Erie St. Clair Local Health Integration Network
2009/10 Annual Business Plan

July 24, 2009

Executive Summary

This document is prepared in conformance with the Agency Establishment and Accountability Directive that applies to all provincial Crown corporations.

Introduction

The Erie St. Clair Local Health Integration Network (ESC LHIN) was established in 2006 as a Crown Corporation Operational Service by the Management Board of Cabinet due to an overriding public interest in the delivery of healthcare; and healthcare is a provincial responsibility under the Canada Health Act. Each LHIN has a Memorandum of Understanding (MOU) with the Ministry of Health and Long-Term Care (MOHLTC) that covers our financial powers, staffing powers, administrative powers and others. Each LHIN has a MLAA that defines funding levels and key performance indicators.

This 2009/10 Annual Business Plan for the ESC LHIN reflects the expectations of all LHINs as explained in our enabling legislation – the Local Health Services Integration Act, 2006 (LHSIA). It is the planning document that operationalizes the Strategic Vision for the ESC LHIN as defined through the detailed implementation strategy for the Integrated Health Service Plan (IHSP).

The ESC LHIN uses the following vision, mission and values for guiding its activities:

Vision:

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

Mission:

A catalyst to improve the health and wellness of Erie St. Clair residents through partnership with health service providers (HSPs) and the community.

Value Statements:

The ESC LHIN believes:

- That the healthcare system should be focused on the patient, publicly funded, sustainable and universally accessible.
- These priorities for change reflect the issues identified in the ESC LHIN community engagement component of the IHSP, but also the priorities identified by the province in the Strategic Plan and the MLAA. The provincial priorities addressed in the plan include:
- Promotion of healthy living
- Enabling individual empowerment and responsibility
- Providing timely access to care
- Expanding community capacity
- Improving evidence-based decision making
- Ensuring equity across the ESC LHIN and the province

Particular initiatives and strategies addressed in the plan are determined in concert with:

- Emergency Department and Medicine Advisory Network
- Mental Health and Addictions Advisory Network
- Surgical Advisory Network (Wait Times Strategies)
- Aging At Home Advisory Network
- Community Services Advisory Network (e.g. Alternate Level of Care (ALC) Working Group, Correct Level of Care Project Team)
- Chronic Disease Prevention and Management (CDPM) Integration Leadership Team
- Diabetes Project Team

Community engagement is a key enabler for setting priorities. Considerable discussion and feedback occurred with respect to the effective functioning of the ESC LHIN. The following key findings from our community consultations are worth noting:

- Issues related to the training, recruitment and retention of health professionals
- The need for increased access and improved wait times
- Increased emphasis on health promotion and disease prevention
- Improved health system navigation and continuity of care
- Issues related to mental health continuum of care
- Increased involvement and participation of Francophones, other minority groups, and rural groups throughout the system's services process
- Improved information and data regarding the needs and the health status of various unique communities within the ESC LHIN
- A focus on primary care
- A shift from provider focus to patient focus

- A focus on transportation
- A need for a long-term, transparent, and sustainable financial plan
- Increased availability and support for advanced technology and therapeutic measures
- Development of best-practice guidelines, quality measures and related accountability
- Issues related to non-acute bed services
- Confidentiality

Through the IHSP planning process, the following list of opportunities and risks were identified in the examination of the total health care system.

Opportunities and strengths:

- Critical mass available to support enhancement of selected hospital and community services
- Widespread interest in innovation and improvement
- Dedicated volunteer base
- Collaborative relationship with academic centres
- Joint staff training and development
- Shared support services
- Best practice advancement
- Health promotion and prevention strategies
- The potential for reduced need for referral to services outside the ESC LHIN
- Return of healthcare professionals due to the stronger Canadian dollar and pension weakness

Risks and weaknesses:

- Limited training capacity for health human resources
- Increased cost of new technology and drugs
- Fundraising capacity decreasing locally
- Professional staff burnout
- Consumer and family involvement in planning, decision-making, and evaluation
- Lack of integrated infrastructure for information sharing capacity at the client level and between organizations
- Border security issues
- Generally shrinking workforce
- Alternate Level of Care patients inhibiting access to acute service beds creating wait time issues in the Emergency Department

Environmental Scan

Geographic Area

The map below shows the three planning communities in Erie St. Clair. The concentration of population is in three urban centres with secondary concentrations in smaller centres and a much dispersed rural community. The widely varying densities of population indicate why equitable access to service is a challenge in our area.

Demographics and Determinants of Health

Erie St. Clair residents continue to have significant variances in comparison to the provincial population:

- Higher proportion of seniors, specifically in the 85+ cohort and a lower proportion of individuals in the 25-39 year age group
- Higher unemployment rates that are expected to continue to increase in the near future due to the impact on manufacturing in the Windsor area
- Significantly higher incidence of overweight/obese individuals
- Slightly higher proportion of individuals who practice poor lifestyle habits (smoking, drinking, poor nutrition, inactivity)
- Significantly higher prevalence of arthritis/rheumatism and higher rates of other chronic conditions such as asthma, diabetes, heart disease and high blood pressure
- Significantly higher rates of hospitalization, potential years of life lost, mortality due to higher rates of neoplasm, circulatory disease and external causes such as injury
- Significantly higher percentage of people without a high school diploma

Of particular interest to us is that four percent of the population in both Windsor/Essex and Chatham-Kent, and two percent of Sarnia/Lambton population reported French as their first language.

As well, two percent of our residents are Aboriginal. Sarnia/Lambton reports over four percent of its population is Aboriginal. Although the Aboriginal population lives throughout Erie St. Clair, there are five local communities that are primarily Aboriginal.

