Hamilton Niagara Haldimand Brant **LHIN**

2008-2009 Annual Service Plan

Ontario
Local Health Integration Network

Table of Contents

Hamilton Niagara Haldimand Brant
LOCAL HEALTH INTEGRATION NETWORK
RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
de Hamilton Niagara Haldimand Brant

270 Main Street East, Units 1-6
Grimsby, ON L3M 1P8
Tel: 1.905.945.4930
1.866.363.5446
Fax: 1.905.945.1992
www.hnhblhin.on.ca

270, rue Main Est, unités 1 à 6
Grimsby, ON L3M 1P8
Tél : 1.905.945.4930
1.866.363.5446
Téléc : 1.905.945.1992
www.hnhblhin.on.ca

August 30, 2007

Mr. Hugh MacLeod, Assistant Deputy Minister
Health System Accountability and Performance Division
Ministry of Health and Long Term Care
80 Grosvenor Street, 10th Floor, Hepburn Block
Toronto, ON M7A 1R3

Dear Mr. MacLeod: Hugh

Re: Hamilton Niagara Haldimand Brant Local Health Integration Network - Draft Annual Service Plan, 2008/09

On behalf of the Board of Directors for the Hamilton Niagara Haldimand Brant Local Health Integration Network, we are pleased to provide you with a copy of our Draft 2008/09 Annual Service Plan (ASP). Consistent with the requirements of Section 18(4) of the Local Health System Integration Act, our ASP summarizes our planned activities to discharge the LHIN mandate to achieve transformation and to maintain accountability to the stakeholders of our community. On August 28, 2007, the Board of Directors approved in principle the attached Draft Annual Service Plan pending further discussion with the ministry in the fall.

Through a number of information gathering processes, for example: key informant interviews, open houses, meetings with key stakeholders, environmental scanning, we have heard our community members express their concerns, opinions and desires for their local health system. These messages helped structure the content and direction for Integrated Health Service Plan (IHSP) released in November 2006. Our ASP identifies strategic investments and opportunities over the next three years to realize the deliverables identified in the IHSP, and the requirements of the Ministry LHIN Accountability Agreement.

We have grouped our ASP initiatives into five key themes:

1. Facilitate persons' return to home and support of the frail elderly
2. Improve access to services and reduce wait times for key services
3. Proactive management to keep people well, engaged in their health care and at home
4. Facilitate processes to support organizational financial health
5. Supporting LHIN operations

Our Board, with the support and assistance of our LHIN staff and health service providers, is committed to implementing our mission for local healthcare:

"To ensure availability of and access to linked services in order to improve the health of the population and the continuity of health care."

Sincerely,

Juanita G. Gledhill
Chair, Board of Directors

Copy of letter to:
Carrie Hayward
Director, LHIN Liaison Branch
80 Grosvenor Street, 5th Floor, Hepburn Block
Toronto, ON M7A 1R3

Copy of letter and ASP to:
Kathryn McCulloch
Manager, West Unit
LHIN Liaison Branch
80 Grosvenor Street 5th Floor, Hepburn Block
Toronto, ON M7A 1R3

SECTION B: INTRODUCTION

The mandate of LHINs is to plan, fund and integrate the local health system for appropriate, coordinated, effective, and efficient health services in its area. A LHIN's Annual Service Plan (ASP) is one of three key reporting features defined in the LHIN-Ministry reporting framework (along with quarterly reports and the annual report). The process and content of these reports are defined by

- LHSIA (2006) – the Local Health System Integration Act;
- Memorandum Of Understanding between Ministry and LHINs;
- MLAA – Ministry LHIN Accountability Agreements
- The Government's agenda; and
- The timing and informational requirements of the Government's and Ministry's fiscal cycle.

The Hamilton Niagara Haldimand Brant (HNHB) LHIN Annual Service Plan (ASP) ASP reflects the LHIN's current understanding of its environment; it's commitment to shared responsibility for health system improvement, and the system requirements for sustained outcomes. The ASP describes the role that community and organizational leadership have for planning and implementation of priority strategies and the range of risk and success factors for goal achievement.

The LHIN plays many roles among its community partners – catalyst, activator, facilitator, planner, mediator, connector, manager and steward - and at all times remains committed to intentional collaboration for an effective and efficient health system. At the same time the LHIN in its initial ASP identified a risk management plan that is still relevant to this submission and to the achievement of its goals over the next three years, which include:

- Facilitate persons' return home and support frail elderly;
- Improve access to services and reduce wait times for key services;
- Proactive management to keep people well, engaged in their health care and at home; and
- Facilitate processes to support organizational financial health.

Finally, the HNHB LHIN has given careful thought to its organizational capacity to stimulate health system improvement and the outcomes are reflected in its operations plan for sustainability.

LHINs are in the formative stages of understanding and building options and support for re-allocation strategies. As the HNHB LHIN evolves its planning, coordinating, performance and funding cycles, future ASPs will describe re-allocation opportunities and related efficiencies.

SECTION C: ENVIRONMENTAL SCAN

INTRODUCTION:
This section highlights opportunities to achieve system improvement in the Hamilton Niagara Haldimand Brant LHIN and support the government's goal to establish an accessible, quality and sustainable health care system. It summarizes:

- Key cost drivers in the LHIN as context
- Opportunities informed by a recent environmental scan (2007) and the LHIN Board of Directors' strategic directions
- Issues and trends with implications for commitments in the Ministry LHIN Accountability Agreement (MLAA), and the HNHB Integrated Health Service Plan Phase 1.
- Activities that directly support the Government's agenda for:
  - Improving access to health care
  - Shorten wait times
  - Promoting health and preventing illness, and
  - Improving access to appropriate care and support for seniors

A. SELECTED KEY COST DRIVERS IN THE HNHB LHIN

- Increased proportion of the LHIN population over 65 years and living with chronic conditions.
- Poor health practices among young people contribute to obesity and the development of health issues at an earlier age. In 2005, 18% of the HNHB LHIN population aged 12-17 was overweight or obese[i], similar to the provincial rate. 18.5% of the HNHB LHIN population aged 18+ is considered overweight or obese[ii], significantly higher than the provincial rate of 15%.
- Access to appropriate levels of care; patients often reside in inappropriate level of care, which is contributing to the high alternative level of care (ALC) rates. As of December 2007, ALC days represented 19% of acute inpatient days in HNHB LHIN hospitals, compared to an Ontario hospitals' average of 14%[iii]
- The number of under serviced areas for primary care within the LHIN; diminished scope of practice by new and existing physicians (i.e. continuum of maternity care, hospital coverage) and the limited scope of practice of allied health professionals limit access to primary care services, which is contributing to increased use of emergency departments.
- Technological advances which expand treatment options at a higher cost to the system.
- Costs associated with providing care, drugs (e.g. cancer drugs), and technology higher than inflationary adjustment provided to providers.
- Lack of community supports and supports within the home are increasing demand for long-term care.
- Limited access to transportation and the rising cost of transportation impacts access to health care services and an individual's choice of where they live.
- Limited availability of health human resources may result in costing the system more as a result of premium pay (competition or establishment of private companies e.g. emergency coverage from private agency rather than staff physicians).
- Aging volunteers providing service through community agencies/services and a changing volunteer demographic put services at risk.

B. REGIONAL HEALTH CONCERNS AND COMMUNITY NEEDS

B1 Population Characteristics:

1. The large number of seniors and the high percent of the population aged 65 years and older in the HNHB LHIN area will require that health care providers serving the HNHB be leaders in providing services sensitive and responsive to the needs of the elderly.

    - As of 2006, seniors represent 16% of the total HNHB LHIN population; approximately 210,000 people age 65 years of age and over, compared to a provincial average of 14%[iv].

2. The large number of seniors living alone means that health care providers serving the HNHB will need to develop and enhance services that support seniors living well independently in the community.

    - According to the 2006 Census, 28% of seniors aged 65+ (54,000) who reside in the HNHB LHIN area live alone, compared to an all Ontario rate of 26%.[v]

3. The region has a high number of foreign born residents; providers will need to develop services that are culturally sensitive and responsive to the needs of new immigrants.

