Champlain LHIN | RLISS de Champlain

Measuring Performance
First Quarterly Report 2018-19

Champlain LHIN

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Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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Executive Summary

This first quarter report of 2018-19 presents a view of the recent performance of our region's health system, including our successes and the performance areas that challenge us most. The report also summarizes corporate performance with respect to our 2018-19 first quarter financial status and up-to-date progress on the 2018-19 planned initiatives in our Annual Business Plan

During the first quarter, on average, Champlain remained 82% of the way to achieving our targets. Compared to the previous quarter, Champlain maintained 8th place of the 14 LHINs.

In this most recent period, Champlain continued as a top performer with respect to readmissions for chronic conditions (3rd place) and wait times for hip and knee replacements (2nd place). However, the LHIN lost some ground on the proportion of repeat emergency visits within 30 days for substance use (from 95% to 80% of target) and mental health concerns (from 91% to 85% of target).

Through 2017-18, the Champlain LHIN's home care wait time indicators have mostly recovered from the dramatic wait list growth in the previous year, as a result of swift implementation of new funding to address the need. Nevertheless, as the LHIN experiences a province-wide capacity shortage for personal support services, improvement reached a plateau while still far from target for two of four indicators. Further improvement will stem from the LHIN's strategies to maximize existing capacity and build future capacity with partners in our region.

The challenge of patients waiting in acute hospital beds for an alternate level of care, an area that is below target and worsening year-over-year since 2015-16, is shared by many other LHINs. In Champlain, the sub-acute capacity plan, which proposes to re-align existing post-acute resources and improve community supports to meet the current needs of our population, is now in implementation with the first related integration decision coming in October 2018.

Finally, despite a number of Ministry and LHIN initiatives to encourage quality improvement with performance-based funding, improve hospital occupancy, and reduce or divert emergency visits, improvement on the time patients stay in the emergency department, which is longer than most LHINs, continues to worsen. Drivers of the current poor results include more people visiting the emergency departments, delays moving patients to inpatient beds, staffing shortages, increasing hospital occupancy, lack of sufficient mental health and substance use specialty and community resources, and limited access to medical coverage, testing, and consultation at night. Some of these challenges are felt most in Ottawa and Eastern Champlain in particular.

In terms of corporate performance, the Champlain LHIN deployed 71.2 million dollars in the first quarter of 2018-19, which was 0.5% in excess of the budget, and represented a 9% increase in spending over the same period in 2017-18. However, part of the way through the first quarter, the LHIN was notified by the Ministry of Health and Long-Term Care of $16.0 million in

additional funding to support services to patients. A refreshed budget in the second quarter will take into account the 0.5% first quarter variance, and target the additional funding to support personal support services, therapy services and nursing services in Champlain.

As of the *second quarter* of the 2018-19 fiscal year, 78% of the 58 Annual Business Plan initiatives are on track. In large part, delayed initiatives are a result of funding availability and/or expenditure constraints.

The Champlain LHIN has completed a new risk assessment for 2018-19, and the Board of Directors approved a revised risk register in September 2018. The LHIN also completed an assessment as of the end of the first quarter of the risks' impact and likelihood, and mitigation strategies are in place for all ten risks.

