

2010-2012

# HOSPITAL ACCOUNTABILITY PLANNING SUBMISSION (HAPS) GUIDELINES

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## EXECUTIVE SUMMARY

The 2010-2012 Hospital Accountability Planning Submission (HAPS) Guidelines were developed with the intention of describing how hospitals and Local Health Integration Networks (LHINs) will work to:

***“Ensure high quality, safe, accessible and sustainable hospital services within the resources available”.***

The HAPS Guidelines are designed to increase the clarity of expectations between the hospitals and the LHINs, to support consistency across the province wherever appropriate and to ensure that information requested will add value to the submission. Hospitals and LHINs will work together to ensure that there are no surprises for anyone upon submission of a HAPS.

### What is different for 2010-2012?

There are a number of differences in the 2010-2012 HAPS from prior versions of the guidelines. The key differences are listed below:

- Name change from “annual” to “accountability” planning submission, but still HAPS.
- Focus on the resources (financial, human and physical) available over the next two years in consideration of the population health needs over the longer term.
- Retirement of the “Seven Steps” decision making framework and the introduction of a “Making Choices” framework.
- Emphasis on engagement among hospitals and with other health service providers.

## 1. Introduction

The Hospital Accountability Planning Submission (HAPS) Guidelines are to be used by hospitals for the development of detailed operating plans to inform the 2010/11-2011/12 Hospital Service Accountability Agreement (H-SAA).

It is the intent of the H-SAA Steering Committee to develop, if possible, a H-SAA that will incorporate all hospital and community services operated by hospitals. The HAPS Guidelines are written in anticipation of a single service accountability agreement for all services run by a hospital with the exception of Long Term Care (LTC) home beds.

### 1.1. Purpose of the HAPS

The purpose or overarching strategy of the guidelines is to encourage the design and delivery of hospital services that ensure the provision of high quality, safe, accessible and sustainable hospital care within the resources available. In keeping with the definitions articulated by the Ontario Health Quality Council (OHQC):

- *High quality* means accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated and focused on population health.
- *Safe* means people should not be harmed by the care that is intended to help them.
- *Accessible* means patients in need should get appropriate care in the most appropriate setting.

A *sustainable* system means that an excellent system of care, informed by population need, can be maintained into the future within the financial, human and physical resources available.

The HAPS will focus on the period 2010/11 through 2011/12. However, hospitals should be mindful that changes necessary to ensure long term, sustainable, quality care are a multi-year and continuous process.

### 1.2. Context for Planning

In the current environment, a number of challenges exist that need to be considered in the context of planning:

- Increasing patient demands/expectations/knowledge;
- Continuing, significant increases in the cost of providing hospital services;

- Limited opportunities to achieve further efficiencies in current hospital operations; and
- Severe pressure on the availability of government financial resources.

### 1.3. Roles and Responsibilities within the Health System

Hospitals are a large and critical component of the broader health care system which includes community providers, LTC homes, physicians, laboratory and pharmacy services, other health professionals, the Local Health Integration Networks (LHINs), the Ministry of Health and Long Term Care (MOHLTC), the Ministry of Health Promotion, the MOHLTC – Emergency Management Unit and public health units. If the health status of residents is considered in the broad context, then many other government ministries, municipal governments, the education system and others play a role.

The various roles and responsibilities of the primary participants in delivering on the patient experience are described below:

**MOHLTC** – stewardship; set provincial strategic direction and standards; ensure that Provincial government resources are appropriately allocated across the province and the continuum of health care services; and ensure value for those funds is received.

**LHINs** – plan, fund and integrate a local health care system to improve the health of Ontarians through better access to high quality health services, co-ordinated health care and effective and efficient management of the local health system.

**Health Service Providers (HSPs)** – as defined in the *Local Health System Integration Act* (LHSIA), HSPs encompass a group of providers including:

- **Hospitals** - provide a variety of in-patient services, ambulatory services and community programs of an acute, rehabilitative, complex continuing care and/or specialty mental health nature at all levels, from primary to quaternary care, and from small community hospitals to large academic health centres.
- **Community Care Access Centres** - provide a variety of health care services in the community and the patient's/client's home that enable a resident to either remain in their home, as healthy as possible, or return home from hospital care as soon as possible.
- **Other HSPs** such as Psychiatric facilities, LTC homes; Not-for-profit providers that operate Community Health Centres, Community Mental Health & Addictions and/or long term care community services.

**Community Providers** – as articulated in the LHSIA, this group provide health services within the scope of their profession but are not considered HSPs: physicians, chiropractors, dentists, optometrists.

Public health units, municipalities, local voluntary bodies and bodies that are supported by government funds including other ministries themselves are also community providers. These bodies typically complement and work with HSPs but are not funded by LHINs.

**Patients/Clients and Families** - make healthy lifestyle choices, become knowledgeable about their own health conditions and participate in their care choices with HSPs.

The increasing importance of chronic disease management and prevention has brought the role of the patient and family into discussions about self-management and personal responsibility. The hospital should consider how it can encourage patient self-management to improve the patient experience and to control both current and future health care costs. This is an area where other HSPs and community providers will be of great benefit.

The provision of high quality, safe, accessible and sustainable care within the resources available requires all stakeholders to play active and productive roles and take shared responsibility in designing and managing change. Clear and early explanation of the challenges facing a hospital and its care collaborators are essential to forming good change relationships and effecting the best change possible.

System change requires all providers to rethink what they do and how they do it in the context of the system of care provided to patients and families. Although tradition and custom are important in day-to-day lives, the health care system is facing a heightened need for change in how, by whom and where health services are provided. New roles and new relationships will need to be discussed with openness and respect. A process to ensure that proposed changes are understood by all those affected, both internal and external, in a thoughtful, positive and timely manner must also be in place.

#### **1.4. Engaging Stakeholders**

To ensure the achievement of the overarching strategy, the 2010-2012 HAPS will be developed in the spirit of system contribution. The ultimate goals of the HAPS are to:

- 1) Ensure the best possible patient/client experience; and
- 2) Plan within the resources available.

In order to facilitate a health system perspective, the hospital's core activity and service delivery choices will consider the hospital's role in the system and the impact of its HAPS choices on:

- Other HSPs (Acute care, rehabilitation, LTC, sub-acute care);
- Community providers;
- Educational resources;
- Patients/Clients and their families; and
- Inter-LHIN service issues impacted by hospital choices.

The involvement of different stakeholders will require different types of engagement activities. Ultimately, a thoughtful, positive and robust engagement plan will encourage coordination with the system to deliver better, more efficient and effective care to the patient/client.

It is the hospital's responsibility to engage stakeholders in the development of their HAPS. The LHINs may assist in facilitating discussions with health care partners. A resource that offers an accessible, organized collection of tools, information and strategies on community engagement for health is Engaging People Improving Care (EPIC) at [www.epicontario.ca](http://www.epicontario.ca).

## 2. Key Planning Considerations

This section lays out the expectations and requirements for hospitals in the development, assessment and completion of a HAPS. Hospitals are urged to review this section carefully to ensure that their submitted HAPS will be accepted by the LHIN. Some sections are prescriptive and required, while others are informative and directional. All LHINs will be using these planning considerations in their assessment and approval processes. In addition, LHINs may add specific items that are relevant to their respective LHIN. Your LHIN will inform you if there are any such items.