Health System Capacity

Currently 1,370 hospital beds (on average) are staffed and in operation across the ESC LHIN. Of this complement, there are 861 acute beds which include:

- 44% medical beds
- 21% surgical beds
- 12% combined medical/surgical beds
- 10% critical care/intensive care beds
- 6% paediatric beds
- 7% obstetric beds

Further, the ESC LHIN has in service a total of:

- 128 mental health beds
- 256 complex continuing care beds
- 119 rehabilitation beds
- 4,400 long-term care home beds
- 5 Assistive Living Beds in Kettle Point

In late 2010 an additional 203 long-term care beds, 50 complex continuing care beds and 10 rehab beds will be added in Windsor.

Erie St. Clair hospitals provided treatment to 85% of ESC LHIN acute inpatients, with the Southwest LHIN serving another 12.5%. The inflow into Erie St. Clair is negligible, comprised mostly of U.S. visitors and other travelers through Windsor or Sarnia. Changes and pressures on hospital services in the Southwest LHIN will have a significant impact on Sarnia/Lambton residents in particular.

Health Human Resources

In general, healthcare processes have been adapted incrementally over time to reflect the shortage of healthcare professionals.

Practicing General Practitioners(GP)/Family Physicians (FP)

Under the Underserviced Areas Program, Erie St. Clair has incentive grant positions for 123 GP/FPs – or 17% of all such positions available in Ontario. Given that we have 5.1% of the total population, our underserviced rate is extremely high.

The status by geography is:

Community	Vacancies	Spaces	% Vacant
Windsor/Essex	68	233	29%
Sarnia/Lambton	25	81	31%
Chatham-Kent	30	80	38%
Erie St. Clair	123	394	31%

Without discounting the challenges for access in the north, Erie St. Clair has more primary care GP/FP positions available than all of Northern Ontario. Erie St. Clair's population is only 12% less than the north.

Other Professionals

Added to this challenge, we have fewer healthcare professionals per 100,000 people than Ontario in all categories, with the exception of Extended Class Registered Nurses and Registered Practical Nurses.

Major Cost Drivers

The most significant cost driver for the ESC LHIN will be due to the severe and sharp decline in well-paid manufacturing jobs associated primarily with the automotive industry. As of June 2009, Windsor continues to have the highest unemployment rate in Canada (14.3%) and additional jobs are expected to be lost permanently. In addition, there are reductions in full-time work. The loss of jobs is not limited to Windsor, but ripples throughout Erie St. Clair. The social determinants of health note the importance of a job to a person, family and community's overall health. The rise in unemployment will likely lead to more poor lifestyles (drinking, drugs, smoking), more mental health needs, and more visits to Emergency Departments. It may also affect the family's ability to provide support to at-risk or ill family members. Local mental health providers report increased numbers of children in need and attribute this increase to the stresses on families. The cause (unemployment) is well understood, but the impacts are not.

The annual inflation rate has been low over the past few years (about 2%), moderating the need for additional funding. However, wage costs have been and will likely continue to be, a large driver of future healthcare costs. This will be an Ontario-wide challenge.

Around the GTA and in some other large urban centres, population growth is a significant pressure. However, the total population in Erie St. Clair is projected to be fairly static over the near term. There will be a challenge due to the increasing numbers of older and very old residents. For example, in 2006/07 the discharge rate from acute inpatient care was 58 per 1,000 persons aged 55 to 59. The discharge rate increases for each older age group. For the 90+ year-old group the discharge rate was 471 – almost six times greater. As the number of elders increase, the demands on the healthcare system will increase out of proportion to simple population changes. It is projected that Erie St. Clair will require 1.5% more CCAC resources, 1% more long-term care home (LTCH) beds and 1.5% more acute hospital resources per year simply due to the aging of our population, *if we make no changes in care delivery.* This excludes the increase in ALC days, the low volume and loss of primary care resources, the Health Human Resource shortages, inflation, and changes in technology.

Patriation is not likely to become a major challenge in terms of patient volume due to the ease of access between Sarnia and London where most of the outflow occurs. The impact of regional psychiatric beds and appropriate resources that will be transferred from London to Erie St. Clair will improve the lives of many of our mental health patients but the exact resources to be transferred has yet to be determined.

In terms of integration activities as an impact on cost, ESC LHIN hospitals merged into five corporations in the 1990's. They are continuing to pursue further service, staff and back-office related integration activities. The goals are related to IHSP Strategic Directions rather than directly oriented at cost savings.

Integration between small agencies is expected to continue, driven primarily by intra-agency issues. New provincial legislation, new accountability agreements with LHINs, fundraising, sustainability and liability are three important changes that will affect all agencies. Any integration would most likely focus on improved/expanded care, simplified administration and better use of volunteers. Currently, the three community mental health agencies are discussing integration and so are the two Community Health Centres in Windsor.

Impacts on our Ministry/LHIN Accountability Agreement and Integrated Health Services Plan

Strengths, Weaknesses, Opportunities, and Threats

Strengths and opportunities are:

- Critical mass available to support enhancement of selected hospital and community services
- Widespread interest in innovation and improvement
- Dedicated volunteer base
- Collaborative relationship with academic centres and the development of the University of Windsor Medical School
- Joint staff training and development
- Successfully shared support services
- Best practice advancement
- Health promotion and prevention strategies
- Reduced need for referral to services outside the ESC LHIN
- Potential return of healthcare professionals due to worsening financial situation in the USA
- Collegial relationships among most HSPs
- Based on the Ontario Cost Distribution Methodology, ESC LHIN hospitals have unmet efficiency opportunities
- The ESC CCAC has adjusted to its new geographic mandate and its performance has been quite good in relation to other CCACs
- Additional funding to the CCAC for more intensive home care to prevent or delay admissions to Long Term Care homes
- Four percent increase in the base CCAC budget, compared to 2.1 to 2.5% for all other providers
- Funding to support a special LHIN-wide focus on Emergency Department and Alternative Level of Care improvements ("ER/ALC Performance Lead")
- Determination of how to allocate up to $17.3M in 2010/11 to support elders to live at home ("Aging At Home" project)
- Access to $2.3M in 2009/10 to support Urgent Priorities in Erie St. Clair