    - Hamilton has the third highest proportion of foreign-born residents among urban areas in Canada, Niagara is a major receiver of refugees, and seasonal migrant workers locate in Niagara, Haldimand and Norfolk[vi].
    - According to the 2006 Census, 11% of the immigrant population residing within the HNHB LHIN area were 'recent immigrants', i.e., immigration occurred between 2001 and 2006, compared to a provincial rate of 17%[vii].

4. a) The dearth of good information on the size and health status of the Aboriginal population within the HNHB LHIN and b) the historical poor health status and barriers to access to health care for Aboriginal populations in Canada, presents a need for the HNHB LHIN to more fully identify the needs of this population and ensure that health services are sensitive and responsive to these needs.

5. High rates of unhealthy lifestyles suggest a need to enhance and expand health promotion activities in the LHIN and develop supports for health promotion activities of primary care providers.

Current HNHB Activity

Currently implementing the 3 year Aging At Home Strategy. First year allocations closed community support service gaps and launched cross Ministry, intergenerational and peer support initiatives for healthy aging. Current planning activities include directional plans for specialized services for frail elderly, supports in the home and falls prevention. LHIN meetings in the areas of transportation, food access and information and referral are being planned for health improvement. In addition, the LHIN is linking healthy aging and independent living with chronic diseases prevention and management (CDPM), aboriginal health and French language service access improvements with aging at home strategies.

The LHIN facilitated a future search conference with the guidance of aboriginal leadership, the outcomes of which include a historical unity of local Metis, First Nations and aboriginal communities working toward a health and health care vision for health improvement. The HNHB LHIN is providing leadership to other LHINs for improved relationship building with First Nations, information and data interpretation and successful dialogue.

Implementing and evaluating a number of strategies identified by the HNHB LHIN Alternate Level of Care Steering Committee that are aimed at improving patient flow by ensuring individuals in hospital and the community have access to the right level of care in the right place when they need it. Current strategies (that have benefited under urgent priority and AAH funding) include; slow stream rehab, ALC Consultant, ALC designation working group, Home to Stay pilot, Transitional Care Team pilot.

Working closely with communities to establish 4 new Community Health Centres (CHC) across the LHIN. Consistent with their mandate the new CHCs will increase access to primary care services, targeting residents most at risk of poor health status, particularly those without family physicians. CHCs will establish programs aimed at promoting healthy life styles through education, support and intervention.

B2 Population Health Status

6. High rates of smoking; unhealthy diet and lack of physical activity in the LHIN contribute to higher rates of chronic health conditions. In 2005, 23% of HNHB LHIN residents reported to be current smokers, significantly higher than the all Ontario rate of 20%[viii]; 50% of HNHB LHIN residents reported consumption of an 'unhealthy diet', compared to an all Ontario rate of 53%[ix]; and, 45% of HNHB LHIN residents reported they were not physically active, similar to the all Ontario rate.[x]

7. As of 2001, life expectancy measured at birth[xi] among male residents of the HNHB LHIN area was 76.8 years and among females 81.5 years, significantly lower than the life expectancy for all Ontario males and females (77.5 and 82.1, respectively). In 2001, the age-standardized all-cause mortality rate[xii] in the Hamilton Niagara Haldimand Brant LHIN area was 629.8/100,000 population, higher than the provincial rate (602.6/100,000). Low life expectancy and the high mortality rate suggests a need to enhance and expand health promotion and disease prevention and support Chronic Disease Prevention & Management activities of primary care providers.

8. High rates of mortality in HNHB LHIN communities are primarily due to high rates of circulatory disease and neoplasms, which are the two leading causes of mortality and morbidity.[xiii] Cancers contribute to more years of potential life lost for HNHB residents than any other cause, followed by circulatory system diseases, and external causes (i.e., injuries). These indicators suggest that there is a need for system-wide improvements in the prevention, diagnosis, and treatment of cancer and circulatory disease.

9. As of 2001, the infant mortality rate[xiv] in the Hamilton Niagara Haldimand Brant LHIN area of 5.8 per 1000 live births was higher than the Ontario rate of 5.4 per 1,000. Relatively high rates of infant mortality suggest a need for significant improvement in pre natal care and in maternal and newborn care.

10. Observations regarding the safety and efficiency of low volume birthing services suggest a need to consider how to sustain quality and safety outcomes while maintaining optimal distribution of pre natal, maternal and newborn care[xv].

11. One in every 5 children or youth suffer a significant mental health issue, and one in five are destined to live with a chronic disease or disability.

Current HNHB LHIN Activity

Identify the appropriate mix, supply and distribution of maternal newborn services to support quality outcomes for mothers and newborns. LHIN facilitated a collaborative meeting to identify service delivery options, including alternative models of care, to support maternal newborn services in a rural community. Plan to partner with the Ministry of Health and Long-Term Care's Health Strategy Division to confirm local designation criteria for level I, II, and III newborn care units within the LHIN. Assess appropriateness of current sites and associated resources required to sustain the service now and into the future.

Confirmed two physician leads to promote and identify opportunities for Chronic Disease Prevention & Management collaboration across sectors. Health leaders across the LHIN identified diabetes as the area of focus for collaboration in 2008/09. Plans for 2008/09 include developing an action plan for improving diabetes prevention and management, establishing a CDPM Collaborative Steering Committee to develop a LHIN CDPM directional plan for 2008/09 and 2009/10; hold a Continued Medical Education event for health care providers in the fall 2008.

Participate in the LHIN Surgical Oncology Work Group to review access to cancer surgical services and outcomes. Continue to monitor the wait time strategies for improved cancer prevention, cancer diagnostics, and treatment outcomes.

B3 Health System Capacity

12. Hospitals within HNHB LHIN are experiencing increasing difficulty with medical staffing of emergency departments, resulting from insufficient numbers of family physicians to cover emergency department shifts, income opportunities for family physicians in other settings, differentials across the LHIN and province in supplementary pay for emergency department shifts, as well as pressures within the emergency department related to non-physician staffing shortages and increased wait times for patient admission to hospital[xvi].

    - Both large and small hospitals within the LHIN are reporting significant shortfalls in physician staffing currently and into coming months. This is a significant reversal from full staffing previously in many LHIN hospitals.

13. HNHB LHIN hospitals have 378 inpatient mental health beds[xvii], including long-term mental health. The LHIN has 11% of the total Ontario population and 8.3% of the total inpatient mental health beds in Ontario. The relative deficiency in inpatient mental health care suggests a need to improve access to mental health services.

14. The ratio of seniors living in supportive housing and receiving 24/7 assisted living services to the total number of seniors in the LHIN is below the Ontario ratio (2006/7). The large number of elderly and the relative deficiency in supportive housing suggests a need to increase access to MOHLTC funded supportive living services.

15. The LHIN has 74 Family Physicians/100,000 Population (2005), lower than Ontario rate of 85[xviii]. Communities designated as under serviced for Family Physicians include all the municipalities within Niagara, as well as the municipalities of Burlington, Brantford, Brant, Haldimand and Norfolk. According to the Under-serviced Area Program criteria, as of May 2008, there were 137 family physician vacancies in the HNHB LHIN area, the highest number of family physician vacancies of all 14 LHINs in Ontario[xix]. The small number of family physicians relative to the population suggests a need for continued efforts to improve access to primary care physicians/primary care.

16. The aging of the population and the aging of the workforce will require efforts to ensure an adequate future supply and distribution of health care professionals.

17. Lack of a continuum of care that is inclusive of palliative care results in patients who could receive end of life care in the community being cared for in acute care hospital[xx].

18. The McMaster Children's Hospital reports that it serves 600,000 children in the HNHB LHIN. It is closed more than 50% of the time for children requiring care and 65% of the time for newborns requiring critical care. Ongoing service gaps exist for eating disorders, paediatric rehabilitation, ambulatory child and youth health, and adolescent and young adult oncology.