### 2.1. Scope of the HAPS

The HAPS will reflect:

- Focus on the population need and patient experience;
- Benefit to the **system** of health care;
- Transparency – demonstration of engagement of all stakeholders (patients, residents, physicians, staff, and HSPs) at the appropriate time and in a positive manner; and
- Sustainability of financial, human and physical resources.

When developing the HAPS, hospitals should consider the following as “givens”:

- Current funding allocations together with known or announced funding planning targets will be considered the total available funding for the provision of services. **The HAPS must not include any additional requests for funding.**
- Stable service volumes based on 2009/10 actual volumes.
- Service plans **must** be congruent with and deliver on provincial and LHIN strategies and priorities, specifically:
  - Access to Care (wait times, ER/ALC, primary care);
  - eHealth Strategy (provincial and local tactical plans);
  - Ministry LHIN Accountability Agreement (MLAA) indicators not captured previously; and
  - LHIN Integrated Health Service Plan (IHSP) priorities/principles.
- Service plans **must** ensure care is delivered safely and at a high quality.
- Full information is never possible so hospitals must plan for the “known” or develop reasonable assumptions consistent across the LHIN.

## **2.2. Links to LHIN and Provincial Priorities**

### **2.2.1. Provincial Priorities**

Hospitals must ensure their plan is closely aligned with provincial priorities. In the Results-Based Plan Briefing Book 2009/10, the MOHLTC stated that it will “continue to focus on two major priority areas identified by Ontarians: reducing wait times with a special focus on emergency rooms (ERs) and improving access to family health care.” The MOHLTC also stated that it will focus on eHealth initiatives and patient safety.

The focus on ER wait times requires a three-fold strategy: reducing the ER demand by improving community care so that ER visits are avoided; building ER capacity; and improving patient flow through in-patient care, reducing alternate level of care (ALC) days and moving patients into more appropriate care settings.

The Family Health Care Strategy will improve access to primary care through the expansion of family health teams, Nurse Practitioner-led clinics and other initiatives related to children and youth. While the responsibility for these initiatives lies outside of the mandate of LHINs, they do affect HSPs and other community providers and should be considered in the planning process.

### **2.2.2. Ministry LHIN Accountability Agreement (MLAA)**

The MLAA between the MOHLTC and the LHIN sets out the responsibilities and obligations of each of the LHINs and the MOHLTC in respect to the planning, funding and integration of the LHIN’s local system. Specific performance targets are negotiated for each LHIN to enable the LHIN to demonstrate its progress towards achievement of provincial priorities and strategies within its system. The LHIN website will contain a copy of the most current MLAA and the local LHIN targets.

While the LHIN is accountable to the MOHLTC for the achievement of the system goals and objectives in the MLAA, each HSP within the LHIN’s system has a role to play in enabling the LHIN to achieve these system goals and objectives. Therefore, a hospital will need to review its performance as it relates to the MLAA targets and describe in its HAPS, how it will contribute to the achievement of these targets.

### **2.2.3. Integrated Health Service Plan (IHSP) 2010/11 to 2012/13**

IHSPs for 2010-2013 will be released on November 30, 2009. All LHIN IHSPs will have the following four priorities:

1. ER service improvement;
2. ALC reduction;
3. Diabetes services improvement; and
4. Mental health and addictions services improvement.

Each LHIN may also have additional local priorities. Enabling strategies (such as Health Human Resources, eHealth, back office integration, etc.) may also be included to support the priorities. Your LHIN will inform you of any additional local priorities. All LHIN priorities should be addressed in the HAPS.

The principles of each IHSP are:

### *Community Engagement*

Health needs and priorities are best addressed when the community providers, HSPs and the people they serve have input that informs the making of decisions.

### *Cooperation, Coordination and Integration*

Community providers, HSPs, LHINs and the government must work together to reduce duplication and better coordinate health service delivery.

### *Equity and Diversity*

Communities are made up of individuals with differing cultures, ethnicities, beliefs and lifestyle choices. The LHINs are committed to equity and respect for diversity in communities. LHINs respect the requirements of the *French Language Services Act* and requirements under the LHSIA in planning for and serving Ontario's French speaking community. The LHSIA also sets out requirements for LHINs regarding relationships with and recognition of Aboriginal and First Nation peoples. Access to health services, except where permitted by the LHSIA, is not to be limited to the geographic area of the LHIN in which an Ontarian lives.

### *Accountability and Transparency*

The health system is governed and managed in a way that reflects the public interest and that promotes efficient delivery of high quality health services to Ontarians.

### *Sustainability*

An integrated health system will deliver health services that people need now and in the future.

These principles are also to be considered and reflected in the development of the HAPS. Hospitals may contact the LHIN for release of available technical documentation relating to the 2010-2013 IHSP to help inform their HAPS submission.

## 2.3. Common Expectations for the HAPS

### 2.3.1. Core Expectations

The HAPS and the process used to develop it will reflect the best possible patient experience within the resources available. This will include best service, best place, best time and best transitions for patients, families and providers.

There will be both early and extensive communication between hospitals, other HSPs and community providers as hospitals reassess their role in the provision of care and service. These communications will take into account the timing and nature of patient transitions between hospitals and other providers. This HAPS will be one that reflects changes in roles, responsibilities and relationships. It will require multi-party discussions that can begin as early as August 2009.

Although a great deal of prescribed information needs to be conveyed in the HAPS, hospitals will focus on consistency, conciseness and clarity. The HAPS must reflect compliance with provincial legislation and regulation, as well as MOHLTC provincial standards (such as operational or service standards, and policies and program eligibility), directives, operating manuals and guidelines.

The HAPS will address plans to achieve targeted service levels as outlined in the H-SAA schedules, which will be informed by the LHIN's MLAA performance targets.

### *Hospital Programs and Services*

**Hospital Programs Funded Through Base Budgets:** Core inpatient, outpatient and day surgery programs, hospital-based Acquired Brain Injury (ABI), Cochlear Implants, Regional Geriatrics Program, Cleft Lip and Palate / Craniofacial Dental Services; and Specialized Hospital Services, which include Trauma, Sexual Assault and Domestic Violence Treatment Centres, Provincial Regional Genetic Services, HIV Outpatient Clinics, Hemophiliac Ambulatory Clinics, and Cardiac Rehabilitation Services. For hospital programs funded through base budgets, the hospital will confirm in its HAPS that service volumes and/or service coordination functions will be maintained.

**Provincial Resources:** Bone Marrow Transplants, Adult Interventional Cardiology for Congenital Heart Defects, Cardiac Laser Lead Removals, Pulmonary Thromboendarterectomy Services, and Thoracoabdominal Aortic Aneurysm Repair. For Provincial Resources, the hospital will confirm in its HAPS that the volume or activity levels and scope of service delivery to at least the levels set out in the hospital's 2007/08 Hospital Accountability Agreement (HAA) will be maintained. If the hospital plans for any reductions or discontinuation in Provincial Resources, the LHIN must approve reallocation of the service(s) and funding to another hospital.

**Provincial Strategies:** Emerging services such as endovascular aortic aneurysm repair, newborn screening program, living organ donation and organ transplantation services that are still in the pilot/developmental phase. For Provincial Strategies, the hospital will apply available strategic and operational program policy including funding methodologies, accountability frameworks, performance indicators, volumes and service delivery models.