Weaknesses and threats are:

- Limited training capacity for health human resources
- Increased cost of new technology and drugs
- Fundraising capacity decreasing locally as a result of the economic downturn in manufacturing
- Professional staff burnout, especially among primary care physicians
- Frequent use of special Emergency Department physician hospital on-call coverage ("HOCC") funding
- Consumer and family involvement in planning, decision-making and evaluation
- Lack of integrated infrastructure for information sharing capacity at the client level
- Generally shrinking workforce, especially among general and family practitioners
- Rapidly growing number of Alternate Level of Care patients inhibiting access to acute service beds in Sarnia/Lambton and in Leamington
- The 2007/08 financial restraints on the CCAC will continue to affect service levels in 2009/10 and 2010/11 until the debt is recovered
- Cancer Care Ontario may remove support for the thoracic cancer surgery program at Hôtel-Dieu Grace Hospital in Windsor, while will severely weaken our ability to maintain the Trauma program, which is part of the Provincial Trauma Network

Planning and Implementing for Erie St. Clair

The development of 2009/10 activities was heavily guided by three elements:

- MLAA targets
- Ministry of Health and Long-Term Care (MOHLTC) priorities
- IHSP Strategic Directions

Because of the complementary nature of many aspects of these elements, an activity structure was established to effectively and efficiently address all aspects of the three elements. The best use of community and ESC LHIN resources was essential in developing the activity plan.

The diagrams below summarize the inter-relationships of the three elements noted above and the operating structure of the ESC LHIN.

This first diagram summarizes how the MOHLTC priorities, MLAA performance indicators, anticipated regulatory additions and 2008-2011 MOHLTC-OMA contract provisions directly support the ESC LHIN's Strategic Directions. It should be noted that e-Health development will have a significant impact on all IHSP Strategic Directions, but it is implemented as a Back Office Integration Initiative. Although there are no guidelines developed for the Physician/MOHLTC/LHIN Collaboration Initiatives, the ESC LHIN will likely be intimately involved in these discussions because of the severe physician resource shortages in Erie St. Clair.

ESC LHIN Strategic Directions

Ministry-Directed Activity/Program	Chronic Disease Management	Reduce Dependence on Hospital Services	Supporting People at Home	Back Office/Administration Integration	System Navigation	Health Human Resources	Health Promotion/Illness Prevention	Timely Access to Care
MOHLTC Vision/Strategic Priorities								
Reducing ER Wait Times								x
Family Health Care	x	x	x		x	x	x	x
Sustainability	x	x	x	x	x	x	x	x
MLAA								
Access Indicators (Wait Times)	x	x	x					x
Quality Indicator (AMI Readmit)	x	x	x					
Integration Indicators (ALC,targeted reasons for ER visits/InPatient admissions, Time to Long-Term Care placement	x	x			x			
eHealth Development				x				
Additional Access Indicators (Wait Times)								
Selected Surgery Wait Times	x	x	x					x
Pediatric Surgeries Wait Times			x					x
Emergency Department Wait Times								x
Anticipated MOHLTC Priorities 2009/10								
Community Mental Health	x	x	x		x	x	x	x
Chronic Disease Prevention & Management	x	x	x		x	x	x	x
Patient Safety Performance Indicators		x					x	x
Health Professionals Advisory Committee	x				x	x		
Francophone Advisory Committee	x	x	x		x	x	x	x
Aboriginal Advisory Committee	x	x	x		x	x	x	x
OMA Contract 2008-2011 LHIN-Physician Collaboration Initiatives								
Most Responsible Physician						x		
Emergency Department		x			x			x
Unattached Patients	x	x			x	x		x
On Call Coverage						x		x

The second diagram shows how 2009/10 ESC LHIN committees and staff activities will address the Ministry-Directed Activities/Programs.

ESC LHIN Standing Committees/Ongoing Activities

Ministry-Directed Activity/Program	Clinical Advisory Networks	Integration Leadership Teams	Project Teams	Geographic Teams (LHIN staff)	Account Management	Community Engagement	LHIN-wide Planning & Utilization
MOHLTC Vision/Strategic Priorities							
Reducing ER Wait Times	ED/Medical		ER/ALC	support	monitoring	Info/Fback**	monitoring
Family Health Care	included in all mandates						
Sustainability	included in all mandates						
MLAA							
Access Indicators (Wait Times)	Surgical			support	monitoring	Info/Fback**	monitoring
Quality Indicator (AMI Readmit)	ED/Medical			support	monitoring	Info/Fback**	monitoring
Integration Indicators (ALC,targeted reasons for ER visits/InPatient admissions, Time to Long-Term Care placement	Aging at Home		Wait Times + TBD*	support	monitoring	Info/Fback**	monitoring
eHealth Development		eHealth*	TBD*			Info/Fback**	
Additional Access Indicators (Wait Times)							
Selected Surgery Wait Times	Surgical			support	monitoring	Info/Fback**	monitoring
Pediatric Surgeries Wait Times	Surgical			support	monitoring	Info/Fback**	monitoring
Emergency Department Wait Times	ED/Medical		ER/ALC	support	monitoring	Info/Fback**	monitoring
Anticipated MOHLTC Priorities 2009/10							
Community Mental Health	MH&A		TBD*	support	monitoring	Info/Fback**	monitoring
Chronic Disease Prevention & Management		CDPM	Diabetes +TBD*	support	monitoring	Info/Fback**	monitoring
Patient Safety Performance Indicators	included in all mandates						
Health Professionals Advisory Committee	HPAC		TBD*			support	support
Francophone Advisory Committee		FAC*	TBD*			support	support
Aboriginal Advisory Committee		AAC*	TBD*			support	support
OMA Contract 2008-2011 LHIN-Physician Collaboration Initiatives							
Most Responsible Physician			TBD*			support	support
Emergency Department	ED/Medical		TBD*			support	support
Unattached Patients	included in all mandates						
On Call Coverage	ED/Medical		TBD*			support	support