Current HNHB LHIN Activity

Plans underway to implement a LHIN wide Emergency Department Access Steering Committee (EDASC). This committee will address issues of emergency department resources and wait times.

In addition, plans are underway to implement an emergency department coordinator to enable rapid progress on EDASC initiatives, liaise with the ALC Steering Committee and ALC Coordinator, and to support the work of the Emergency Department Lead.

Continue the work of the Emergency Department Chiefs of Staff Committee, chaired by the LHIN Emergency Department Lead to address emergency department pressures.

An approach to LHIN wide mental health and addiction health improvement in priority areas is underway. Approaches will be informed by local area strategic planning processes in Niagara and Brant County. The LHIN will facilitate discussions between St. Joseph's Health Care in Hamilton and Norfolk General Hospital (NGH) to improve access to mental health services for the NGH referral population. Areas that have benefited from urgent priority funding include a) wellness program for individuals at risk of developing physical health conditions in Hamilton, b) transitional housing program in Brantford; aging at home funding is supporting a) a peer support program in Hamilton, linking young persons and older persons, both with mental health challenges, to assist older persons with activities of daily living; and b) day and respite program capacity enhancements for older persons with dementias.

Supports in the home is a principle planning initiative of the LHIN in partnership with stakeholders across the LHIN. It is being informed by models and practices both across Canada and internationally. Supports in the home/assisted living have been enhanced through Urgent Priorities Fund and Year 1 Aging at Home funding.

The LHIN will invite the Palliative Care Network to work with Norfolk General Hospital to explore opportunities to establish community palliative care service in Norfolk.

Support the integration of multi disciplinary approaches and practice scopes in health system improvement options. A 15-member Health Professionals Advisory Committee held its second meeting May 2008. The Committee will meet quarterly and will focus on providing advice to the LHIN around models of care, scope of practice, and common language around terminology.

The LHIN undertook a reallocation process amongst service providers that considered pressures within the LHIN and the Integrated Health Service Plan priorities, and that allowed the LHIN to optimize available funds.

McMaster Children's Hospital in partnership with the HNHB and WW LHINs is reviewing the appropriate program range and scope of its services and related continuum requirements for continuity of care and support for children and youth. The Children's Hospital as well is developing a model for Access to Better Care designed to strengthen care for children and youth, among other populations, in Hamilton and the LHIN.

B4 Health Care System Utilization

19. Hospitals within the HNHB LHIN report increasing wait times in Emergency Departments resulting, in part, from rising ALC rates.

    - Over the last six months, hospital reporting of data reflecting pressures generated by ALC and indicated rising wait times for admission to hospital from emergency rooms. During the last two weeks of April, average wait times for admission from the emergency department ranged from 10 to greater than 24 hours.

    - The high rate of emergency department utilization suggests a need for improvements in access to and effectiveness of primary care for people under 55 years of age HNHB residents have the second highest rate of non-urgent emergency visits of all of southern Ontario [xxi].

20. The high rate of hospitalization for ambulatory care sensitive conditions, although varied across the LHIN, suggests a need for evaluation of admission practices, especially where poor access to family physicians is most pronounced.

    - In 2006/07, HNHB LHIN rate of separation for ambulatory care sensitive conditions was 373.82/100,000 population, well above the Ontario average of 325.52/100,000 and the fifth highest rate in the province[xxii].

    - In 2006/07, inpatient separations for ambulatory care sensitive conditions by census division of patient residence within the HNHB LHIN ranged from 275 to 513/100,000, with four out of five areas demonstrating a rate in excess of the provincial average.

21. The higher utilization of acute care orthopaedic and trauma services and the high cost of injuries suggest a need for a focus on safety and accident prevention initiatives[xxiii].

22. Falls are the leading cause of injury among older adults, accounting for 59% of injury related to emergency department visits and 80% of injury hospitalizations[xxiv].

23. In 2005, age-standardized rates of hospitalization for injuries among residents of HNHB LHIN were 506/100,000, significantly higher than the provincial rate of 450/100,000[xxv].

24. The low rate of use of inpatient rehabilitation suggests a need to improve access to inpatient rehabilitation for HNHB residents.

    - In 2004/05, the rate of inpatient rehabilitation episodes among HNHB LHIN residents was 1.2/1,000 population, much lower than the Ontario rate (2.0/1,000)[xxvi].

25. The wide variation in use of inpatient complex continuing care (CCC) beds suggests a need to ensure equitable access to CCC beds across LHIN communities[xxvii].

    - HNHB LHIN residents had the highest volume of CCC hospital admissions (2004/5) among the 14 LHIN populations (3,274 complex continuing care admissions,

representing 16.4% of the total CCC admissions at Ontario hospitals) rates of CCC admissions varied substantially.

26. The wide variation in Long-Term Care (LTC) Home beds suggests a need to ensure equitable access to LTC home beds across HNHB communities.

    - LTC Home beds vary from a low of 88.1 beds per 1,000 population aged 75 years and older in Haldimand/Norfolk, to a high of 108.6 in Hamilton.

Current HNHB LHIN Activity

The Emergency Department Access Steering Committee will address issues of appropriate emergency department utilization.

The LHIN is piloting a strategy to address pressures created by rising ALC rates. This is a regular rotational access to 1A crisis pilot protocol that balances community and hospital needs,

The LHIN will assess by census subdivision and hospital the trends in hospitalization for ambulatory care sensitive conditions. These findings will be shared with existing joint hospital committees, including emergency department Chiefs of Staff and the Clinical VP committees to identify the need for further investigation, and ultimately possible solutions.

Identify and implement collaborative strategies to reduce injury rates in the LHIN:

- A LHIN wide framework for Falls Prevention is being developed and will inform Aging at Home investments, priorities for implementation, and partner requirements for goal achievement.
- A LHIN Occupational Health/Primary Care Working Group is working with community health centres, family heath teams and occupational health specialists across the LHIN to develop tools for the early detection of workplace risk factors and to explore systems to effectively manage and rehabilitate injured workers.

Committed funding to support 15 interim rehab beds in the Niagara Region for 2008/09 and 2009/10.

Work with providers to identify opportunities to reduce myocardial readmission rates by promoting care based on best practices and improving access to advanced cardiac care for all LHIN residents.

Facilitate a collaborative meeting between Norfolk General Hospital, Brant Community Health Centre and Hotel Dieu Shaver Rehabilitation to develop a LHIN plan for rehabilitation beds.

A study is underway in the LHIN that will recommend a LHIN-wide model of CCC care delivery which fits within the framework of an integrated system for seniors that is sustainable into the future.

Link the deliberations of the ALC Steering Committee, Aging at Home planning for independent living and associated resources to ensure, among other health improvements, equitable access to LTC Home beds.

SECTION C. ISSUES AND TRENDS

C1 Potential impact on MLAA Commitments

Issues and risks:

Wait times

- Quality of wait times data, and therefore the reported situation on wait times, remains a significant issue. In 2007/08 one hospital in the LHIN achieved significant reductions in wait times for total joint replacement services (hip and knees) through reviewing wait lists and educating clerical staff in use of the Wait Time Information System. These efforts are challenging, given that surgeon offices do not fall under the management of hospital administration. Where surgeons welcome this assistance, this hospital has initiated maintenance activities that will continue to help the surgeon offices to maintain accurate lists. The success of this project was recognized at the provincial level and resulted in one-time funding for wait list management activities. The LHIN used these funds to implement the same model for wait list improvement mentioned above at another hospital. Further enhancement of wait time data quality will not be readily achieved without the availability of sufficient resources.

- Magnetic Resonance Imaging (MRI) – At the end of 2007/08, MRI wait times were above both the provincial Priority IV benchmark of 28 days and the LHIN projected target of 95 days. Throughput for MRI services in the LHIN was increased in 2007/08 with the addition of a new MRI scanner and will be further increased with an additional scanner in 2008/09. Despite efforts to improve throughput by increasing the number of scans available in the LHIN, the growing demand for MRI services continues to challenge success in reducing wait times. Demand for MRI presents two major challenges at present. We need to examine the possibility of inappropriate ordering practices, including ordering MRI where MRI is not required or recommended, placing the same order at multiple service delivery sites, and submitting negative description of the patient's condition to increase priority level.

