meetings required in the legislation, the Board continues to contribute significantly to the LHIN community & provider engagement activities. For example, Board members participate in collaborative sessions with provider Boards, community of care planning sessions, and attend tours with the Minister of Health and Long-Term Care.

In the 2008-09 year, efforts will be focused in the following areas.

- Developing a collaborative governance approach by meeting with provider Boards in each community of care
- Refining a decision-making framework which includes principles and criteria to be used in prioritizing and evaluating strategies and business cases. This will enable decision-making in an efficient and transparent process
- Continuing education to develop a strong understanding of the main issues/risks associated with each of the six Strategic Directions. This understanding will support the decision-making process
- Developing an understanding of key financial pressures and performance gaps across the Champlain LHIN. This will be facilitated by the development of a quarterly reporting process using a 'balanced scorecard' approach
- Overseeing the implementation of the IHSP
- Monitoring the progress of the Aging at Home strategy and determining whether funds from this initiative should be utilised to operate additional long-term care beds
- Endorsing the plan for the creation of a comprehensive regional clinical services model

F. ASP Communications Plan

The Annual Service Plan contains many elements for announcements and rollouts but does not, by itself, require a separate strategic communications plan. The approved Annual Service Plan will be made available in English and French to the public, health service providers, and other partners by posting it on the bilingual Champlain LHIN website. Printed copies will also be circulated upon request.