* new groups to be formed in 2009/10
** Information between the community/customers and committes/staff and Feedback from community/customers/providers

Clinical Advisory Networks serve as experts in advancing clinically-oriented integration opportunities and provide advice to better understand our local healthcare system. They act as resources to the Integration Leadership Teams and review planning recommendations.

Integration Leadership Teams advance the implementation plans for their respective mandates and advise on effective and efficient use of ESC LHIN resources. They are resources to the Project Teams/Working Groups and review planning recommendations.

Project Teams/Working Groups provide program-level support in response to service models and frameworks put forward by the Integration Leadership Teams and Clinical Advisory Networks.

The three **Geographic Teams** are ESC LHIN-staffed. Each one is focused on one of the ESC LHIN's three Planning Communities (Windsor/Essex, Sarnia/Lambton and Chatham-Kent). Each team is led by an Account Manager who is supported by a Program Assistant, a Planner (0.5 FTE per team), a Funding Consultant (0.5 FTE per team) and a Community Engagement Consultant (0.3 FTE per team). In addition, they support and are supported by a Regional Planner and the Manager, Utilization and Performance. The goal is to reflect "thinking provincially and acting locally" with regional coordination.

The **Account Managers** are directly accountable for understanding the progress towards the performance targets, discussing the positive and negative variances and, where necessary, corrective actions. Performance indicators and targets, either those provided by the MOHLTC or those developed by the ESC LHIN, in concert with the affected HSPs, are monitored for all funding programs. This includes responsibility for monitoring performance under all accountability agreements. Weekly, monthly and quarterly reports will be prepared to assist the Account Managers in understanding key resource and service trends so that correction, reinforcement, and ultimately resource reassignment can be implemented.

Community Engagement will continue to support the major milestones and organizational objectives of the Erie St. Clair LHIN.

A number of major projects will be rolled-out this year for which communications and community engagement will be critical components. These major projects include: the Integrated Health Services Plan for 2010/11 to 2012/13; the Hospital Accountability Planning Submissions for 2010/11 to 2011/12 and the associated Hospital Services Accountability Agreements; the Long Term Care Homes Accountability Planning Submissions and the associated Long Term Care Homes Service Accountability Agreements; and the Small Community Hospital Emergency Department Study.

Where appropriate and required, communications will be coordinated with Provincial-LHIN Working Groups and MOHLTC strategic directions. Communications planning will also support other minor projects and issues that arise or are ongoing (e.g. Malden Park Continuing Care Centre transition planning).

The Integrated Health Service Plan will be the primary focus of Community Engagement in 2009/10. Support will be provided for the launch of the initiative, engagement with community and stakeholders, and the dissemination of both the draft and final documents.

In keeping with the theme of proactive communications, the 'Education Series' launched in 2008/09 will be further developed to support the education of community and provider stakeholders regarding system pressures and the role of the LHIN in providing coordination and funding. The education pieces to be developed will address specific and timely subject matter and will be linked to important provincial and LHIN processes and decision-making.

Finally, Community Engagement will lead in organizing the first Erie St. Clair LHIN Annual Conference. The conference will bring together health service providers and other stakeholders from across the three counties of Erie St. Clair, for a one-day conference entitled, "Courageous Decisions".

LHIN-wide Planning and Utilization resources will provide a coordinating role for pan-ESC LHIN projects. Reflecting the importance of diversity in its mandate, there will be region-wide support from the Aboriginal Services Consultant (0.5 FTE), French Language Services Advisor. To strengthen the ESC LHIN's role in health human resources, the activities of the HealthForceOntario Partnership Coordinator will be incorporated into the daily work of the ESC LHIN. Although the latter two persons are not ESC LHIN employees, they are assets that are essential to proper planning and functioning of the ESC LHIN. As well, specific funded was provided in late 2008/09 to provide a focus on Emergency Department and Alternate Level of Care challenges. The LHIN created an additional data support position to inform the ER/ALC Performance Lead, who is also an Account Manager. The separation of the funding to support two roles provides very specialized talents to a very pressing issue.

MLAA Targets

The table below shows the 12 Performance Indicators ("PIs") that are key to the success of the ESC LHIN.

PEROFRMANCE INDICATOR	Provincial Target	LHIN Baseline	LHIN Target		
			2007-08	2008-09	2009-10
Access Indicators					
Wait Time for 9 out of 10 persons who are treated					
Cancer Surgery	84 days	80	58		45
Cardiac By-Pass	182 days		Not Applicable		
Cataract Surgery	182 days	78	78	78	78
Hip Replacement	182 days	223	197	180	162
Knee Replacement	182 days	406	284	240	182
MRI Scan	28 days	89	37	67	36
CT Scan	28 days	65	48	46	44
Quality Indicator					
Readmission Rates for Heart Attack (AMI)	3.8%	7.1%		5.6%	
Integration Indicators					
Percent Alternate Level of Care days	9.5%	11%		10%	9
ED Visits that could be managed elsewhere	11.8 per1,000 residents	40		33	N/A
Hospitalization for Ambulatory Care Sensitive Conditions	291 per 100,000 residents	425		335	N/A
Median Wait Time to Long-Term Care Home placement	50 days	59		53	75

In addition to these targets, in July 2009 the MOHLTC will provide the LHIN with two additional targets that will improve the length of stay for Emergency Department patients.