- Computed Tomography (CT) – CT wait times continue to improve steadily since April 2006 yet remain above the provincial Priority IV benchmark. Both MRI and CT wait times have been aided by enabling contrast media injection during evening hours by training existing staff and adding nurses to the diagnostic imaging teams.

- Total Joint Replacement (TJR) – While the HNHB LHIN has made significant improvements in decreasing wait times for TJR since April 2005, current performance remains above the provincial Priority IV benchmark for both hips and knees. Decreases in wait times throughout 2007/08, have been largely attributed to the success of wait list management activities in one hospital. Similar outcomes are anticipated for 2008/09 when the same project will be implemented at another hospital within the LHIN. In addition to enhancing data quality, access to TJR in Hamilton was improved with the opening of the TJR Assessment Centre in April 2007. There are currently 17 physicians making referrals to the centre and this number is expected to grow with further exposure in the community and

increased physician acceptance. Despite wait list improvements and efforts to increase throughout in 2007/08, most hospitals delivering TJR services in the LHIN were unable to complete volumes as allocated through the wait time strategy. A major factor contributing to this underperformance was the increasing ALC pressures resulting in cancelled TJR surgeries. The LHIN is actively supporting strategies to address the ALC issue and will assess the impact of these efforts on TJR services at the end of 2008/09.

- Cataract surgery - Cataract wait times are below the provincial Priority IV benchmark of 180 days. Progress continues on track at the Regional Eye Surgery and Eye Medicine Centre in Stoney Creek which became fully operational in January 2008. The opening of this centre, a collaboration among three hospitals in HNHB LHIN, will be key to further improving cataract surgery wait times.

- Cancer surgery - HNHB LHIN has performed well in providing cancer surgery well within the provincial benchmark. At the same time, there are a few cancer surgeries that show higher wait times because of high demand or a relative shortage of particular surgical specialties. At times, HNHB LHIN experiences short term reduction in a surgical specialty due to surgeon illness or maternity leave. These occasionally cause a temporary increase in wait times.

- Cardiac Bypass Surgery - HNHB LHIN has demonstrated wait times for bypass surgery well below provincial benchmarks since the inception of the Wait Times initiative. All surgeries are performed at the Hamilton General Hospital site of Hamilton Health Sciences Corporation. Periodically, brief increases in wait times will be experienced as a result of greater numbers of more urgent cases and complex surgeries that occupy surgical suite, intensive care and ward care for longer periods of time.

<u>Non Wait Time Strategy MLAA Indicators</u>

- Median Wait Time for Long-Term Care (LTC) Placement – Wait times for LTC placement in HNHB LHIN were the third highest in the province in 2006/07 at 64 days, despite a supply of Long-Term care beds consistent with MoHLTC policy and better than in neighboring LHINs. The HNHB ALC Steering Committee and LHIN are currently investing significant effort into strategies to enable return to community after hospitalization for frail elderly patients, as well as into strategies that will result in best practices related to hospital discharge planning, and education of providers and the community regarding lifestyle choices and community supports for this population. The HNHB ALC Steering Committee reports to the LHIN quarterly on progress toward improved utilization of LTC capacity.

- Rate of Alternative Level of Care – ALC rates in HNHB LHIN have remained the highest or one of the highest in the province for some two years. Given a 60% rate of ALC to LTC designation, this rate is, in part, a reflection of LTC bed utilization and discharge planning practices, but is also a reflection of utilization of complex continuing care, rehabilitation and mental health beds for individuals who do not require this level of service, and of capacity to deliver services to individuals with significant behavioral challenges. Several strategies are being pursued, including regular rotational access to 1A crisis pilot protocol that balances community and hospital needs, three pilot projects in slow stream rehabilitation that are

successfully returning ALC to LTC patients to the community, improved discharge planning processes, strategies for reactivation of persistently idle LTC beds, and education of providers and the public regarding lifestyle choices for the aging. The high ALC rates continue to challenge hospitals surgical and emergency services and their capacity to meet targets and reduce wait times. The HNHB ALC Steering Committee reports to the LHIN quarterly on wait times, progress in strategies and ALC rates.

- Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC) – The HNHB LHIN demonstrates the fifth highest rate (2006/07) in the province for hospitalization for ambulatory care sensitive conditions. The LHIN will be completing more detailed analysis of ACSC data and sharing findings with key committees to address the need for further, organization-level evaluation and development of strategies to reduce this potential contributor to bed pressures. The Emergency Department Access Steering Committee will report quarterly to the LHIN on progress with evaluation, strategies and ACSC trends.

- Rate of Emergency Department Visits that could be Managed Elsewhere – HNHB LHIN is slightly above the provincial average for emergency department visits that could be managed elsewhere. At the sub-LHIN level, these rates are elevated only in areas served by smaller hospitals and experiencing significant shortages of family physicians. While some improvement might be expected through improved emergency department practices, family physician recruitment is likely to be critical to modifying this rate. The Emergency Department Access Steering Committee will report quarterly to the LHIN on evaluation of provider-level data, strategies to improve Ed utilization and trends in this indicator.

<u>General Issues</u>

- Availability of health human resources will continue to present a challenge in the HNHB LHIN. The following areas have been reported as pressures:
    - MRI technologists, LHIN provider's ability to recruit and retain MRI technologies is challenged by limited supply, change in educational process and competition between centres.
    - Nurses; particularly in some locales or sectors. Long-Term Care, in particular in particular, has noted the issue of competing with higher pay in hospitals and CCAC for registered nursing staff. Ministry programs that enable hiring are expected to begin to alleviate this to some degree.
    - Anaesthetists; some locales within the LHIN report constraints on surgical throughput. The Ministry has introduced a program of anaesthesia assistants that expands the reach of each anaesthetist. These programs are being considered within LHIN hospitals.
    - Primary care providers. Access to family physicians remains a significant challenge across the LHIN, which impacts continuity and potentially the quality, of care received by those without a physician. It also effects staffing in emergency departments outside of the academic health science centres (AHSCs), where family physicians are often key emergency department staff members. The implementation of new community health centres in the LHIN will alleviate some access issues at the community level.

- LHIN hospitals that have achieved a balanced position in 2008/09 will be challenged to maintain this position in the event of unexpected operating pressures (i.e. infection, increased demand for services as a result of reduced services elsewhere, costs associated with contract settlements).

- The potential risks pursuant with those hospitals that have yet to sign the H-SAA are unknown, but could impact access to services and wait times.

Adequacy of Staff Component in HNHB LHIN
The HNHB LHIN Staff experiences challenges to meet the requirements of the MLAA:

- The number of heath service providers (250+) is high relative to other LHINs and the associated work load is not supported by proportionate staffing.

- The participation rate of Staff to support emerging collaborations for integration is low given the volume of opportunity and, limited staff resources.

- Work load volume increases significantly in 2008 as the LHIN assumes responsibility for service agreements for other than hospitals.

C2 Potential impact on the IHSP Phase 1

Impact on IHSP of cost drivers, local conditions/issues, demand and supply issues, and regional health concerns, and HNHB activities (as of May 31 2008):

Children and youth health care needs are in part being addressed by the Access To Better Care directional planning at Hamilton Heath Sciences, with a view to appropriately scoping the role of the Children's Hospital for best care and support for HNHB LHIN children and youth and their families.

Access **to mental health and addiction services** is being supported through strategic planning in several LHIN communities; and is being stimulated through by the Government's foci on mental health and supportive housing improvement in the budget announcement March 2008.

Pressures in Norfolk General Hospital (NGH) have triggered 2 initiatives within IHSP priority activities: a) opportunities for strengthening community based **end of life care** to alleviate palliative care requirements on up to 4 beds at NGH, and b) facilitated discussion between NGH and St. Joseph's Health Care in Hamilton re strengthened access to **mental health** care and support for area residents.