Measuring Our Progress

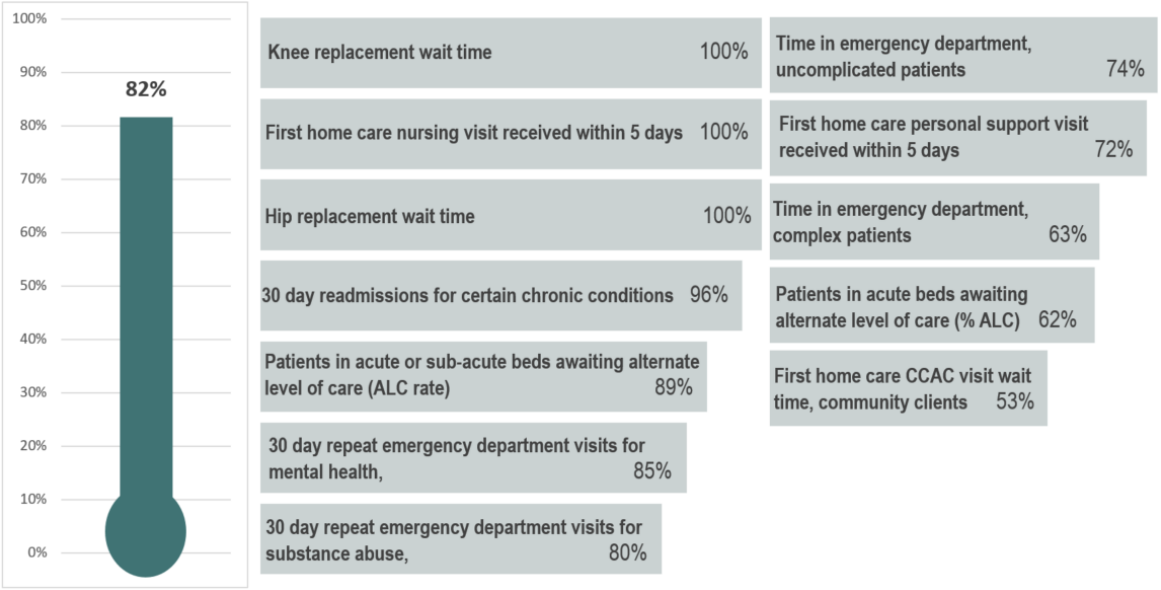
The Champlain LHIN's overarching objectives include ensuring timely, equitable access to high quality health services, improving patient and family experience, and increasing the value of the health system. Over the duration of the LHIN's accountability agreement with the Ministry of Health and Long-Term Care, the LHIN is required to move towards provincial targets for 13 indicators.

This first quarterly report of 2018-19[1] presents a view of the recent performance of our region's health system. In more detail, we review the performance areas that challenge us most, in particular the region's emergency department wait times and opportunities for improvement. As a measure of corporate performance, the report also summarizes the LHIN's financial performance, progress on the 2018-19 planned initiatives, and organizational risks.

System performance

An average of the percent of target achieved for each Ministry-LHIN Accountability Agreement (MLAA) indicator is reported in Figure 1. The "thermometer" provides a single number that summarizes how far the LHIN is from achieving all of its targets. During the first quarter of 2018-19, on average, Champlain was 82% of the way to achieving our targets (Figure 1) and in 8th place of the 14 LHINs.

Figure 1 Percent of target achieved, accountability indicators, Champlain, Q1 2018-19



[1] While this is the "First Quarterly Report", some reported results occurred the previous fiscal year. While we include the data that is the most recent available to us, some data is delayed by one to two quarters. See Figure 3.

Figure 2 depicts our accountability indicators with respect to their distance from target[2] and their trend[3] towards better or worse performance. The Champlain LHIN met three of the 13 targets in the past quarter (top row of Figure 2), as a result of continued high performance with respect to wait times for hip and knee replacements and home care nursing visits. In particular, the proportion of hip replacements (93.5%) that was completed within the target times in the first quarter of 2018-19 was the highest ever[4] seen in Champlain.