**Cardiac Services:** Cardiac Catheterization, Cardiac Surgery, Permanent Cardiac Pacemaker Services, Electrophysiology Studies (EPS)/Ablation, Percutaneous Coronary Intervention ((PCI) (angioplasty)) and Implantable Cardioverter Defibrillators (ICD). For Cardiac Services, the hospital will identify how provincial service delivery requirements, standards and any other conditions for Cardiac Services will be met within the dedicated funding envelope provided. Note that the LHIN has the ability to consider and adjust the location and volume of these services within the entire LHIN cardiac services funding envelope to meet anticipated patient need.

**Chronic Kidney Disease (CKD) Services:** Pre-dialysis and other related clinical activities, all forms of dialysis, including in-home, and in-hospitals and their associated sites, and surgical access for hemo/peritoneal dialysis. For CKD Services, the hospital will identify how provincial service delivery requirements, standards and any other conditions for CKD Services will be met within the dedicated funding envelope provided. Note that the LHIN has the ability to consider and adjust the location and volume of these services within the entire LHIN CKD services funding envelope to meet anticipated patient need.

**Protected Stroke Services:**

*For designated Regional and Enhanced District Stroke Centres, the host hospital will:*

- Sustain and act as the trustee for the funds for regional planning, implementation, improvement and education roles and infrastructure throughout their region and across all points in the care continuum (including health promotion; primary, secondary, and tertiary prevention; pre-hospital care; emergency, diagnostic, and acute care; rehabilitation; LTC and community reintegration) according to the original service guidelines. This includes infrastructure for stroke prevention.
- Lead a regional network (committee) of health care agencies and others for collaboration, integration, access and approval and monitoring of the regional plan and implementation of stroke best practices across the continuum.

*For designated District Stroke Centres, the host hospital will:*

- Sustain and act as the trustee for the funds for district/local planning, implementation, improvement and education roles and infrastructure throughout

their district and across all points in the care continuum (including health promotion; primary, secondary, and tertiary prevention; pre-hospital care; emergency, diagnostic, and acute care; rehabilitation; long-term care and community reintegration) according to the original service guidelines. This includes infrastructure for stroke prevention.

- Collaborate with district/local health care agencies and others for integration, access and approval and monitoring of the district plan and implementation of stroke best practices across the continuum.

*For designated Community Hospital Stroke Prevention Clinics the host hospital will:*

- Sustain the infrastructure and roles for stroke prevention focusing on those individuals that are at high risk and serving its geographic catchment area, according to the original service guidelines.

**Wait Times Strategy Services:** Cataracts, hip and knee, MRI/CT services, and pediatric and general surgery, ER wait times and capacity. For Wait Times Strategy Services, the hospital will present plans to meet or exceed MLAA targets and confirm that it will use the Wait Time allocations for the intended purposes or notify the LHIN as soon as it determines it cannot expend all the funds so that those funds may be reallocated. The LHIN may include additional conditions of funding that are consistent with the specifications determined by the MOHLTC. These additions should also be incorporated in the HAPS.

With regard to the ER Wait Times Strategy, the hospital will work with the LHIN ER Lead. The LHIN ER Lead will confirm that the hospital's HAPS plans are consistent with the province's and LHIN's ER strategy. As related to hip and knee wait times, the hospital will work with the CCAC to ensure coordinated and appropriate care for these patients.

**Critical Care Strategy:** Includes the adoption of MOHLTC-developed specifications, including volumes, funding levels, dedicated funding envelopes and any other conditions that will be part of the Critical Care Strategy. For the Critical Care Strategy, the hospital will work with the LHIN Critical Care Lead. The LHIN Critical Care Lead will confirm that the hospital's HAPS plans are consistent with the province's and LHIN's Critical Care Strategy.

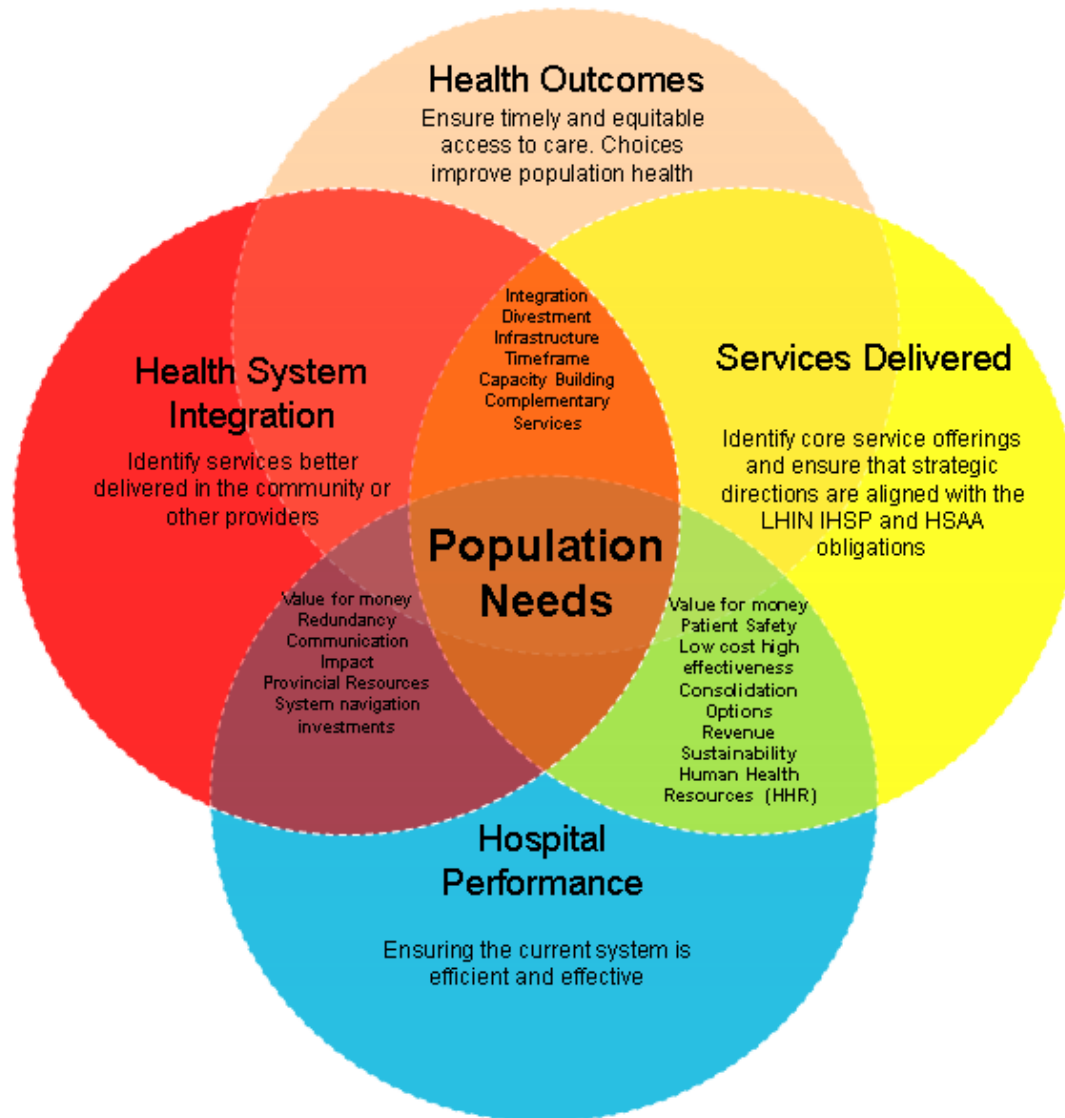
**Non-Assigned Programs:** Bariatric surgery, Burns (severe), Cancer (not funded by Cancer Care Ontario), Endovascular aneurysm repair (EVAR) with fenestrated grafts, External ventricular devices (Berlin Heart), Forensic mental health, Hand and foot reattachment, Hand transplant, Interventional radiology, In-Vitro Fertilization, Lithotripsy, Neurological Coils – use of coils for treating inter-cranial aneurysms, Neurological

modulation, Organ transplant bridge services, Paediatric oncology, Paediatric surgery, Small bowel transplant, Tuberculosis (TB) Inpatient Units & Clinics.

