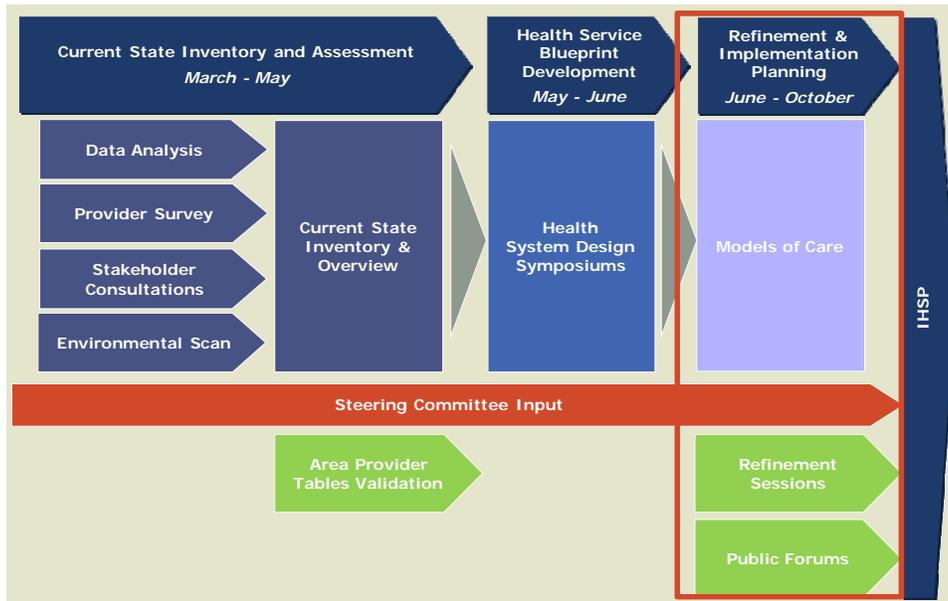


Appendix C

Project Scope & Overview of the Approach

Project Scope & Overview of the Approach

The project approach was intended to create and execute a Blueprint development process that integrated a significant level of stakeholder engagement, iterative development cycles, was based on the “best available” data/information, and integrated insights of leading practices.



Key activities have been included below.

- The project began with assessing the LHIN's current service utilization patterns and projecting the overall future service needs. Consultations with over 150 key cross-sectoral and cross-ministerial stakeholders (e.g. existing task forces and coalitions, clinical leaders, community and academic leaders) helped develop a well-rounded profile balanced with data and qualitative findings.
- This current state assessment complemented a cross-jurisdictional review of peer models of care to provide context into service delivery elements that should be incorporated into the development of future models of care. This enabled the Health System Design (HSD) Steering Committee to understand the service gaps and set the stage for the next phase in developing a future state health services Blueprint.
- The LHIN held two health system design symposiums over two days, with 400+ participants, which orchestrated the planning of future models of care for eight health program areas. Building on the work of Priority Action Teams where available and informed by service utilization profiles and peer models of care research, participants were facilitated to work through a model of care framework to discuss, develop, and gain consensus on the components comprising a future model of care. Models of care were developed for Mental Health and Addictions, Long-Term Care Services and Complex Continuing Care, Chronic Disease Prevention and Management, Women's Health and Paediatrics, Emergency Services, Surgical Services, Medicine Services, and Critical Care Services.

- The models of care were then refined and enhanced through the facilitation of 12 refinement sessions with existing and ad-hoc task forces. This enabled concentrated clinical input and pivotal cross-sectoral conversations on the integrated approach to delivering these models of care.
- An order of magnitude analysis was conducted to better understand the implications of the future models of care on today's service delivery models. Base-case future state projections were adjusted with future health system planning assumptions to better understand the realities of capacity, HHR, and infrastructure implications to year 2022.
- 17 community sessions were held to engage the public on the Blueprint and IHSP.
- Based upon input from various forums of stakeholder engagement, the LHIN and HSD Steering Committee developed a future health system with two service delivery approaches for the South West LHIN community based upon common underpinnings of the models of care.
- This approach helped derive the implementation elements required to operationalize the health services Blueprint to inform the development of the 2010-2013 IHSP.