The Aging at Home strategy is expediting opportunities to support **frail seniors'** health and independence in the community.

Regional health concerns about the appropriate supply, distribution and utilization of rehab services and complex continuing care, for **continuity of care and care plans** are being addressed through a LHIN stakeholder led strategy planning.

The Government's budget in March 2008 signalled new Province wide priorities that are being integrated with a refreshed HNHB IHSP in June 2008.

The pace of integrated communication technology (**e-Health**) across providers in the LHIN impedes timely access to patient information as people move across the continuum of care and support.

SECTION D: DETAILED PLANS TO IMPLEMENT IHSP COMMITMENTS AND PRIORITIES FOR THE LOCAL HEALTH SYSTEM

INTERIM REPORT ON HNHB IHSP PHASE 1 - APRIL 2008 (Pending IHSP Refresh June 2008)

Occupational Health Promotion and Prevention
A LHIN Occupational Health/Primary Care Working Group has conducted a review of best practices and has connected with community health centres, family heath teams and occupational health specialists across the LHIN to develop tools for the early detection of workplace risk factors and to explore systems to effectively manage and rehabilitate injured workers.
Children and Youth: Bringing best practice services closer to home
Child Health Knowledge Exchange
The new McMaster Child Health Research Institute (MCHRI) is developing a proposal for the dissemination of research and knowledge to front line providers. The proposal will shortly be available for boarder consultation.
e-CHN Electronic Child Health Network
Hamilton Health Sciences is feeding all clinical data for patients less than 19 years of age to the eCHN data system, making that data available to all eCHN member sites across Ontario. Next steps will increase utilization of the eCHN clinical record in local LHIN organizations, and to identify community hospitals that are interested in feeding their clinical data to eCHN.
Child and Youth Rehabilitation Network
The network includes children's treatment centres (4), the HNHB CCAC School Support Services, and representatives from the Ministry of Children and Youth Services. The network has examined an innovative school transition program in Niagara, shared concerns about coordination of services across the two Ministries, and hopes to look at shared data on service delivery patterns across the region. There has been preliminary discussion about preparing a Children's Rehabilitation Plan modeled on the Acute Child Health Plan.
Community Capacity: assessing and treating young people with mental health problems
Construction is underway on the inpatient mental health unit at the McMaster Children's Hospital. Much of the community capacity building has focused on the Mental Health Outreach Team at the Chedoke site. Recruitment of mental health professionals (especially child psychiatrists) continues to be challenging.

Improve access and support for persons with mental health and addictions issues

A priorities framework is underway to outline a health improvement plan building on a November 2007 LHIN wide session, complemented by stakeholder strategic planning underway in Niagara and Brant County.

Assist persons to live independently in the community

The Aging at Home strategy is expediting planning coordination and funding to close care gaps; requirements for supports in the home, integrated transportation and falls prevention improvements; and, explore opportunities to complement existing food access & information & referral services.

Ensure the right elder care and support at the right time

A directional plan is underway by the Geriatric Assessment and Integration Network (GAIN) to identify a directional plan for specialised services for frail elderly, to inform aging at Home funding options.

Provide best care and support to people who are dying: End of Life

The HNHB LHIN Hospice and Palliative Care Network is undertaking a LHIN wide system plan for end of life care, and, is being invited to work with Norfolk General Hospital (NGH) to identify ways to strengthen community based options for end of life care to promote choice and reduce reliance on inpatient services

e-Health

The HNHB LHIN has revised its e-Health strategy to focus on:

- Managing Chronic Diseases, in particular, Diabetes;
- Implementing the provincial Aging at Home strategy
- Integrating services across hospitals, CCACs and Physicians

Through reallocation process the HNHB LHIN has identified one time funds to support the following e-Health initiatives in 2008/09

- Integrated decision support strategy
- CCAC Interface to common viewer
- Community support email
- Family Health Team portal update

Hamilton Niagara Haldimand Brant LHIN
Annual Service Plan 2008 – 2009

SECTION E: ATTACHMENT A

Index	Table 1: LHIN Financial Summary ($000s - excluding inter-LHIN transfers and e-Health)	2006/07 Restated Interim Actuals [A]			2007/08 Allocation [B]			2008/09 Funding Target [C]			2008/09 Planned Expenses			2008/09 Variance			2009/10 Funding Target [D]			2009/10 Planned Expenses			2009/10 Variance			2010/11 Funding Target (flat-lined from 2009/10) [E]			2010/11 Planned Expenses			2010/11 Variance		
		GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total
1	**LHIN Operations (GRE)[1]**			3,930.7			4,474.7			4,949.0			4,949.0			0.0			4,949.0			5,262.9			313.9			4,949.0			5,512.4			563.4
2	**Operations of Hospitals - Total**	1,489,706.1		1,489,706.1	1,599,087.0		1,599,087.0	1,626,518.9		1,626,518.9	1,626,518.9	0.0	1,626,518.9	0.0	0.0	0.0	1,641,405.8		1,641,405.8	1,641,405.8	0.0	1,641,405.8	0.0	0.0	0.0	1,641,405.8		1,641,405.8	1,641,405.8	0.0	1,641,405.8	0.0	0.0	0.0
3	**Grants to Compensate for Municipal Taxation - Public Hospitals**		470.9	470.9		462.1	462.1		462.1	462.1	0.0	462.1	462.1	0.0	0.0	0.0		462.1	462.1	0.0	462.1	462.1	0.0	0.0	0.0		462.1	462.1	0.0	462.1	462.1	0.0	0.0	0.0
4	**Long-Term Care Homes**		328,897.9	328,897.9		356,860.1	356,860.1		366,177.5	366,177.5	0.0	366,177.5	366,177.5	0.0	0.0	0.0		366,177.5	366,177.5	0.0	366,177.5	366,177.5	0.0	0.0	0.0		366,177.5	366,177.5	0.0	366,177.5	366,177.5	0.0	0.0	0.0
5	**Community Care Access Centres**		208,213.4	208,213.4		203,404.5	203,404.5		209,942.1	209,942.1	0.0	209,942.1	209,942.1	0.0	0.0	0.0		218,339.8	218,339.8	0.0	218,339.8	218,339.8	0.0	0.0	0.0		229,256.8	229,256.8	0.0	229,256.8	229,256.8	0.0	0.0	0.0
6	**Community Support Services[2]**		29,844.1	29,844.1		35,241.1	35,241.1		48,970.8	48,970.8	0.0	48,970.8	48,970.8	0.0	0.0	0.0		60,843.3	60,843.3	0.0	60,843.3	60,843.3	0.0	0.0	0.0		76,209.8	76,209.8	0.0	76,209.8	76,209.8	0.0	0.0	0.0
7	**Assisted Living Services in Supportive Housing**		20,774.9	20,774.9		22,102.0	22,102.0		21,396.2	21,396.2	0.0	21,396.2	21,396.2	0.0	0.0	0.0		21,877.6	21,877.6	0.0	21,877.6	21,877.6	0.0	0.0	0.0		22,369.9	22,369.9	0.0	22,369.9	22,369.9	0.0	0.0	0.0
8	**Community Health Centres**		7,490.9	7,490.9		9,060.7	9,060.7		8,881.5	8,881.5	0.0	8,881.5	8,881.5	0.0	0.0	0.0		8,881.5	8,881.5	0.0	8,881.5	8,881.5	0.0	0.0	0.0		8,881.5	8,881.5	0.0	8,881.5	8,881.5	0.0	0.0	0.0
9	**Community Mental Health**		40,926.9	40,926.9		43,745.0	43,745.0		44,358.3	44,358.3	0.0	44,358.3	44,358.3	0.0	0.0	0.0		45,356.3	45,356.3	0.0	45,356.3	45,356.3	0.0	0.0	0.0		46,376.8	46,376.8	0.0	46,376.8	46,376.8	0.0	0.0	0.0
10	**Addictions Programs**		11,903.0	11,903.0		12,087.7	12,087.7		12,156.1	12,156.1	0.0	12,156.1	12,156.1	0.0	0.0	0.0		12,429.7	12,429.7	0.0	12,429.7	12,429.7	0.0	0.0	0.0		12,709.3	12,709.3	0.0	12,709.3	12,709.3	0.0	0.0	0.0
11	**Specialty Psychiatric Hospitals - Total**		682.2	682.2		0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
12	**Grants to Compensate for Municipal Taxation - Psychiatric Hospitals**		0.0	0.0		0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total LHIN Budget	1,489,706.1	649,204.3	2,142,841.0	1,599,087.0	682,963.2	2,286,524.9	1,626,518.9	712,344.6	2,343,812.5	1,626,518.9	712,344.6	2,343,812.5	0.0	0.0	0.0	1,641,405.8	734,367.8	2,380,722.6	1,641,405.8	734,367.8	2,381,036.5	0.0	0.0	313.9	1,641,405.8	762,443.7	2,408,798.5	1,641,405.8	762,443.7	2,409,361.9	0.0	0.0	563.4