As presented by the “Final Report of Provincial Program Task Group (September 2008)”, these programs were identified as ones that meet the criteria for inclusion as provincial programs but are not yet designated as “Provincial Strategy” or “Provincial Resource” programs. The sponsoring hospital will work with its LHIN to ensure appropriate and coordinated care for patients, recognizing that Ontario residents should have reasonable access to all programs under discussion with the understanding that not all programs will be offered in all LHINs.

## 2.4. Guidelines for Making Choices

### 2.4.1. Context for Making Choices



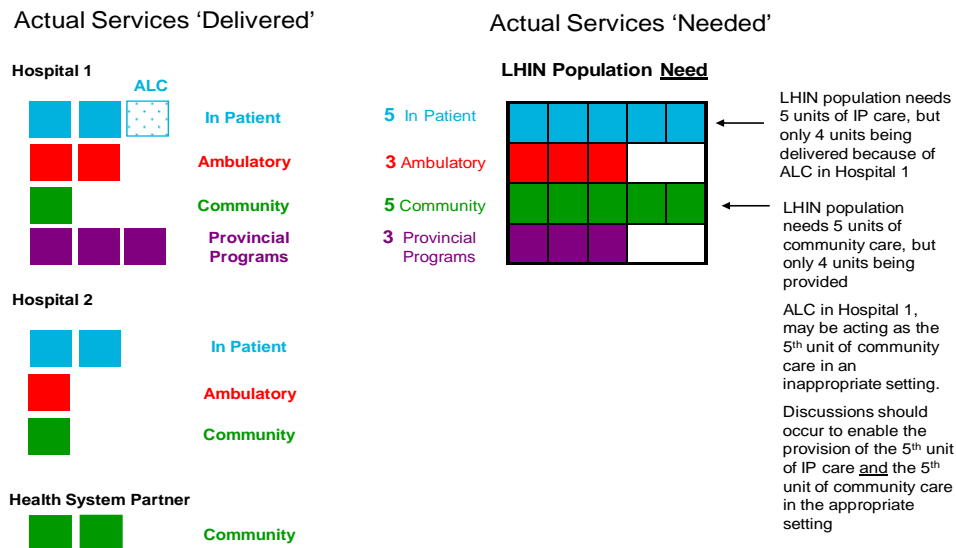
The diagram above reflects the considerations that will guide hospitals and LHINs in the development and assessment of strategies and options for changes necessary to enable the hospital to provide safe, high quality, accessible and sustainable hospital care within the resources available. Population needs will be the core consideration for the hospital and the LHIN in finalizing the hospital's operating plan for the purposes of the HAPS.

Key themes to consider when developing and evaluating options for service delivery are:

- Improving hospital performance;
- Ensuring that core hospital services are stable, aligned with provincial priorities and the LHIN's IHSP, and contribute to the achievement of the MLAA targets;
- Being cognizant of the impact of service delivery and internal efficiency improvement decisions on community partners and other providers;
- Optimizing health outcomes;
- Being conscious of the complexity of decisions at the interface of these themes; and
- Current and anticipated patient/client need.

### 2.4.2. Health Services Inventory

The intent of this section is to provide guidance to hospitals, their health care partners and LHINs on their detailed inventory of health services. The inventory of services can be used as a valuable tool for organizations to identify system wide opportunities. The graphic below depicts this concept at a high level where Hospital 1 has identified specific services that may be ideally shifted to a community partner.



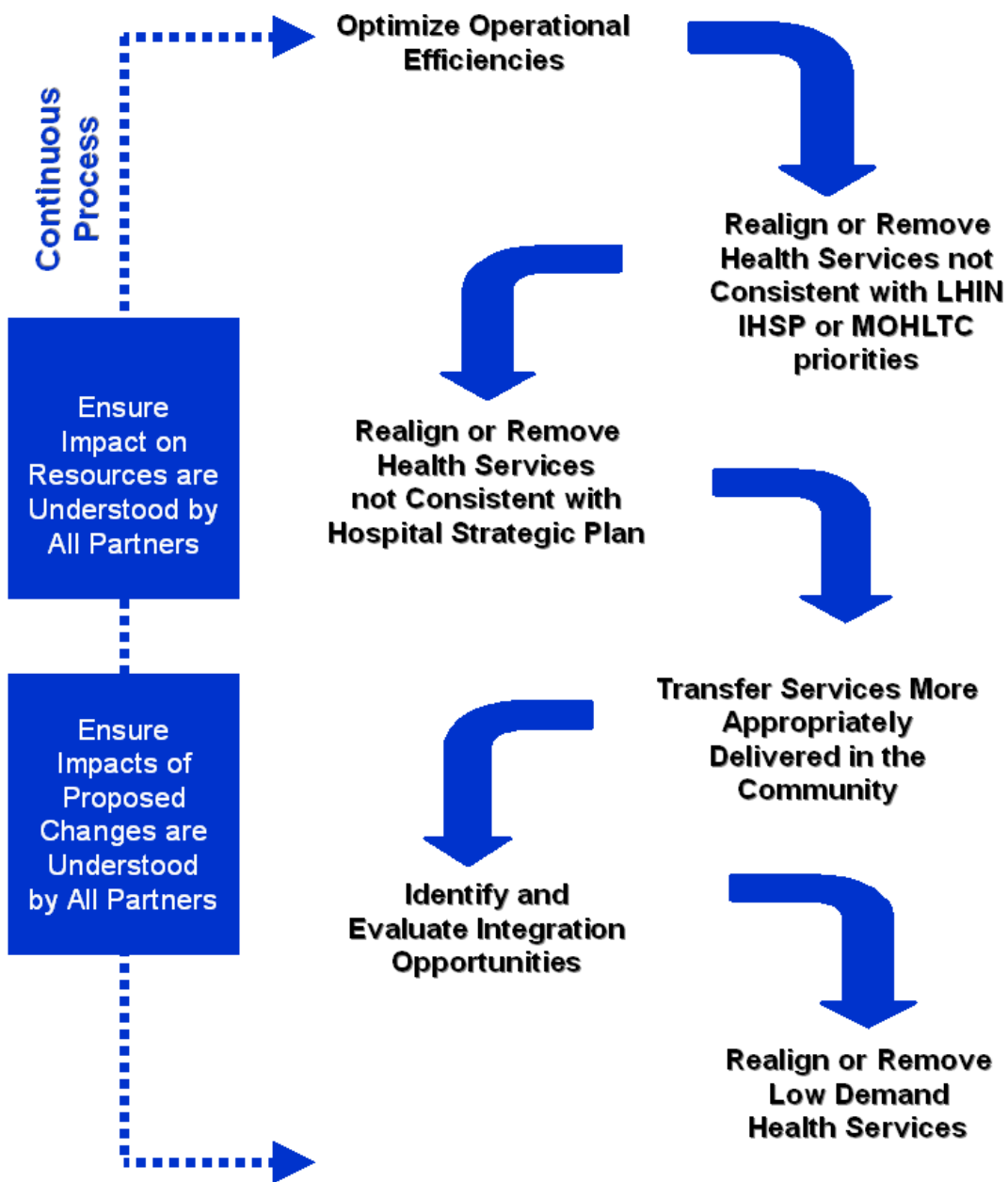
Population demand analyses serve as a catalyst for provider introspection and evaluation of the current inventory of services being offered. The analyses provide an honest and frank evaluation regarding which services need to be continued, expanded, curtailed or discontinued. Discussions cannot occur in isolation. HSPs must engage each other to ensure that demand is met by the agency best suited to provide that care, as close to the patient as possible, and as early as possible to ensure that care provided achieves a positive result and improved health for all residents.