Further details regarding the specific methodologies and assumptions applied throughout this process are described in the remainder of this appendix.

Current State Analysis

Quantitative/qualitative data analysis was undertaken to reveal the following findings:

- Cross-sectoral utilization profiles by geographic cluster;
- Population profiles by geographic cluster;
- Indicators by health program;
- Inventory of LHIN-funded services;
- Current state utilization profiles;
- Identification of gaps and duplication; and
- Blueprint implications.

Various data sources were leveraged to collect the relevant information (e.g. CIHI). These sources provided utilization metrics and a deeper understanding of how the various providers deliver services, identifying strengths and challenges to be considered for planning purposes.

When considering the South West LHIN population, it was important to acknowledge the impact of all health services, LHIN and non-LHIN funded. The Blueprint focused on assessing LHIN-funded services, while acknowledging non-LHIN funded services where appropriate. The Blueprint serves to integrate services beyond those that are LHIN-funded, including services across primary care, public health, and broader social service providers. For example, while the LHIN is not directly responsible for physicians and family health teams, it is responsible for some community health centres which provide that service. Thus, through partnerships, the LHIN can influence change in this sector which is highlighted later in the report.

Health Services Blueprint Survey

As data is collected in numerous databases, including LHIN-wide templates (i.e. Community Annual Planning Submissions) and provider-specific systems, provider survey templates for hospitals, community and long-term care organizations were created to provide specific information that complements that of existing data sources.

This provided a method for health service providers to contribute qualitative concerns into the Blueprint planning process. Both thehealthline.ca and ConnexOntario were leveraged to avoid duplication and ensure that the output would be of on-going value.

Additional data sources that were utilized

As the Blueprint project spans all LHIN-funded and select non-LHIN funded providers, a variety of quantitative data repositories were leveraged for data input. It also included the review of current LHIN documents (e.g. Priority Action Team Reports) which served as a stepping stone for certain health programs. The visual below provides a complete look as to the data sources used to create the current state report.

Health Data	Population Data	Qualitative Information Sources
<p>Community Data</p> <ul style="list-style-type: none"> South West CCAC data submitted: <ul style="list-style-type: none"> Programmatic breakdown in alignment with blueprint model was not available, thus aggregate data by resident county for South West CCAC has been included Fiscal Year 07-08 actuals in CAPs 09-11 <p>Long-Term Care</p> <ul style="list-style-type: none"> Long-Term Care Home System Report January 2009 South West LHIN Long-term Care Beds Inventory South West CCAC data on waitlists and inappropriate admissions <p>Hospital Data</p> <ul style="list-style-type: none"> Hospital Annual Planning submissions 2007/08 Intellihealth 2005/06 – 2007/08 Courtyard Group – Emergency Department Analytics <p>Physician Data</p> <ul style="list-style-type: none"> OPHRDC Active Physician Registry 2007 	<p>Current and Historical Populations:</p> <ul style="list-style-type: none"> Statistics Canada – Census: 1996, 2001 and 2006 <p>Population Estimates & Projections</p> <ul style="list-style-type: none"> Intellihealth May 2008 <p>Canadian Community Health Survey 2007</p>	<ul style="list-style-type: none"> Consultation themes from interviews & focus groups CCC/Rehabilitation Strategic Resources Report March 2009 Critical Care Strategy for LHIN 2 Regional Chronic Disease System Model Priority Action Team Reports Community Annual Planning submissions 2009/10, 2010/2011 Hospital Annual Planning submissions 2008/09, 2009/2010 South West CCAC Fact Sheet FY 2007-08 Health Services Blueprint Surveys

In order to ensure that data was directionally correct, a series of validation sessions were conducted with appropriate groups of representatives to vet and confirm the baseline data. This included LHIN Area Provider Tables, the LHIN team, and the HSD Steering Committee.

Stakeholder Engagement

A series of consultations were conducted with over 150 stakeholders through 45+ consultations to provide context to the data and enable a means to collect provider direction for the Blueprint process. The HSD Steering Committee helped identify the appropriate interviewees/focus groups.

These sessions provided insight into the provider’s strategic priorities, programs and services in need of change, innovative models of concepts in care delivery, key issues, strengths to be leveraged in the future and drivers for change.