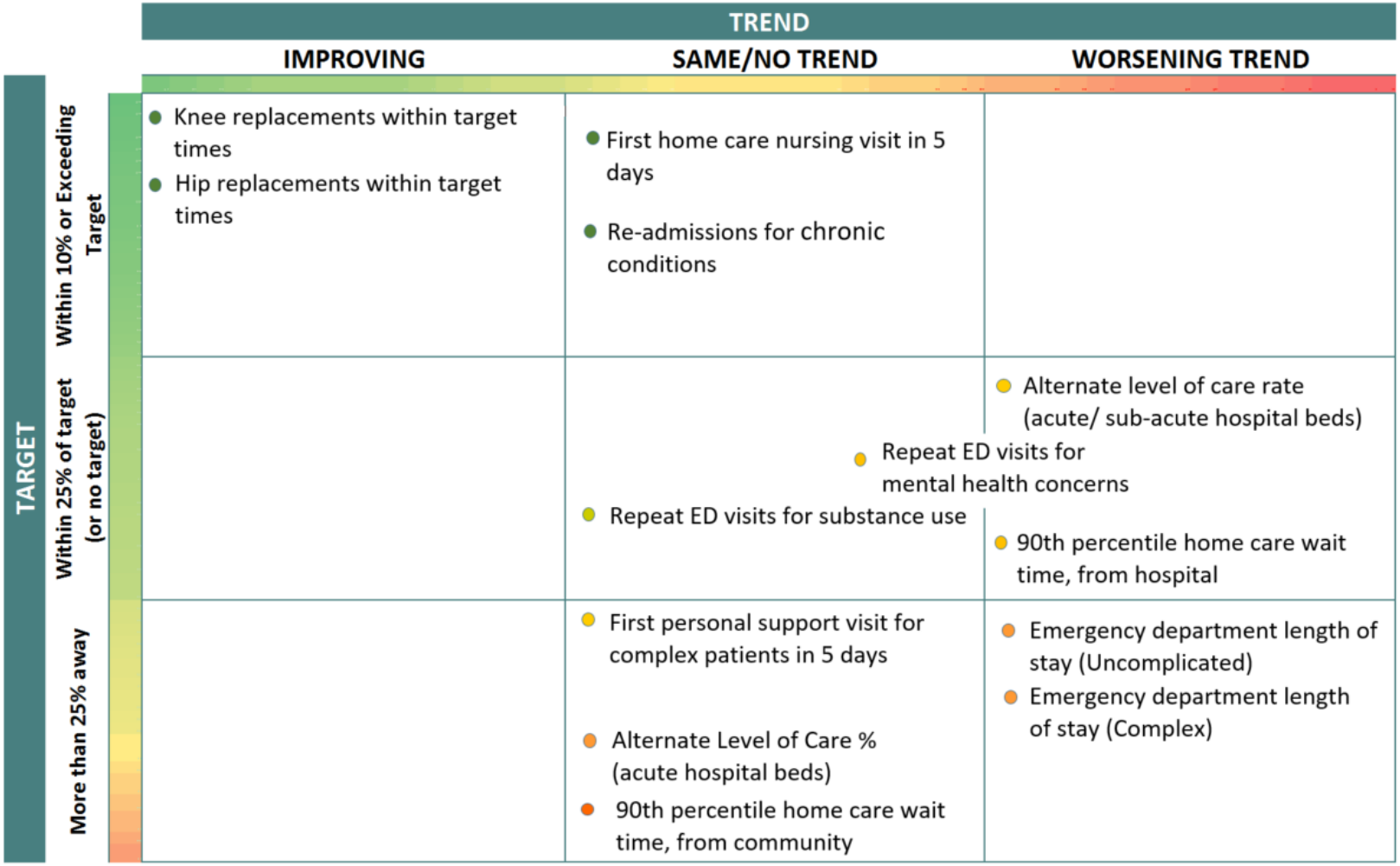
The Champlain LHIN's rate of readmissions to hospital for certain chronic conditions continues to be close (96%) to the target, and third best of all Ontario LHINs (Figure 3).

Since the previous quarter, indicators related to 30-day repeat emergency visits for substance use and mental health both worsened (from 95% to 80% and 91% and 85% of target, respectively). It is too soon to say whether this represents a sustained trend.

Five indicators are lagging the LHIN's targets by 25% or more. They relate to home care wait times, time spent in emergency departments and time spent waiting in acute hospital beds for an alternate level of care (bottom of Figure 2).