Using the demographic characteristics of residents' and patients' in and out flows to estimate their future health services needs is essential if resources are to be appropriately aligned. Ensuring that health care services align to need ensures that HSPs, community providers and LHINS will be well positioned to optimize future funding allocations.

#### ***2.4.3. Framework for Making Choices***

The "Framework for Making Choices" is a cascading strategy that depicts a series of prompts/questions for hospitals and LHINS to consider when developing and selecting options for the hospital to deliver on the HAPS overarching strategy and hospital specific performance expectations. The intent of the process is not just to have a balanced budget and/or be efficient, but to reflect the underlying principle of making choices that have positive system impacts within the context outlined above. The primary goal is that of ensuring each patient receives the best care at the best place at the best cost. It is important to note that all hospitals are expected to start the process by optimizing operational efficiencies.

## Framework for Making Choices



A description of the cascading strategy is noted on the following pages.

### Optimize Operational Efficiencies

Optimizing operational efficiencies is a continuous process which may include but not be limited to:

- Increasing, new, self-generated revenue;
- Sharing clinical and administrative services between independent hospitals;
- Optimizing attendance management programs;
- Benchmarking exercises;
- Utilizing LEAN processes;
- Reviewing staffing patterns and mix to ensure staff are working to maximum scope; and
- Maximizing the use of electronic tools.

When making plans, hospitals will manage all changes in consideration of their collective agreement obligations.

When considering options hospitals should answer the following questions:

- Will a change in one area to achieve targets result in an increase in expenditure in another area of the organization?
- Will implementation of the option transfer costs to other community partners?

Hospitals are reminded of the various tools and information available to assist in the continuous process of maximizing operational efficiencies:

- MOHLTC Financial and Information Management (**FIM**);
- Hospital Indicator Tool (**HIT**);
- Planning Decision Support Tool (**PDST**) web-site;
- Canadian Institute of Healthcare Information (**CIHI**);
- Discharge Abstract Dataset (**DAD**); and
- Ontario Cost Distribution Methodology (**OCDM**).

## Realign or Remove Health Services Not Consistent with LHIN IHSP and MOHLTC Priorities

Ensuring equitable access based on need is a mandate of each hospital, community provider and LHIN. Hospitals will work with each other and in collaboration with other HSPs, community providers and LHINs to ensure that provincial targets for access are met or bettered. HSPs, community providers and LHINs will also align services towards achievement of IHSP priorities (see Section 2.2.3).

## Realign or Remove Health Services Not Consistent with Hospital Strategic Plan

Hospitals develop strategies and plans to fulfill a specific vision and mission. A strategic plan provides the hospital with a roadmap for positive change with the ultimate goal of system improvement. As part of the Making Choices Framework, hospitals will look at their existing services to ensure they are in close alignment with their vision and strategy. In addition, hospitals will review services that are not generating anticipated results.

Options for inclusion in the HAPS must incorporate detailed planning information including population demographics and health status, utilization patterns, agreements with other providers detailing their ability and/or willingness to take on a program, and the calculation of funds to be transferred with the program.

### Example

*A hospital has historically provided an inpatient detoxification service which is no longer consistent with the hospital's role as a large, acute, tertiary care hospital. This addiction treatment service may be more appropriately provided in the community under the auspices of a local community addictions treatment centre enabling a focus on the continuum of care. The hospital would make an agreement with the HSP to make the appropriate transfer.*

## Transfer Services More Appropriately Delivered In the Community

When considering options in this category, hospitals may want to ask the following questions:

1. Does the service require the resources of the hospital to operate?
2. Could the service be assumed by other HSPs or community providers?
3. Has the hospital addressed collective agreement considerations prior to, during or after transfers?
4. Are services currently operating in the community similar in type (same care) or result (similar conditions) to hospital services?

5. Would provision of the service in the community free up human, financial, and physical resources that could be employed to improve core service delivery?
6. Would the patient's experience and outcome be improved with the transfer?

In developing options under this category, the hospital will have high level discussions with the potential "receiving" provider to determine willingness and capacity to receive the service and to determine the appropriate funds necessary to transfer with the service. The LHINs may assist in facilitating these discussions.

### Identify and Evaluate Integration Opportunities

HSPs are required by the LHSIA to identify and evaluate the potential benefits of integration opportunities within and among themselves. These obligations are intended to support system transformation by having providers participate in the identification of better, faster, more effective and efficient service delivery, while continuing to support population health care needs. Service improvements could mean service expansion, or could result in a provider reducing service where the need is no longer warranted, or where another provider is better positioned to provide those services to the community.

Proactive service realignments may benefit patients and providers. Shared services may reduce cost profiles. Better coordination may improve access, staff knowledge and client satisfaction.

#### **Example**

*Groups of hospitals could cohort key services into one or two locations to improve critical mass, specialization, access to staffing and reduction of costs through economies of scale.*

As a reminder to hospitals when considering service changes, the definition of "integrate" and "integration" under the LHSIA includes:

- to coordinate services and interactions between different persons and entities;
- to partner with another person or entity in providing services or in operating;
- to transfer, merge or amalgamate services, operations, persons or entities;
- to start or cease providing services; and

- to cease to operate or to dissolve or wind up the operation of a person or entity.

See [Local Health System Integration Act, 2006, S.O. 2006, c. 4](#) and LHN/HSP Governance Resources on your LHN website.

### Realign or Remove Low Demand Health Services

Provision of existing low demand services will be reviewed as part of the hospital's Making Choices process. Low demand but mission or LHN critical services will be partnered (integrated) with another provider to enable opportunities for consistent and improved clinical outcomes and for efficiency gains. Low demand services for conditions that have alternate therapies or treatment protocols will be reconsidered – especially if the hospital is providing more than one treatment approach for the same condition.

It is recognized that a decision to discontinue certain low demand services will be dependant on the type of organization or availability of the service from another health care partner.

#### Example

*An academic centre may perform low demand services that are cutting edge and while they have not gained critical mass, such procedures are considered critical for development and training e.g. Neuromodulation. Likewise, specialty hospitals may be required to provide services to unique populations to meet emerging health care requirements (e.g. bariatric care). It is important that hospitals and LHNs discuss such procedures that push the healthcare agenda forward for the benefit of Ontarians.*

### 2.5. Proposing Service Changes

Developing the HAPS for fiscal 2010/11 to 2011/12 presents the opportunity to review a hospital's services in light of the hospital's vision, mission and strategic direction, potential for service integration, new care models and demographic trends. Hospitals need to explore the potential for shifting services to other HSPs or community providers to achieve better outcomes or equivalent but more efficient care.

As noted in the Making Choices Framework section above, certain types of operational changes will require acceptance by the LHN **before** the proposed change can be incorporated into the hospital's HAPS. These would include any changes affecting funding, MOHLTC and/or LHN priority service levels, and activities falling under the definition of integration as noted in the LHSIA.