The collection of this information drove the creation of the current state report and current state inventory by health program. The inventory provides a collection of services including the information below:

- Services available, services delivered and by whom;
- Capacity metrics;
- Identified catchment area; and
- Qualitative findings.

Cross-jurisdictional Scan of Peer Models of Care

The current state assessment was complemented with a cross-jurisdictional review of the models of care to provide context into service delivery elements that should be incorporated into the development of future models of care.

This cross-jurisdictional review was conducted by health programs and provided to the health system design symposium participants in efforts to prepare individuals for in-depth discussion on developing future models of care.

The review involved leveraging existing Deloitte health repositories and peer-reviewed literature.

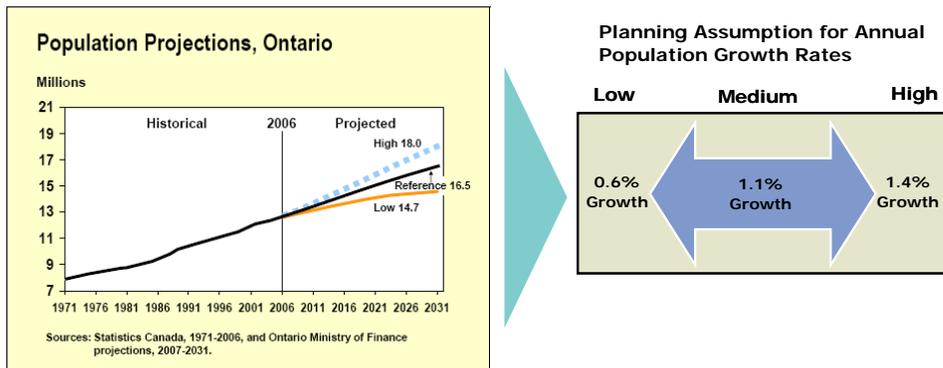
Future State Projections Methodology

In order to gain a better understanding of the future implications of the current service delivery model, an analysis of future projections for the health system into year 2022 was conducted to provide directional insight. In assessing the issues into the future, service implications were projected across community, acute, and long-term care sectors by health programs. The following assumptions and methodologies enabled better understanding of future state implications:

Population projections

South West LHIN population growth data are based on Ministry of Finance projections and planning assumptions for the purpose of health care planning.

MOF Population Projections and Annual Growth Rates for Projection Analysis



Average Acute Length of Stay

In planning for future health care services, it is difficult to determine the clinical practice changes, technological innovations or policy decisions that will change how services are used in the future. It was determined, in collaboration with the HSD Steering Committee, that the impact of these factors could be summarized at a high level through the historical change in the ALOS for acute inpatients in hospital beds. Historically, clinical practice changes, technology innovations or policy decisions, have resulted in changes to inpatient admissions, increased availability and shift to outpatient services. For this planning analysis, these and other changes were assumed to continue into the future.

From 1995-96 to 2004-05 fiscal years, Ontario has observed a 3% decline in ALOS, equivalent to an annual decline of 0.33%, as depicted in the table below. Assuming that this macro trend of a reduction in ALOS and other factors will continue, it was agreed with the HSD Steering Committee to assume an annual decline in ALOS of 0.33% for the planning analysis of health care needs.

Historical Trend in Ontario ALOS, 1995-96 to 2004-05

Province	1995-96 Ontario Province-Wide ALOS	2004-05 Ontario Province-Wide ALOS	% Change from 1995-96 to 2004-05	Planning Assumption for Annual Decline in ALOS
Ontario	6.6 Days	6.4 Days	3.0%	% Annual Change in ALOS from 1995-96 to 2004-05 0.33%

Source: CIHI - Hospital Morbidity Database: Inpatient Hospitalizations and Average Length of Stay Trends in Canada, November 2005

Average Occupancy Rates

Planning for hospital services typically assumes that most designated beds will not have 100% patient occupancy throughout the duration of the calendar years, due to average turnover within patient units and a need for flexibility to respond to emergencies, and other factors. As a result, average targeted occupancy was used to understand future capacity requirements. Although each hospital negotiates their own rate, and there were annual fluctuations, the following are considered to be averages over the year. The table on the right outlines these average annual bed occupancies by service area, and in several cases, a range of rates were applied for comparison purposes as requested by the HSD Steering Committee.