* GRE = Government Reporting Entity

[1] Includes amounts for Wait List Management, Aging At Home, Emergency Department Lead and Aboriginal Plannin

[2] Includes amount for initiatives that have not yet been allocated to various sector

Hamilton Niagara Haldimand Brant LHIN
Annual Service Plan 2008 – 2009

SECTION E: ATTACHMENT B1

Table 2a: Proposed Program Changes (Operations of Hospitals)

Proposed Change	Financial Impact ($000's)									Short Description	Tangible Results Expected
	2008/09			2009/10			2010/11				
	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total		
Pre-Approved Funding Targets	1,626,518.9	0.0	1,626,518.9	1,641,405.8	0.0	1,641,405.8	1,641,405.8	0.0	1,641,405.8		
Program Change 1			0.0			0.0			0.0		
Program Change 2			0.0			0.0			0.0		
Program Change 3			0.0			0.0			0.0		
Program Change 4			0.0			0.0			0.0		
Program Change 5			0.0			0.0			0.0		
Sub-Total Program Changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Efficiency Gains (Pending Policy)											
Efficiency Reinvestment (Pending Policy)											
Total Planned Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		

SECTION E: ATTACHMENT B2

Table 2b: Proposed Program Changes (Municipal Taxation Grants - Public Hospitals)

Proposed Change	Financial Impact ($000's)									Short Description	Tangible Results Expected
	2008/09			2009/10			2010/11				
	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total		
Pre-Approved Funding Targets	0.0	462.1	462.1	0.0	462.1	462.1	0.0	462.1	462.1		
Program Change 1			0.0			0.0			0.0		
Program Change 2			0.0			0.0			0.0		
Program Change 3			0.0			0.0			0.0		
Program Change 4			0.0			0.0			0.0		
Program Change 5			0.0			0.0			0.0		
Sub-Total Program Changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Efficiency Gains (Pending Policy)											
Efficiency Reinvestment (Pending Policy)											
Total Planned Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		

Hamilton Niagara Haldimand Brant LHIN
Annual Service Plan 2008 – 2009

SECTION E: ATTACHMENT B3

Table 2c: Proposed Program Changes (Long-Term Care Homes)

Proposed Change	Financial Impact ($000's)									Short Description	Tangible Results Expected
	2008/09			2009/10			2010/11				
	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total		
Pre-Approved Funding Targets	0.0	366,177.5	366,177.5	0.0	366,177.5	366,177.5	0.0	366,177.5	366,177.5		
Program Change 1			0.0			0.0			0.0		
Program Change 2			0.0			0.0			0.0		
Program Change 3			0.0			0.0			0.0		
Program Change 4			0.0			0.0			0.0		
Program Change 5			0.0			0.0			0.0		
Sub-Total Program Changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Efficiency Gains (Pending Policy)											
Efficiency Reinvestment (Pending Policy)											
Total Planned Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		

SECTION E: ATTACHMENT B4

Table 2d: Proposed Program Changes (Community Care Access Centres)

Proposed Change	Financial Impact ($000's)									Short Description	Tangible Results Expected
	2008/09			2009/10			2010/11				
	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total		
Pre-Approved Funding Targets	0.0	209,942.1	209,942.1	0.0	218,339.8	218,339.8	0.0	229,256.8	229,256.8		
Program Change 1			0.0			0.0			0.0		
Program Change 2			0.0			0.0			0.0		
Program Change 3			0.0			0.0			0.0		
Program Change 4			0.0			0.0			0.0		
Program Change 5			0.0			0.0			0.0		
Sub-Total Program Changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Efficiency Gains (Pending Policy)											
Efficiency Reinvestment (Pending Policy)											
Total Planned Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		

SECTION E: ATTACHMENT B5 **Table 2e: Proposed Program Changes (Community Support Services)**

Proposed Change	Financial Impact ($000's)									Short Description	Tangible Results Expected
	2008/09			2009/10			2010/11				
	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total		
Pre-Approved Funding Targets	0.0	48,970.8	48,970.8	0.0	60,843.3	60,843.3	0.0	76,209.8	76,209.8		
Program Change 1			0.0			0.0			0.0		
Program Change 2			0.0			0.0			0.0		
Program Change 3			0.0			0.0			0.0		
Program Change 4			0.0			0.0			0.0		
Program Change 5			0.0			0.0			0.0		
Sub-Total Program Changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Efficiency Gains (Pending Policy)											
Efficiency Reinvestment (Pending Policy)											
Total Planned Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		

SECTION E: ATTACHMENT B6

Table 2f: Proposed Program Changes (Assisted Living Services in Supportive Housing)

Proposed Change	Financial Impact ($000's)									Short Description	Tangible Results Expected
	2008/09			2009/10			2010/11				
	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total		
Pre-Approved Funding Targets	0.0	21,396.2	21,396.2	0.0	21,877.6	21,877.6	0.0	22,369.9	22,369.9		
Program Change 1			0.0			0.0			0.0		
Program Change 2			0.0			0.0			0.0		
Program Change 3			0.0			0.0			0.0		
Program Change 4			0.0			0.0			0.0		
Program Change 5			0.0			0.0			0.0		
Sub-Total Program Changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Efficiency Gains (Pending Policy)											
Efficiency Reinvestment (Pending Policy)											
Total Planned Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		

SECTION E: ATTACHMENT B7

Table 2g: Proposed Program Changes (Community Health Centres)

Proposed Change	Financial Impact ($000's)									Short Description	Tangible Results Expected
	2008/09			2009/10			2010/11				
	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total		
Pre-Approved Funding Targets	0.0	8,881.5	8,881.5	0.0	8,881.5	8,881.5	0.0	8,881.5	8,881.5		
Program Change 1			0.0			0.0			0.0		
Program Change 2			0.0			0.0			0.0		
Program Change 3			0.0			0.0			0.0		
Program Change 4			0.0			0.0			0.0		
Program Change 5			0.0			0.0			0.0		
Sub-Total Program Changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Efficiency Gains (Pending Policy)											
Efficiency Reinvestment (Pending Policy)											
Total Planned Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		

SECTION E: ATTACHMENT B8

Table 2h: Proposed Program Changes (Community Mental Health)

Proposed Change	Financial Impact ($000's)									Short Description	Tangible Results Expected
	2008/09			2009/10			2010/11				
	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total		
Pre-Approved Funding Targets	0.0	44,358.3	44,358.3	0.0	45,356.3	45,356.3	0.0	46,376.8	46,376.8		
Program Change 1			0.0			0.0			0.0		
Program Change 2			0.0			0.0			0.0		
Program Change 3			0.0			0.0			0.0		
Program Change 4			0.0			0.0			0.0		
Program Change 5			0.0			0.0			0.0		
Sub-Total Program Changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Efficiency Gains (Pending Policy)											
Efficiency Reinvestment (Pending Policy)											
Total Planned Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		

SECTION E: ATTACHMENT B9

Table 2i: Proposed Program Changes (Addictions Program)