## **2.6. Obtaining LHIN Acceptance of a Service Change for Inclusion in the HAPS**

If a change will or could impact other providers, discussion of the components of proposed service changes with all affected parties and the LHIN will occur prior to the HAPS submission. These discussions will aid the hospital in ensuring that the choices included in the HAPS are acceptable to the LHIN prior to signing the H-SAA.

The discussion and evaluation of possible service changes for inclusion in the HAPS will be focused on the implications for patients, the accomplishment of MOHLTC and LHIN health system priorities, LHIN MLAA commitments, the contribution to development of a health system in the LHIN and overall sustainability of the hospital. Hospitals should check with their LHIN regarding their local HAPS process and the appropriate forms to be used for completion and submission in regards to proposed service changes.

It is recognized that there may be significant service changes required to meet the H-SAA performance requirements that cannot be fully developed/reviewed prior to the HAPS submission due date. In these cases, the hospital and LHIN will agree to a new submission due date that will occur prior to the signing of the H-SAA.

### **2.6.1. Inter-LHIN Service Changes**

If the proposed service change affects residents or HSPs in other LHINs, the following process will be followed:

1. The initiating hospital will ensure early notification of the expected change to their local LHIN.
2. The local LHIN will contact the affected LHINs about the expected change.
3. The affected LHINs will determine if the change is material and contact their local HSPs.
4. The affected LHINs will notify the local LHIN of the expected impacts.
5. The initiating LHIN will negotiate the service change revision with their initiating hospital and inform the potentially affected LHINs of the decision.

## **2.7. Transfer of Funding**

When a hospital reduces, transfers, or eliminates a service, a new or additional service demand is often placed upon another HSP.

If the recipient HSP can provide equivalent or better care at a lower cost (e.g. the recipient hospital has a superior economy of scale or lower cost LTC home placement for ALC patients), the transferring hospital may be able to retain some of the funds associated with the displaced service. Any transfer of funding will need to be reviewed

and approved by the LHIN, in consultation with the transferring and recipient HSPs on a case by case basis.

**Example**

*Hospital A provides 1000 units of service at a cost of \$1M. Hospital A would like to transfer these 1000 units of service to community provider B. Community provider B can provide 1000 units of service at an anticipated cost of \$800K (reflective of their current model of care). The hospital and the community provider will determine the appropriate amount of money to transfer and will then provide formal notice to the LHIN (as per the LHSIA). If no agreement can be reached and the proposed transfer is acceptable to the LHIN, the LHIN will determine the final transfer amount.*

**2.8. Timelines**

The HAPS schedule\* is noted below:

- *November 30, 2009* – Hospital Board approved HAPS submitted to LHIN
- *November 30, 2009* – IHSP published by each LHIN
- *March 31, 2010* – H-SAA signed by both the hospital and LHIN

\* These dates are subject to change pending release of funding allocation and planning targets by the MOHLTC. If these dates are changed, the LHINs will notify hospitals as soon as possible.

**2.9. Funding Planning Targets**

LHINs will release planning allocations to hospitals as early in the HAPS process as possible, once the LHIN transfer payment allocation has been confirmed through the MOHLTC budgeting process.

Approved funding allocations will occur during the period of the H-SAA and may be different than the funding planning targets for any of the types of funding noted below. Funding approval letters with appendices describing the conditions or obligations with regard to that funding, with sign-backs from the hospitals indicating acceptance of the conditions, will serve to update the contractual commitment of the H-SAA.

**Base funding** – LHINs have determined that preliminary planning targets will be necessary in order to assist hospitals in advancing the planning process since final government funding planning targets will not be available to the LHINs until the fall of 2009.

**Wait Times and Provincial Programs** – The funding for these programs are either ongoing, one-time or a combination of base and ongoing, one-time. Since multi-year planning targets are not possible, hospitals are advised to use a planning target for both years based on 2009/10 levels of volumes and rates for planning purposes. LHINs are now responsible for the management of cardiac and CKD programs. As such, LHINs must work with the hospitals to determine the appropriate distribution of the funds in each program amongst the various procedures incorporated within those programs. The 2009/10 total funding amount for each of the aforementioned programs will be the funding planning target for each of fiscal 2010/11 and 2011/12. However, the distribution amongst the procedures within each program may change subject to agreement with the LHIN. Note that program funds may not be distributed between provincial programs without the approval of the MOHLTC.

**Post Construction Operating Plans (PCOP)** – Multi-year planning targets will not be available for hospitals which have recently completed construction or are scheduled to complete construction within the period of the H-SAA. LHINs and hospitals will need to determine reasonable assumptions to inform service and funding targets for the years in question and prudence is recommended with regard to setting those assumptions. LHINs and hospitals will consider population need, the overall LHIN situation with regard to access to care and the economic environment when planning for higher service volumes. Further, it is recommended that the funding planning assumptions be determined separately for additional fixed costs related to new space and variable or additional service related costs.

## **2.10. Capital Planning**

### **2.10.1. Context**

Through the MOHLTC/LHIN Capital Working Group, the MOHLTC and LHINs have been collaborating to revise the current Pre-Proposal, Proposal/Business, and Functional Program stages to better align LHIN planning at these early planning stages, as outlined.

LHIN involvement in the early stages of capital planning is critical in developing program and service projections with a system context; providing direction for program and service integration, collaboration, and alternate service delivery models including key support functions; setting short-term program and service priorities for implementation.

**2.10.2. *Capital Planning Requirements***

A brief description of the capital projects being planned in the next 2 year, 5 year, and 10 year timeframe must be described in the narrative section – Capital (see Section 3.3 for requirements).

### 3. HAPS Submission Components

#### 3.1. Narrative

The narrative section provides an opportunity for the hospital to explain its plan to provide required hospital services within available resources while maintaining high quality, safe, accessible, patient-centred care. The hospital will frame its narrative submission in terms of how the hospital, and implementation of its plan, will support the sustainability of the local health care system.

#### Planning To the Known

As in any plan, the HAPS should be prepared with full consideration of **known** circumstances and/or reasonable assumptions (including funding allocations, volumes, and targets under Ontario's Wait Time Strategy as well as other required targets). The hospital should also disclose and account for likely, or highly probable, circumstances over the period of the HAPS; which may be known through discussions with the LHIN, the MOHLTC or others.

#### General Guidelines for Narrative Development

General guidelines to follow when developing the narrative include:

1. Reflect population needs.
2. Align with the LHIN's IHSP priorities, provincial priorities and H-SAA performance obligations.
  - a. Communicate how the hospital will assist the local health system to meet the LHIN's performance obligations.
3. Present options to attend to or mitigate any identified performance challenges. The focus of the narrative is expected to be on problem solving. **New funding requests will not be considered.**
4. Describe:
  - a. The terms of operating within a balanced budget. OR,
  - b. Hospital operations and choices that must be made in order to be in a balanced budget position ("Total Margin" as defined in H-SAA 2008-2010) for each year 2010/11 and 2011/12.
5. Assume approved 2009/10 Q2 funded volumes, excluding in-year adjustments for all wait times and provincial program planning targets.

6. For service volume changes (either growth or reduction) and or programmatic investment/divestment, include:
  - a. The potential impact of such changes on other healthcare sectors;
  - b. The identification of other providers of that service within the sector; and,
  - c. General themes/action items from the discussions from community engagements regarding such proposed changes.
  