Access Indicators

The seven Access Indicators share common attributes. For example, the surgical wait times all rely on Operating Room time and space in hospitals, access to inpatient beds, as well as staff and medical specialties. MRI and CT scans require Imaging Service supports in hospitals and medical specialties. These seven Access Indicators are heavily under the direct control of hospitals and their medical staff. Community resources can be helpful in providing effective and efficient pre and post surgery services, but it is primarily within the hospital sphere of influence to affect these items. It should be noted that cardiac by-pass surgery for Erie St. Clair residents is provided primarily in the Southwest LHIN.

There are two Clinical Advisory Networks (Surgical Advisory Network and Emergency Department and Medicine Advisory Network) established in 2008. Within the areas defined by their titles, their mandates include serving as a forum for:

- Monitoring performance indicators
- Needs and issues identification as well as joint problem-solving
- Best practice advancement and care path development
- Data quality development and reporting (dashboard development)
- To share/advance innovation
- The expression of ESC LHIN viewpoints and directions
- An integrated system of services that links with the wider healthcare system
- Advising on the allocation and reallocation of service volumes

There is also a Wait Time Steering Committee (a Project Team) comprised of hospital and ESC CCAC administration, physicians and CNOs who could implement change in the institution. They serve as a forum to provide similar advice as the Clinical Advisory Networks.

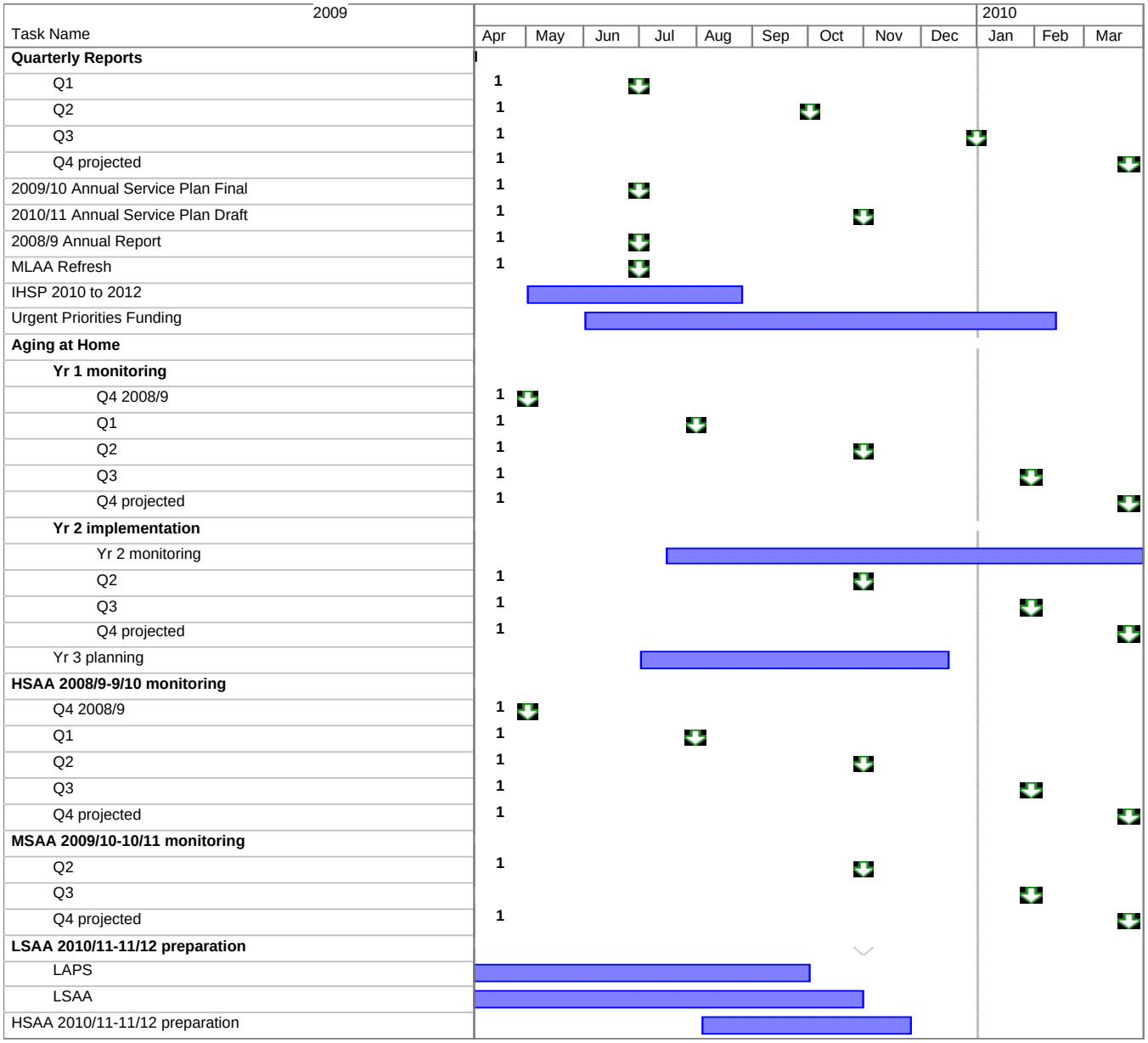
Quality Indicator

The single Quality indicator – Readmission for AMI, is being addressed in collaboration with the ESC LHIN Regional Cardiac Centre at Hôtel-Dieu Grace Hospital (HDGH) and under the guidance of the Cardiac Care Network. The Cardiac Care Network has developed standards of care based on work with the Ottawa Heart Institute. A toolkit for the audit of these standards of care has been received and a rollout plan for these best practices at HDGH is being developed for implementation through 2009/10. The expectation of the ESC LHIN is that HDGH provides continued leadership in the assessment of these standards at our other ESC LHIN hospitals. Identifying gaps in best practices and assisting in the implementation of these cardiac standards is also required. These initiatives are anticipated to reduce AMI readmissions in the ESC LHIN.