Area	Planning Occupancy Rates
General Medicine	85%
General Surgery	90%
ICU	80%
CCU	80%
ICU/CCU Combined	80%
Obstetrics (LDRP)	75%
NICU/SCU	70%
Paediatrics	70%
Mental Health	90%
Specialized Geriatrics	90%
Rehabilitation	90%
Palliative Care	90%

These suggested occupancy rates have been previously utilized by other LHINs and were validated through the MOHLTC.

Projection methodology for long-term care, complex continuing care, and rehabilitation beds

As utilization data characteristics available for LTC, complex continuing care and rehabilitation services differ from acute hospital services, the HSD Steering Committee considered several methodologies for projecting the South West LHIN’s capacity needs in these areas to inform future planning. Where appropriate, the following methodologies were utilized to provide potential service volumes for LHIN residents:

- MOHLTC Health Services Restructuring Commission (HSRC) Population Planning Ratio
- High-level, age-cohort growth rates by geographic cluster or LHIN

A number of assumptions were developed to ensure that future relevant population requirements will be appropriately represented, including the use of HSRC planning targets, which are outlined below:

Projected Bed Methodologies	
LTC	HSRC planning targets = 99.1 beds per 1000 (75+ years cohort)
CCC	HSRC planning targets = 7.62 beds per 1000 (75+ years cohort)
Rehabilitation	Utilize HSRC planning targets = 0.25 beds per 1000 (20+ years cohort)

Per the request of the HSD Steering Committee, long-term care capacity has been projected using two methodologies, HSRC as mentioned above and the Local Area Planning (LAP) Report analysis. The process considers not only patients waitlisted for LTC placement but also, identifies current LTC home clients whose needs could be met by community-based LTC services.

Projections of community services

Projected Community Service Methodology	
Growth rates	<ul style="list-style-type: none"> • Where services or individuals served are reported for all 3 geographic clusters, average regional growth rates were applied • For SWCCAC-facilitated services, average LHIN-wide growth rates were used, as services were delivered throughout the LHIN • The workload measures used include: <ul style="list-style-type: none"> Visits (face-to-face or telephone) Attendance Days (the number of days the organization provided to a client, where 1 or multiple encounters occur during a calendar day, depending on the client needs) Individuals Served (refers to the unique number of individuals served in the service/program) Hours of Care Number of Group Sessions
Population	<ul style="list-style-type: none"> • Where appropriate, specific age-cohort growth rates were applied to determine targeted services e.g. utilized 75+ growth rates for a Primary Care Psycho-geriatrics program

Community Annual Planning Submissions (CAPS) track budgeting for LHIN-funded community delivered health services. In order to understand implications for the future, we used population-based growth rates to project these services for relevant age cohorts as depicted below.

It is important to note the following considerations when reviewing this data:

- While services are aligned to a specific health program, they may span multiple health programs

- Due to the variability among organizations’ CAPS submissions, only a select number of community services were highlighted where there appears to be consistent capture of workload data for that particular program. Therefore, where it appears only a proportion of organizations submitted data on a defined community program, they were not included in these projections.

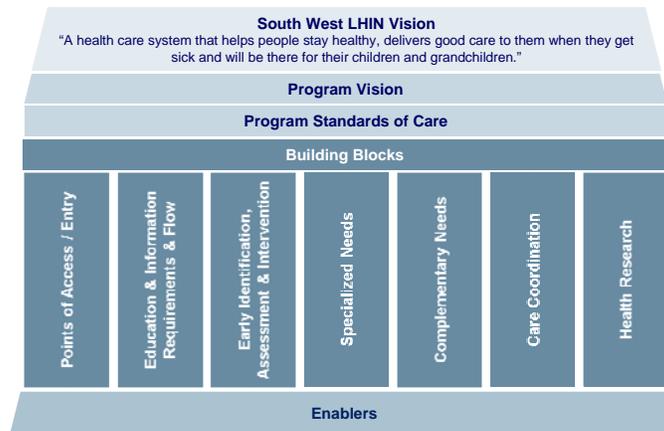
Overall, these population-based growth projections served as directional insight, complete with qualitative findings to provide a balanced interpretation.