7. Where changes in service volumes (either growth or reduction) are being proposed, or program investment/divestment considered, include:
  - a. The potential impact of such changes on other HSPs within the LHIN and outside the LHIN (as applicable) ;
  - b. A summary of community engagement activities and overview of proposed future engagement activities related to the decision-making for these service changes; include any specific issues that may not be addressed if the service change proceeds.

The narrative is expected to be succinct and describe material risks/actions together with mitigation strategies. The narrative submission for operations must be self contained, complete and not exceed 10 pages. The narrative submission for capital must also be self contained, complete and not exceed two pages.

Section 3.2 and 3.3 note the narrative requirements for operations and capital respectively. The information contained in the tables are recommendations for the narrative section. It is recognized that not all components will be applicable to every hospital.

### 3.2. Narrative Requirements – Operations

Component	Response/Considerations	
Planning assumptions*	<p style="text-align: center;"><b>2010/11</b></p> Salaries and benefits: Supplies: Drugs: Utilities: Liability Insurance: Vacancy/turnover rates: Pension: Other revenues:	<p style="text-align: center;"><b>2011/12</b></p> Salaries and benefits: Supplies: Drugs: Utilities: Liability Insurance: Vacancy/turnover rates: Pension: Other revenues:
Health System	<ul style="list-style-type: none"> <li>• The hospital’s role in the health system:                             <ul style="list-style-type: none"> <li>▪ Who is served and why.</li> <li>▪ How provincial and local priorities are met.</li> <li>▪ The determination of current and future core services</li> </ul> </li> </ul>	
Hospital Performance: Efficiency and Effectiveness	<ul style="list-style-type: none"> <li>• Areas the hospital has identified that require the most improvement with regard to efficiency.</li> <li>• Strategies adopted to manage such inefficiencies.</li> <li>• Where savings will be reinvested.</li> </ul>	
Service Delivery	<ul style="list-style-type: none"> <li>• Choices made to achieve a balanced budget (with supporting justification) and the expected impact on patients and costs.</li> <li>• How health partner engagement has been utilized in determining choices to ensure a sustainable system for the region.</li> <li>• Critical risks to success and mitigation/management plans.</li> </ul>	
Alignment and System Contributions	<ul style="list-style-type: none"> <li>• Initiatives in place or to be implemented to contribute to the achievement of Provincial and LHIN priorities</li> </ul>	
Risks	Key risks and mitigation strategies that may include: <ul style="list-style-type: none"> <li>▪ Strategic</li> <li>▪ Clinical</li> <li>▪ Financial</li> <li>▪ Safety</li> <li>▪ Legislative</li> <li>▪ Major capital projects</li> </ul>	

*\*Planning assumptions are also included in the schedules however it is critical to include in the narrative. 1 page maximum. This will not be considered part of the 10 page limit.*

### 3.3. Narrative Requirements – Capital

A brief description of the capital projects being planned in the next 2, 5 and 10 year timeframe should include:

Component	Response/Considerations
<p>Improvement being proposed:</p> <ul style="list-style-type: none"> <li>▪ New service</li> <li>▪ Change to existing service</li> <li>▪ Facility change only.</li> </ul>	<ul style="list-style-type: none"> <li>▪ The hospital’s current and proposed future role in the local health system</li> <li>▪ How the proposal aligns with LHIN planning priorities</li> <li>▪ A demographic profile of the population served and how the proposal addresses this profile</li> <li>▪ The challenges facing the program, service, and/or facility and the rationale for the improvement</li> <li>▪ How the hospital has coordinated/collaborated with other HSPs</li> </ul>

### 3.4. Service Volume and Financial Forms

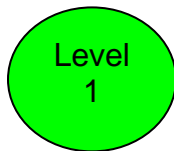
These forms will be available on the MOHTLC Web Enabled Reporting System (WERS) at [www.mohltchb.com](http://www.mohltchb.com).

## 4. LHIN Evaluation of HAPS

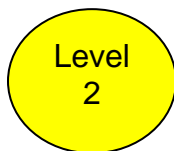
### 4.1. Evaluative Process

The following evaluative process and tools are available for use by the LHINs to guide and support the detailed review of HAPS submissions. The information has been provided in the HAPS Guidelines in the interest of assisting hospitals in the development of their HAPS. While each HAPS is submitted by individual hospitals, the review process will consider each submission in relation to the health system as a whole.

Each hospital will be assigned a priority level based on results of the LHIN assessment of submission. The assigned level will dictate the intensity and frequency of meetings with LHIN HAPS teams to further review the submission:



Straightforward submissions with no obvious data errors or significant variances may be fast tracked for negotiation and final approval.



Submissions with ambiguous results will be flagged for further LHIN analysis and discussions with the hospital. If issues can be easily resolved the submission may be fast tracked for negotiation and final approval.



If issues are not easily resolved, LHIN HAPS teams may immediately begin discussions with the hospital to understand outstanding issues and determine options/next steps.

#### 4.2. LHIN HAPS Review Process

The HAPS review may:

- Ensure the submission is complete;
- Identify any performance measure concerns;
- Determine if the hospital has used the Making Choices Framework (see Section 2.4);
- Ensure the hospital is maintaining required services (see Section 2.3);
- Compare the narrative component with financial and service volume tables for consistency;
- Review financial and service volume tables for consistency and reasonableness;
- Review assumptions for consistency and reasonableness;
- Confirm that community engagement has occurred by the hospital as part of its planning process;
- Identify inconsistencies or anomalies in submissions;
- Review integration initiatives/opportunities presented;
- Identify any proposed clinical reductions that haven't been approved for inclusion in the HAPS;
- Determine appropriate priority level for hospital;
- Generate a list of questions for the hospital that require clarification; and
- Prepare a summary document for each hospital.

Once the review on the final submission is completed, LHIN staff will contact each hospital to clarify any outstanding questions that have been raised as part of the final review. Once the initial fact-finding discussions have occurred, the first negotiation meetings will take place. The intensity and frequency of meetings will be determined based on need.

### 4.3. Evaluative tools

The LHINs will use the following tools/datasets to review hospital submissions that do not clear the validation process:

- **HIT** - to establish that hospitals are achieving best quartile results (establish that limited opportunities for saving exist);
- **Historical functional centre analysis: year-over-year analysis** - to flag substantive changes in costs, either spikes in costs or changes due to allocation (i.e. transfer of costs to outpatient services);
- **FIM daily census data** - to validate average length of stay (ALOS) and occupancy; and
- Other tools or indicators for root analyses.