Integration Indicators

The four Integration Indicators will be addressed primarily through Aging At Home Year 2 and Year 3 investments. In 2009/10, the ESC LHIN will be implementing Year 2 initiatives and planning for Year 3 initiatives. The Year 3 procedure will use a Request for Proposal (RFP) process to allocate Year 3 funds. The RFP will include conditions requiring multiple partners across service sectors, minimum access equity standards, flexibility in meeting consumer/client needs and measurable direct change in the Integration Indicators. The process will require groups of HSPs to collaborate effectively to deliver integrated services across sectors that directly address the four Integration Indicators. Some funds will be set aside for non-MLAA targeted activity after consultation with the communities, HSPs, and the Ministry. The use of these funds will be determined by January 2010.

Core Schedule of Activities for 2009/10



Task Name	2009 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2010 Jan	Feb	Mar
Quarterly Reports												
Q1	1											
Q2	1											
Q3	1											
Q4 projected	1											
2009/10 Annual Service Plan Final	1											
2010/11 Annual Service Plan Draft	1											
2008/9 Annual Report	1											
MLAA Refresh	1											
IHSP 2010 to 2012												
Urgent Priorities Funding												
Aging at Home												
Yr 1 monitoring												
Q4 2008/9	1											
Q1	1											
Q2	1											
Q3	1											
Q4 projected	1											
Yr 2 implementation												
Yr 2 monitoring												
Q2	1											
Q3	1											
Q4 projected	1											
Yr 3 planning												
HSAA 2008/9-9/10 monitoring												
Q4 2008/9	1											
Q1	1											
Q2	1											
Q3	1											
Q4 projected	1											
MSAA 2009/10-10/11 monitoring												
Q2	1											
Q3												
Q4 projected	1											
LSAA 2010/11-11/12 preparation												
LAPS												
LSAA												
HSAA 2010/11-11/12 preparation												

The diagram above shows the scheduled activities that are already known for 2009/10. New activities will be scheduled and resourced to complement these activities. This is a significant but known challenge. As provincial directions become clearer for 2009/10, new activities will be incorporated within the resource limits of the ESC LHIN and its HSPs.

A Few Words About Our IHSP Priorities

The ESC LHIN has eight Strategic Directions and associated actions. The criteria were based on those used by Cancer Care Ontario and modified to align with the ESC LHIN's IHSP process. The Strategic Directions were determined by applying seven criteria to the quantitative, qualitative and community survey information ("voice of the customer") we developed in the creation of the IHSP.
The criteria were:

- Strategic Fit/Alignment with External Directives
- Alignment with Academic Mandates
- Clinical Impact
- Community Needs Assessment
- Building on External Partnerships
- Building on Interdependency
- Resource Implications

The Strategic Directions are very similar to those across Ontario because the historically centralized approach to program development and resource allocation has created very similar strengths and limitations in each LHIN. As shown in the diagrams above, the Strategic Directions are validated by their integration with the Strategic Priorities of the MOHLTC and the MLAA targets. Their performance is measured primarily by the targets established in the MOHLTC and MLAA requirements.

The performance targets for Access and Quality Indicators of the MLAA, for example, are mutually agreed upon targets between the MOHLTC and the ESC LHIN at annual meetings. The targets are chosen based on the overall provincial target (either a national or a provincial target) applied to the local current result. The resulting local target represents the most reasonable expectation of local change to support the provincial target.

The second IHSP will incorporate four priorities that will be common across Ontario. They are:

- Improve the Emergency Department experience by shortening length of stay and reducing demand for ED care'
- Reducing Alternate Level of Care days in all levels of hospital care,
- Improving diabetes care, and
- Improving mental health and addictions services.

The specific performance measures and milestones will be established in the IHSP which be made public at the end of November 2009.

An Example of Erie St. Clair's Approach to Pay for Results

The allocation of Aging At Home funding presents one example of the ESC LHIN's approach to meeting Integration Indicators. The example below reflects the ESC LHIN's approach to seeking Aging At Home projects to address the Alternate Level of Care ("ALC") target for 2009/10.

The 2009/10 ALC day target is 8.9% of all acute inpatient days. In 2007/08, Erie St. Clair hospitals reported a total of 32,100 ALC days, however, this is above the 8.9% target. To achieve the 8.9% target in 2007/08, local hospitals would have to report 7,200 fewer days. The ultimate idealized target would be to have no ALC days – a theoretical maximum of 32,100 days. The table below shows the impact of these changes for each Planning Community.