In order to move forward with future system design planning, the HSD Steering Committee agreed to combine services under eight health programmatic buckets: Mental Health and Addictions, Long Term Care Services and Complex Continuing Care, Chronic Disease Prevention and Management, Women’s Health and Paediatrics, Emergency Services, Surgical Services, Medicine Services and Critical Care Services.

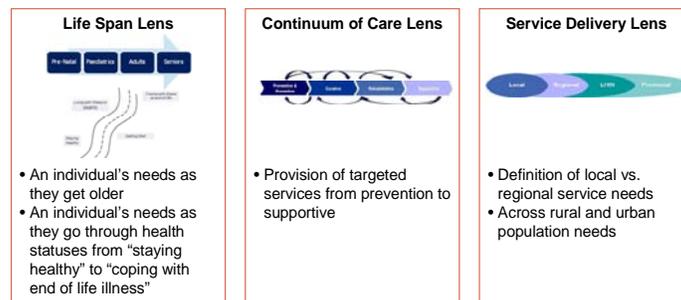
Going forward, analysis was presented through these health program areas.

Model of Care Framework

The South West LHIN held two, 2-day symposiums which brought together cross-sectoral and cross-ministerial health professionals, provider leadership and partner leadership to embark on the development of future models of care by health programs. Participants were informed of current state information, leading practice models, and findings from PAT reports to enable rich discussion on the key issues and concerns impacting health programs today. The participants were then facilitated to work through the following framework to discuss, develop, and gain consensus on the components comprising a future model of care.



Each group of participants was then tasked with validating the models of care against the three lenses below.



The lenses were used to test the models of care against realistic scenarios.

These models of care were then enhanced through facilitated refinement sessions with subject matter experts (SMEs) and relevant stakeholders. Refinement sessions were held for each model of care to refine the model so that it:

- Captures the issues with today's service delivery and needs of the future;
- Includes innovative concepts from leading practice scan and SME input;
- Reflects directional service delivery configuration; and
- Considers implications on HHR, e-health, funding, legislation, and governance.

In addition, the South West LHIN, in partnership with the Ontario Medical Association and Ontario College of Family Physicians, hosted and facilitated four refinement sessions throughout the LHIN in order to further engage physicians in dialogue regarding the current issues and future models of care. Physician attendees reviewed specific models of care and shared their perspective on the implications to current practice. They also discussed key implementation activities and physician engagement strategies.

Additionally, the Health Professional Advisory Council was engaged to review the impacts of the models of care on inter-professional resources.

Overall, this approach yielded models of care for the eight health programs.

Order of magnitude methodology

In order to better understand the implications of the models of care on today's service delivery models, the future state projections were adjusted to reveal the realities of capacity, HHR, and infrastructure needs to year 2022.

Assumptions were applied to each health program to better understand the order of magnitude on the current South West LHIN health system.

The assumptions and findings derived from this analysis are presented in the Appendix H.

These findings, along with the future models of care, helped derive the implementation elements required to operationalize the health services Blueprint.

Service Delivery Approaches

The models of care are built upon overlapping elements which are common across many health programs. These common service delivery elements are due to the reliance on overlapping providers, population catchment, and philosophy to care. Based upon these similarities, the models of care formed an Integrated Health System of Care.

This future health system collectively covers all the health programs and LHIN-wide enablers. It is delivered to the South West LHIN residents through two service delivery approaches, Population-based Integrated Health Services and Centrally Coordinated Resource Capacity.

Implementation Planning

The aforementioned approaches and methodologies guided the development of an implementation roadmap comprised of elements that are needed to operationalize the Integrated Health System of Care. These elements underwent preliminary sequencing which

involved alignment to current on-going initiatives and placement by logical order. The elements were sequenced to start within Years 1-3 and Post Year 3. Elements within Years 1-3 have been captured in the IHSP 2010-2013.

The technical appendices provide further detail on the findings that resulted from the detailed project approach and methodologies.