Proposed Change	Financial Impact ($000's)									Short Description	Tangible Results Expected
	2008/09			2009/10			2010/11				
	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total		
Pre-Approved Funding Targets	0.0	12,156.1	12,156.1	0.0	12,429.7	12,429.7	0.0	12,709.3	12,709.3		
Program Change 1			0.0			0.0			0.0		
Program Change 2			0.0			0.0			0.0		
Program Change 3			0.0			0.0			0.0		
Program Change 4			0.0			0.0			0.0		
Program Change 5			0.0			0.0			0.0		
Sub-Total Program Changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Efficiency Gains (Pending Policy)											
Efficiency Reinvestment (Pending Policy)											
Total Planned Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		

SECTION E: ATTACHMENT B10

Table 2j: Proposed Program Changes (Specialty Psychiatric Hospitals)

Proposed Change	Financial Impact ($000's)									Short Description	Tangible Results Expected
	2008/09			2009/10			2010/11				
	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total		
Pre-Approved Funding Targets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Program Change 1			0.0			0.0			0.0		
Program Change 2			0.0			0.0			0.0		
Program Change 3			0.0			0.0			0.0		
Program Change 4			0.0			0.0			0.0		
Program Change 5			0.0			0.0			0.0		
Sub-Total Program Changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Efficiency Gains (Pending Policy)											
Efficiency Reinvestment (Pending Policy)											
Total Planned Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		

SECTION E: ATTACHMENT B11

Table 2k: Proposed Program Changes (Municipal Taxation Grants - Specialty Psychiatric Hospitals)

Proposed Change	Financial Impact ($000's)									Short Description	Tangible Results Expected
	2008/09			2009/10			2010/11				
	GRE	Non-GRE	Total	GRE	Non-GRE	Total	GRE	Non-GRE	Total		
Pre-Approved Funding Targets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Program Change 1			0.0			0.0			0.0		
Program Change 2			0.0			0.0			0.0		
Program Change 3			0.0			0.0			0.0		
Program Change 4			0.0			0.0			0.0		
Program Change 5			0.0			0.0			0.0		
Sub-Total Program Changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Efficiency Gains (Pending Policy)											
Efficiency Reinvestment (Pending Policy)											
Total Planned Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		

SECTION E: ATTACHMENT B12

Table 2l: eHealth Financial Summary ($000s)

eHealth (000s)	2006/07 Actuals [A]	2007/08 Allocation [B]	2008/09 Planned Expenses [C]	2009/10 Planned Expenses [D]	2010/11 Planned Expenses [E]
LHIN Operations*	0.0	275.0	120.0	TBD	TBD
Operations of Hospitals - Total	0.0	0.0			
Grants to Compensate for Municipal Taxation - Public Hospitals	0.0	0.0			
Long-Term Care Homes	0.0	0.0			
Community Care Access Centres	0.0	0.0			
Community Support Services	0.0	0.0			
Assisted Living Services in Supportive Housing	0.0	0.0			
Community Health Centres	0.0	0.0			
Community Mental Health	0.0	0.0			
Addictions Programs	0.0	0.0			
Specialty Psychiatric Hospitals - Total	0.0	0.0			
Grants to Compensate for Municipal Taxation - Psychiatric Hospitals	0.0	0.0			
Total LHIN Budget	0.0	275.0	120.0	0.0	0.0

* One-Time Funding Only will not be part of LHIN operations but transferred to HSPs (sector breakdown unknown at this time)
** Capital funding requirement $20 million in each of the three years

SECTION E: ATTACHMENT F

Table 5a: 2008-09 Inter-LHIN Transfers ($000s)

	Erie St. Clair		South West		Waterloo Wellington		Hamilton Niagara Haldimand Brant		Central West		Mississauga Halton		Toronto Central		Central		Central East		South East		Champlain		North Simcoe Muskoka		North East		North West		Total	
	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE
LHIN Operations																													0.0	0.0
Operations of Hospitals - Total																													0.0	0.0
Grants to Compensate for Municipal Taxation - Public Hospitals																													0.0	0.0
Long-Term Care Homes																													0.0	0.0
Community Care Access Centres																													0.0	0.0
Community Support Services																													0.0	0.0
Assisted Living Services in Supportive Housing																													0.0	0.0
Community Health Centres																													0.0	0.0
Community Mental Health																													0.0	0.0
Addictions Programs																													0.0	0.0
Specialty Psychiatric Hospitals - Total																													0.0	0.0
Grants to Compensate for Municipal Taxation - Psychiatric Hospitals																													0.0	0.0
Total to be Transferred	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Table 5a: 2009-10 Inter-LHIN Transfers ($000s)

	Erie St. Clair		South West		Waterloo Wellington		Hamilton Niagara Haldimand Brant		Central West		Mississauga Halton		Toronto Central		Central		Central East		South East		Champlain		North Simcoe Muskoka		North East		North West		Total	
	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE
LHIN Operations																													0.0	0.0
Operations of Hospitals - Total																													0.0	0.0
Grants to Compensate for Municipal Taxation - Public Hospitals																													0.0	0.0
Long-Term Care Homes																													0.0	0.0
Community Care Access Centres																													0.0	0.0
Community Support Services																													0.0	0.0
Assisted Living Services in Supportive Housing																													0.0	0.0
Community Health Centres																													0.0	0.0
Community Mental Health																													0.0	0.0
Addictions Programs																													0.0	0.0
Specialty Psychiatric Hospitals - Total																													0.0	0.0
Grants to Compensate for Municipal Taxation - Psychiatric Hospitals																													0.0	0.0
Total to be Transferred	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Table 5a: 2010-11 Inter-LHIN Transfers ($000s)

	Erie St. Clair		South West		Waterloo Wellington		Hamilton Niagara Haldimand Brant		Central West		Mississauga Halton		Toronto Central		Central		Central East		South East		Champlain		North Simcoe Muskoka		North East		North West		Total	
	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE	GRE	Non-GRE
LHIN Operations																													0.0	0.0
Operations of Hospitals - Total																													0.0	0.0
Grants to Compensate for Municipal Taxation - Public Hospitals																													0.0	0.0
Long-Term Care Homes																													0.0	0.0
Community Care Access Centres																													0.0	0.0
Community Support Services																													0.0	0.0
Assisted Living Services in Supportive Housing																													0.0	0.0
Community Health Centres																													0.0	0.0
Community Mental Health																													0.0	0.0
Addictions Programs																													0.0	0.0
Specialty Psychiatric Hospitals - Total																													0.0	0.0
Grants to Compensate for Municipal Taxation - Psychiatric Hospitals																													0.0	0.0
Total to be Transferred	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Hamilton Niagara Haldimand Brant LHIN
Annual Service Plan 2008 – 2009

SECTION F: ATTACHMENT D

Table 5: LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2006/07 Actuals	2007/08 Allocation	2008/09 Planned Expenses	2009/10 Planned Expenses	2010/11 Planned Expenses
Salaries and Wages	**1,229,230**	**2,402,966**	**2,810,142**	**2,978,751**	**3,157,476**
Employee Benefits					
HOOPP	68,532	191,145	227,622	241,279	255,756
Other Benefits	124,019	409,596	382,734	405,698	430,040
Total Employee Benefits	***192,551***	***600,741***	***610,356***	***646,977***	***685,796***
Transportation and Communication					
Staff Travel	56,415	56,250	61,000	62,220	63,464
Governance Travel	23,571	18,750	22,000	22,440	22,889
Communications		19,676	60,000	61,200	62,424
Other			7,000	7,140	7,283
Total Transportation and Communication	***79,986***	***94,676***	***150,000***	***153,000***	***156,060***
Services					
Accomodation	267,850	145,344	199,441	282,269	287,915
Advertising				-	-
Banking	673		-	-	-
Community Engagement	305,944	-	-	-	-
Consulting Fees	718,191		188,000	191,760	195,595
Equipment Rentals				-	-
Governance Per Diems	148,926	125,000	195,494	199,404	203,392
Insurance		16,038	15,967	16,286	16,612
LSSO Shared Costs	290,201	300,000	300,000	306,000	312,120
Other Meeting Expenses			127,000	129,540	132,131
Other Governance Costs				-	-
Printing & Translation				-	-
Staff Development				-	-
Total Services	***1,731,785***	***586,382***	***1,025,902***	***1,125,260***	***1,147,765***
Supplies and Equipment					
IT Equipment				-	-
Office Supplies & Purchased Equipment	425,068	343,655	315,100	321,402	327,830
Total Supplies and Equipment	***425,068***	***343,655***	***315,100***	***321,402***	***327,830***
Capital Assets Purchased	**145,561**			**-**	**-**
LHIN Operations: Total Planned Expense	**3,804,181**	**4,028,420**	**4,911,500**	**5,225,390**	**5,474,926**
Annual Funding Target			4,911,500	4,911,500	4,911,500
Variance			-	- 313,890	- 563,426