Targeting Percent of Alternate Level of Care days in acute care

2007/08 data

Target		Windsor/Essex	Sarnia/Lambton	Chatham-Kent	ESC
8.9%	min	4,500	2,500	0	7,000
4.5%	**mid**	**12,750**	**4,750**	**2,050**	**19,550**
0%	max	21,000	7,000	4,100	32,100

The "0" in Chatham-Kent reflects the fact that Chatham-Kent Health Alliance had an exceptionally good ALC volume that was less than the 2009/10 target. If Windsor/Essex hospitals had achieved the 8.9% ALC target in 2007/08, the hospitals would have to reduce their ALC days by 4,500. This becomes the minimum number of ALC days that need to be removed from the hospital sector. It is expected that the ALC volume in 2009/10 will be higher than the figures shown above. Any service plan and funding allocation to reduce ALC days would need to accommodate more than the minimums shown above. Seeking new service delivery models that support the "mid" range would be a useful service-planning target. The development of request for proposal processes for ALC day reduction would reflect these volumes and a percentage of the Aging At Home funding available for 2009/10. To respect other goals, the RFP would include:

- Increased points of service (promoting equity)
- Cultural appropriateness (promoting equity)
- Flexibility
- At least three inter-sectoral HSPs delivering integrated care (this may include non-LHIN HSPs)
- Larger projects that focus directly on system performance indicators
- Process improvement component (such as Lean/Six Sigma)
- Rigorous external evaluation

This approach will be applied to address the other Integration Indicators using Aging At Home funding.

To ensure that all projects are delivering their intended results successfully, the LHIN will implement its Earned Value Management tool. This is a standard tool in Project Management that is used to track the success of projects in terms of timing, cost and outputs. It allows the provider to see how they are doing so that they can report to the LHIN, if necessary, what generated a challenge to performance and what they intend to do to solve the problem. It is a tool that is used to collaboratively solve problems, not merely identify them.

Our Approach to Risk Mitigation

The role and abilities of the ESC LHIN and its partners is evolving. There will be risk in all endeavours, regardless of whether the intent is to stabilize an existing situation or change an existing situation. It is essential that clear communication, good information for decision-making, accountability and goodwill weave themselves through all ESC LHIN activities and interactions.

ESC LHIN staff has been reorganized to provide a geographic team approach to accountability. Community Engagement and Communication will have an integral role in all team activities. Utilization, performance and quality information will be enhanced in terms of usefulness, timeliness and application to performance measures. Weekly, monthly and quarterly reports will be developed that are targeted to system management and performance. Timely information will assist in assessing success and failure to deliver on key performance targets and making earlier corrections as necessary.

Our Approach to Aging at Home

ESC LHIN is responsible for allocating $30.1M to support activities that keep elders at home. The most important measure of success is the reduction in Alternate Level of Care ("ALC") days. That is, days spent in acute care hospital beds by people who could be at home or in another facility such as a long term care home. In 2008/09, the LHIN focused funding on: transportation, meals and nutrition, end of life/palliative care, enhanced home care services, and assistive devices. In 2009/10, the LHIN is focusing additional funding on: specialized support for elders in emergency departments to help them go home sooner, additional long term care beds, friendly visiting and security checks for those at home, home maintenance, and day programs.

Our Use of Urgent Priorities Funding

ESC LHIN has a special fund of $2.5M in 2009/10 to support challenges that arise during the year that, if not resolved, could create severe challenges in the provision of care or significantly benefit the local system. The LHIN continues to support the North Lambton Community Health Centre satellite in Watford and will be supporting a geropsychiatric program at HDGH. Funds were also provided to the Community Care Access Centre (CCAC) to support their transformation and supporting funds have been offered to each hospital to choose and implement a common utilization management tool to support LHIN ALC strategies. The remaining funds will be allocated on an as-needed basis.

The external committee structure has been designed to be an integrated approach to planning, monitoring and advice provision. The strengthening of the Health Professionals Advisory Committee along with the implementation of the Francophone Advisory Committee and the Aboriginal Advisory Committee will strengthen lines of communication into three extremely important and diverse groups of customers.

The ESC LHIN will strengthen its support to decision support staff in its HSPs by providing them with tools, forums and open lines of communication to develop timely information in advance of the current reporting timeframes.

Financial Summary

	2008/09 Funding Allocation (000's) [1]	2009/10 Funding Target (000's) [1]	2010/11 Funding Target (000's) [1]
Total LHIN Budget	**922,465.5**	**930,554.6**	**949,850.4**
Total Health Service Provider (HSP) Transfer Payments	916,268.1	930,554.6	949,850.4
Operation of LHIN [2]	5,237.4	TBD	TBD
Initiatives [3]	35.0	TBD	TBD
E-Health	925.0	TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector:			
Operations of Hospitals [4]	589,523.5	587,033.6	586,033.6
Grants to compensate for Municipal Taxation - public hospitals	163.7	163.7	163.7
Long Term Care Homes	153,712.0	158,629.0	163,075.4
Community Care Access Centres	100,204.7	104,303.1	111,432.0
Community Support Services	14,057.6	13,575.0	13,880.5
Acquired Brain Injury	1,089.5	1,078.2	1,102.5
Assisted Living Services in Supportive Housing	5,301.4	5,248.3	5,366.4
Community Health Centres	16,418.9	15,798.6	15,798.6
Community Mental Health	26,887.8	27,415.4	28,016.2
Addictions Program	7,637.8	7,780.4	7,955.3
Specialty Psych Hospitals	0.0	0.0	0.0
Grants to compensate for Municipal Taxation - psychiatric hospitals	0.0	0.0	0.0
Initiatives [5]	1,271.2	9,529.2	17,026.3

Note:

1. The 2008/09 funding allocation and the 2009/10 and 2010/11 funding targets are updated as of March 31, 2009 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 only base 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 adjustments for these programs will be confirmed as part of the 2009/10 Provincial Budget.

   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 include Aboriginal Community Engagement.
4. Operation of Hospitals allocations and funding targets include private and public hospitals. It may also include, as appropriate, any approved PCOP funding as described further in Table 3 - Dedicated Funding.
5. Transfer payment initiatives by LHIN will be allocated by sector by the LHIN at a later date. Initiatives include Aging at Home, Urgent Priorities Funds, Flo Collaborative, and Emergency Department Action Plan that are unallocated. It should be noted that as the LHIN allocates by sector, the allocation will be distributed at the sector level.