## 5. Linking the HAPS to the H-SAA

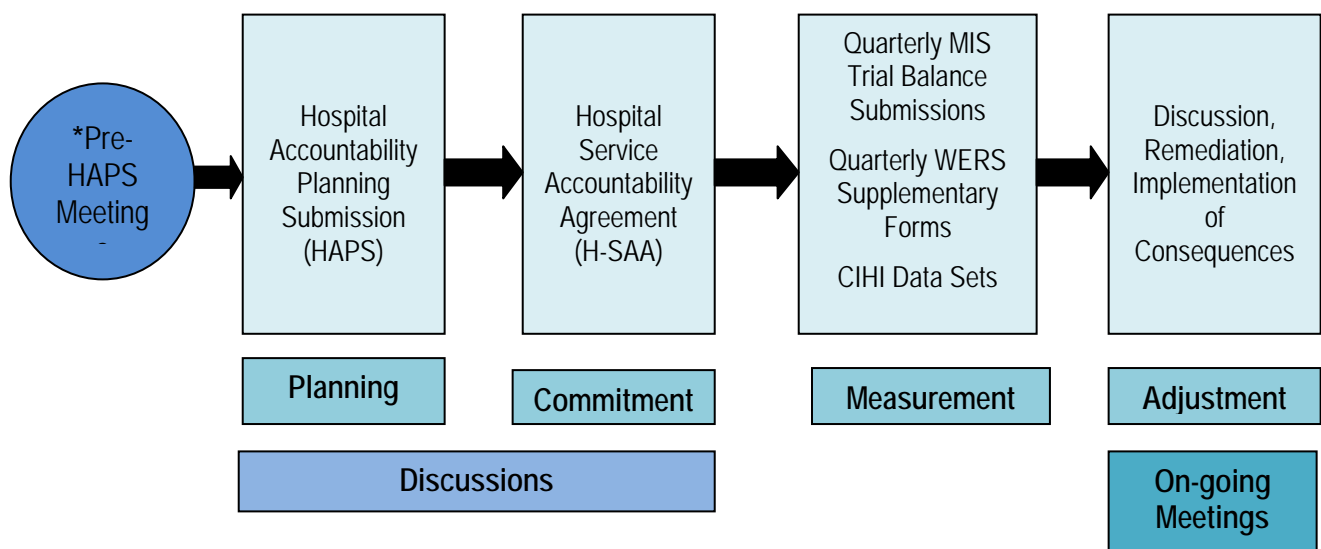
### 5.1. Overview

The HAPS is a hospital-owned document that focuses on service planning and the measurement and evaluation of hospital services and organizational performance. Data submitted by hospitals in the HAPS is used to calculate targets, corridors and performance standards in the H-SAA:

- Financial performance/fiscal health;
- Organizational capacity;
- High quality health services;
- Patient/client perspective; and
- System perspective.

The H-SAA, a public document, is the legal agreement between the hospitals and the LHINs. The H-SAA, which is informed by the HAPS, commits the hospital to accountability through multi-year planning and funding projections. LHINs are committed to achieving balanced, innovative and realistic H-SAAs that rely on regular discussion and collaboration to the greatest extent possible. The H-SAAs must also fulfill the requirements of the LHSIA and the CFMA. Once signed, the LHINs and hospitals each have a role in ensuring that the terms of the H-SAA are fulfilled.

The process from development of a HAPS through to potential performance activities during the period of the H-SAA is depicted below:



*\*Pre-HAPS meetings between hospitals and the LHIN are recommended to: discuss, clarify and align expectations of and roles in the process; to agree and discuss principles, values and assumptions; and to share and discuss possible options and levers that both sides could draw on during the proceedings.*

## 6. Indicators

The indicators and related background material will be released as soon as they are available. The 2010-2012 indicators will reflect the intent of previous indicators.

## 7. Glossary of Terms

Terms used throughout these guidelines are defined below.

**Accessible** - patients in need should get appropriate care in the most appropriate setting.

**ALC** – Alternate Level of Care. ALC refers to those patients who are in the hospital and waiting to move from their current bed type to more appropriate services.

**Balanced Budget** – Total Margin as defined in H-SAA 2008-2010. The percent by which total revenues exceed or fall short of total expenses, excluding the impact of facility amortization, in a given year. The formula is:

$$\text{Total Margin} = \frac{\text{Total Surplus / Deficit}}{\text{Total Revenues}} = \frac{\text{Total Corporate Revenues (excluding facility related revenues and inter-dept recoveries)} - \text{Total Corporate Expenses (excluding facility related and inter-dept expenses)}}{\text{Total Corporate Revenues (excluding facility related revenues and inter-dept recoveries)}}$$

**CFMA** – *Commitment to the Future of Medicare Act, 2004*. The CFMA contains provisions applicable to Service Accountability Agreements. Further information can be found in Part III of the CFMA.

**EPIC** - Engaging People Improving Care. EPIC is a web-site which offers an accessible, organized collection of resources for strategies on community engagement. Further information can be found at [www.epicontario.ca](http://www.epicontario.ca).

**ER** – Emergency Room or Department.

**HAA** – Hospital Accountability Agreement. The 2007-2008 HAA was assigned by the Minister to the LHINs. In 2008, the HAA was replaced by the 2008-2010 H-SAA.

**HAPS** – Hospital Accountability Planning Submission. The HAPS is the planning tool used by hospitals to inform the negotiation of the Hospital Service Accountability Agreement (H-SAA).

**High quality** - accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated, and focused on population health.

**H-SAA** – Hospital Service Accountability Agreement. The H-SAA is the service accountability agreement that the LHINs are required to enter into with the hospitals pursuant to the terms of the *Local Health Integration Act* (LHSIA). More information on service accountability agreements can be found in s. 20 of the LHSIA and Part III of the CMFA.

**HSP** – Health Service Provider. HSP refers to hospital and community health providers.

**Integration** – defined in the LHSIA.

To integrate includes: 1. To co-ordinate services and interactions between different persons and entities; 2. To partner with another person or entity in providing services or in operating; 3. To transfer, merge or amalgamate services, operations, persons or entities; 4. To start or cease providing services; 5. To cease to operate or to dissolve or wind up the operations of a person or entity. Integration activities can be:

- self-initiated by a HSP under sections 24 and 27 of the Act (“voluntary integration initiatives”);
- facilitated and negotiated by a LHIN under section 25 of the Act;
- resulting from changes in funding under section 19 of the Act;
- required by a LHIN under section 26 of the Act; or
- ordered by the Minister under section 28 of the Act.

**IHSP** – Integrated Health Service Plan. Published by each Local Health Integration Network (LHIN) pursuant to s. 15 of the LHSIA. A copy of a LHIN’s IHSP is available through the LHIN’s office and on its web site.

**LHIN** – Local Health Integration Network. The LHINs are 14 networks established by the LHSIA across the province of Ontario. Specific information about their geographic parameters and contact information can be found at [www.lhins.on.ca](http://www.lhins.on.ca).

**LHSIA** – *Local Health System Integration Act, 2006*. This is the legislation that established the LHINs and sets out the terms under which the LHINs may exercise the powers devolved from the Minister in respect of the planning, funding and integration of their local health system.

**Minister** – refers to the Minister of Health and Long Term Care, an elected official.

**MLAA** – Ministry-LHIN Accountability Agreement. The accountability agreement that is signed between the LHINs and the Minister pursuant to the terms of the LHSIA. Further information can be found in s.18 of the LHSIA.

**MOHLTC** – Ministry of Health and Long Term Care.

**OHQC** - Ontario Health Quality Council. The Council was created under the CFMA that reports to the Minister of Health and Long Term Care. The mandate of the Council is: (1) to monitor and report to the people of Ontario on: access to publicly funded health services; health human resources in publicly funded health services; consumer and population health status; and health system outcomes; and (2) to support continuous quality improvement. Further information can be found at <http://www.ohqc.ca>.

**Service** - as defined by the LHSIA, includes: a service or program that is provided directly to people a service or program, other than a service or program described above, that supports a service or program provided directly to people; or a function that supports the operations of a person or entity that provides a service or program as described above.

**Sustainable system** - an excellent system of care, that is informed by population need and can be maintained into the future within the financial, human and physical resources available.

**WERS** – Web Enabled Reporting System. WERS can be accessed at [www.mohltchb.com](http://www.mohltchb.com)