Hamilton Niagara Haldimand Brant LHIN
Annual Service Plan 2008 – 2009

SECTION F: ATTACHMENT E

Table 6: LHIN Staffing Plan

	2006/07 Actuals as of March 31	2007/08 Forecast	2008/09 Plan	2009/10 Plan	2010/11 Plan
Position Title					
CEO	1	1	1	1	1
Senior Director	2	2	2	2	2
Senior Consultant	3	4	4	4	4
Business Support Manager	1	1	1	1	1
Corporate Coordinator	1	1	1	1	1
Executive Assistant	1	1	1	1	1
Administrative Assistant	1	1	1	1	1
Program Assistant	2	2	2	2	2
Receptionist	1	1	1	1	1
Office Assistant		1	1	1	1
Decision Support Consultant	1	1	1	1	1
Funding & Allocation Consultant	2	2	3	3	3
Controller/F & A Consultant		1	1	1	1
Community Engagement Consultant	2	2	2	2	2
Performance & Integration Consultant	1	1	1	1	1
Performance & Contract Mgnt Consultant		2	2	2	2
Planning & Integration Consultant		2	3	3	3
Planner	1	3	1	1	1
CE/Planning Support			1	1	1
Number of FTE	20	29	30	30	30

SECTION H: COMMUNICATION PLAN

The Communication Plan describes the methods the LHIN will use to release the post-budget, Ministry approved Annual Service Plan (ASP) including its funding and allocation details. Guidelines will be provided by the Ministry for LHIN communication staff to consider regarding press releases, funding announcements, etc., related to the ASP.

Objective:
To demonstrate the HNHB LHIN's responsiveness to community needs.

To communicate the HNHB LHIN"s transformation activities and initiatives to stakeholders and the broader community.

Audiences:
There are primary and secondary audiences to be considered.

Primary Audience: Broader health sector including health services providers (HSPs) and hospitals; media outlets

Secondary Audience: Communities of Hamilton, Niagara, Haldimand, Brant, Norfolk and Burlington including elected officials (MPPs, Mayors and Regional Chairs)

Messaging:
The Annual Service Plan will assist the public in understanding how the HNHB LHIN is planning to address the needs of its community.

The Annual Service Plan is based on numerous discussions the HNHB LHIN has had with members of the public, health service providers, and stakeholders.

Strategy:
Highlight the focus of the Annual Service Plan and any special considerations required in meeting the identified needs of the LHIN as well as health service providers and community stakeholders.

Tactics:
Many province-wide tactics will need to be coordinated between all LHINs and the MOHLTC to ensure same day release across LHINs (release date to be confirmed).

As per MOHLTC direction to date: No direction or information has been provided.

"Day of" Morning:
The HNHB LHIN will notify its health service providers and community stakeholder groups via email distribution. The email will notify them of the Annual Service Plan release and provide a link to the document on the HNHB LHIN website.

"Day of" Afternoon:
The HNHB LHIN will post the Annual Service Plan to the website.

The HNHB LHIN will issue a media release. The media release template will be provided by MOHLTC's LHIN Communications Team.

Followup:
- HNHB LHIN hosted community meetings with health service providers and community stakeholder groups
- Article in LHINsight (HNHB LHIN newsletter)
- Matte article provided to health service providers and hospitals for inclusion in their newsletters
- Editorial Board meetings to discuss
- Fact Sheet development
- Inservice session with HNHB LHIN staff

Timetable
To be confirmed based on timing from MOHLTC

End Notes

[i] Body mass index (BMI) for youth is different from that of adults as they are still maturing. A youth BMI of at least 25 indicates overweight and a BMI of 30, obese. Source: Statistics Canada, Canadian Community Health Survey 2005.
[ii] Body Mass Index (BMI) is a method of classifying body weight according to health risk. BMI is calculated as follows: weight in kilograms divided by height in meters squared. The adult population (aged 18+) with a BMI of between 25-29 is considered overweight and those with a BMI of 30 or more, obese. Source: Statistics Canada, Canadian Community Health Survey 2005.
[iii] Q3, 2007 Report on ALC days and rates, HNHB LHIN WTIS reports.
[iv] Population Counts, 2006 Census, Statistics Canada.
[v] 2006 Census, Statistics Canada.
[vi] Source: Settlement and Integration Services Organization (SISO) Hamilton.
[vii] 2006 Census, Statistics Canada.
[viii] Population aged 12 and over who reported being a current smoker (daily or occasional). Source: Statistics Canada, Canadian Community Health Survey 2005.
[ix] Population aged 12 and over, who consume fruits and vegetables 5 or less times/day. Source: Statistics Canada, Canadian Community Health Survey 2005.
[x] Population aged 12 and over reporting leisure-time as physically inactive. Source: Statistics Canada, Canadian Community Health Survey 2005.
[xi] Life expectancy is the number of years a person would be expected to live, starting from birth (for life expectancy at birth) and similarly for other age groups, on the basis of the mortality statistics for a given observation period. Source: Statistics Canada, Vital Statistics, Death Database, and Demography Division (population estimates)

[xii] Age-standardized rate of death from all causes per 100,000 population. Source: Statistics Canada, Vital Statistics, Death Database, and Demography Division (population estimates)

[xiii] Statistics Canada, Vital Statistics, Death Database, and Demography Division (population estimates); Population Health Profile: Hamilton Niagara Haldimand Brant LHIN, Health System Intelligence Project, 2005.

[xiv] Infants who die in the first year of life, expressed as a count and a rate per 1,000 live births. Source: Statistics Canada, Vital Statistics, Birth and Death Databases

[xv] Final Report of the Maternal Newborn Steering Committee, HNHB LHIN, September 2007.

[xvi] HNHB LHIN hospital reports to the LHIN.

[xvii] Source: Average number of beds staffed and in operation as of December, 2007, Daily Census.

[xviii] Physician counts include all active general practitioners and family practitioners as of December 31 of 2004. The data include physicians in clinical and non-clinical practice and exclude residents and physicians who are not licensed to provide clinical practice and have requested that their information not be published in the Canadian Medical Directory. Source: Canadian Institute for Health Information, Scott's Medical Database.

[xix] Communities across the province may be designated for General/Family Practitioners (GP/FPs) if they are experiencing a severe shortage of physicians. Designation of communities as Underserviced is an ongoing self-assessment process, wherein communities identify themselves to the ministry as being in need of recruitment and retention assistance. The UAP designates communities as Underserviced when specific criteria are met. Factors considered include :health care professional data (how many serve the community), population and physician-to-population ratios, previous recruitment efforts, local demand for services, additional health service needs and resources, support of local health care professionals, etc. Health professionals relocating to Underserviced areas may be eligible for financial incentives and practice supports. Source: Ontario Ministry of Health and Long-Term Care.

[xx] HNHB LHIN Hospice and Palliative Care Network

[xxi] Source: Utilization of Hospital-based Ambulatory Care in Ontario LHINs, Health System Intelligence Project, March 2007.

[xxii] Source: Health System Intelligence Project.

[xxiii] Source: Health System Intelligence Project.

[xxiv] Source: Health System Intelligence Project.

[xxv] Source: Health System Intelligence Project.

[xxvi] Source: Population Health Planning Database.

[xxvii] Source: Population Health Planning Database.