Planning the ESC LHIN Operations

The Operating Financials assume that the funding allocation to ESC LHIN operations remains flat. The ESC LHIN is expected to assume more duties and responsibilities next year with the addition of Multi-Sectoral Service Accountability Agreements. As well, the ESC LHIN prepares to assume responsibility for LTCHs; therefore, one FTE was added to the 2008/09 staffing complement for 2009/10. The additional FTE was a Program Assistant. The planned staffing for 2009/10 is 27.5 FTEs. This is not the preferred staffing plan, but is within the funding anticipated. It is anticipated that there will be two additional staff in 2010/11. This will require facility expansion or office relocation. Conservatively, $250,000 is shown for this change in the next table. This number is very preliminary, but highlights the importance of additional space needs. The forecast does not include any items that may be required as a result of the ESC LHIN Effectiveness Review.

The table below highlights the proposed expenditures by line item.

LHIN Staffing Plan (FTE)					
Position Title	**2007/08 Actuals as of March 31**	**2008/09 Forecast**	**2009/10 Plan**	**2010/11 Plan**	**2011/12 Plan**
CEO	1	1	1	1	1
Senior Director	2	2	2	2	2
Controller	1	1	1	1	1
Sr. Cons CE	1	1	1	1	1
Corp Coordinator	1	1	1	1	1
EA	1	1	1	1	1
AA	2	2	2	2	2
Receptionist	1	1	1	1	1
Program Asst	2.5	4.5	5.5	5.5	5.5
Comm Eng Cons.	1	1	1	1	1
Designer, Web & Mktg	1	1	1	1	1
Account Manager	0	3	3	3	3
Planner	1	2.5	3	4	4
Funding & Allocation	2	2	2	3	3
Quality Manager	0	1	2	2	2
Project Manager	0	0.5	1.0	1.0	1.0
Project Assistant	0	1	1	1	1
Integration Cons	2	0	0	0	0
Perf/Cont/Alloc Cons	2	0	0	0	0
Total FTEs	21.5	26.5	29.5	32.5	32.5

ESC LHIN Operations Spending Plan

LHIN Operations ($)	2007/08 Actuals	2008/09 Budget	2009/10 Planned Expenses	2010/11 Planned Expenses	2011/12 Planned Expenses
Operating Funding	**3,437,644**	**4,191,248**	**TBD**	**TBD**	**TBD**
Salaries and Wages	1,768,543	2,210,610	2,600,000	3,000,000	3,050,000
Employee Benefits					
HOOPP	144,940	213,360	250,000	290,000	300,000
Other Benefits	175,945	243,680	275,000	310,000	340,000
Total Employee Benefits	***320,885***	***457,040***	***525,000***	***600,000***	***640,000***
Transportation and Communication					
Staff Travel	80,785	109,800	110,000	115,000	120,000
Governance Travel	17,088	52,300	50,000	52,000	55,000
Communications	53,692	50,000	55,000	55,000	60,000
Others	4,805	10,000	10,000	10,000	10,000
Total Transportation and Communication	***156,370***	***222,100***	***225,000***	***232,000***	***245,000***
Services					
Accommodation	154,165	155,000	165,000	200,000	200,000
Advertising	1,721	2,500	2,500	3,500	3,500
Banking	- 10	-	-	-	-
Community Engagement	10,703	60,000	60,000	60,000	60,000
Consulting Fees	175,209	269,800	150,000	150,000	150,000
Equipment Rentals	20,400	18,000	24,000	24,000	24,000
Governance Per Diems	77,250	118,800	120,000	120,000	120,000
Insurance - Operations Only	17,800	18,500	19,000	19,500	20,000
LSSO Shared Costs	300,000	305,000	300,000	300,000	300,000
Other Meeting Expenses	50,749	50,000	50,000	50,000	50,000
Other Governance Costs	42,293	95,900	100,000	100,000	100,000
Printing & Translation	2,424	15,000	10,000	10,000	10,000
Staff Development	49,470	50,500	50,000	50,000	50,000
Other Services	3,739	10,000	10,000	10,000	10,000
Total Services	***905,913***	***1,169,000***	***1,060,500***	***1,097,000***	***1,097,500***
Supplies and Equipment					
IT Equipment	22,000	30,000	30,000	30,000	30,000
Office Supplies & Purchased Equipment	132,421	92,498	90,000	90,000	90,000
Other S & E	-	10,000	10,000	10,000	10,000
Total Supplies and Equipment	***154,421***	***132,498***	***130,000***	***130,000***	***130,000***
Capital Expenditures	-	-	250,000		
LHIN Operations: Total Planned Expense	**3,306,132**	**4,191,248**	**4,790,500**	**5,059,000**	**5,162,500**
Annual Funding Target		4,191,248	4,191,248	4,191,248	4,191,248
Operating Surplus (Shortfall)	131,512	-	- 599,252	- 867,752	- 971,252
Amortization of Tangible Capital Assets	208,701	215,000	250,000	70,000	70,000
Initiatives Funding					
E-Health	275,000	275,000	TBD	TBD	TBD
A@H	187,000				
Aboriginal Community Engagement	20,000	20,000	20,000	20,000	20,000
ED Lead	37,500	37,500			
Wait List Management	70,000				
Other Initiatives (please specify - LHIN Operations Only)					
Other Initiatives (please specify - LHIN Operations Only)					
Other Initiatives (please specify - LHIN Operations Only)					
LHIN Operations - Total Planned Expense	**4,027,144**	**4,523,748**	**4,650,000**	**4,854,900**	**5,074,100**