[2] Indicators are placed vertically with respect to one another in terms of percent of the target achieved.
[3] Trend is determined using control charts for each indicator, using quarterly results since 2013-14, adjusting for seasonality where appropriate, and applying health care control chart rules.
[4] Since the LHIN began measuring achievement of wait times in this way, in 2013-14, when only 72% of hip replacements and 73% of knee replacements were completed within target times.

Figure 2 Performance map of 13 MLAA Indicators: Distance from target and trend, Champlain LHIN, 2018-19 (Most recent reported result)



What can we expect in the future?

Forecasting future trends (last column of Figure 3) in performance can help us to understand where we are going so that we can take proactive actions to improve.

In reviewing our forecast in the latest fourth quarterly performance report, we note that most of our predictions were within 5% of the actual results within this Q1 report. However, our trend-based forecasts did not anticipate the worsening of emergency department repeat visits within 30 days for mental health (11% difference) and substance use (20% difference). Reasons for the unanticipated change, which may only be temporary, in these indicators are still under review.

Over the next quarters, the forecast predicts continued success regarding readmissions for chronic conditions and joint replacement wait times, and a recovery of the indicators relating to 30-day repeat emergency mental health and substance use. However, the forecasts anticipate continued challenges related to patients in acute hospital beds waiting for an alternate level of care, and the length of stay in the emergency department for patients with both complex and uncomplicated needs.

While we are still trying to quantify the severity of personal support capacity and home care resource constraints, we predict very little change in the 90th percentile wait time for home care service for patients referred from the community and slight deterioration in the 90th percentile wait time for home care service for patients referred from the hospital.

Figure 3 MLAA Indicator Performance -- Percent of target met, Rank among LHINs, 10 quarter trend and forecast, by indicator, Champlain

Indicator	Current Result (% of target) Q1 2018-19	Rank out of 14 LHINs	10 Quarter Trend[3] (% of target) Higher is better	Four Quarter Forecast[4]
Knee replacement wait time	100%	2	Q1	
Hip replacement wait time	100%	5	Q1	
First home care nursing visit received within 5 days	100%	11	Q4	
30 day readmissions for certain chronic conditions	96%	3	Q3	
Patients in acute or sub-acute beds awaiting alternate level of care (ALC rate)	89%	8	Q1	
30 day repeat emergency department visits for mental health	85%	5	Q4	
30 day repeat emergency department visits for substance abuse	80%	7	Q4	
Time in emergency department, uncomplicated patients[1]	73%	14	Q1	
First home care personal support visit received within 5 days	71%	13	Q4	
Time in emergency department, complex patients[1]	70%	12	Q1	
Patients in acute beds awaiting alternate level of care (% ALC)	62%	5	Q4	
First home care visit wait time, community clients[1]	51%	13	Q4	
First home care visit wait time from hospital discharge[2]		11	Q4	
Average	**82%**	**8**		

[1] 90th percentile: Time waited by the 9th patient out of 10 patients.

[2] Provincial average used as target for trend line, until a target is set.

[3] Reporting periods vary for each indicator depending on the data source, and are reflected with the trend lines. The actual quarter of the latest result (Q1, Q2, Q3, Q4) is noted.

[4] Forecasts take into account historical trends, with emphasis on recent performance, as well as known influences e.g. investment and project implementation, or growth of wait lists.

Where are our performance gaps and what are we doing about them?

Champlain is more than 25% away from the target for five performance indicators:

- **Two home care wait time indicators:** Patients with complex needs receiving the first personal support visit within 5 days (72% of target) and the 90th percentile number of days to the first home care visit for patients referred from the community (53% of target).
- **Time in emergency department**, complex (63% of target) and uncomplicated needs (74% of target)
- Patients in **acute beds awaiting an alternate level of care** (62% of target)

The following sections include an assessment of challenges related to closing gaps in performance and an overview of the strategies the LHIN has put in place, including an extended look at the challenges and opportunities involved with improving emergency department performance.

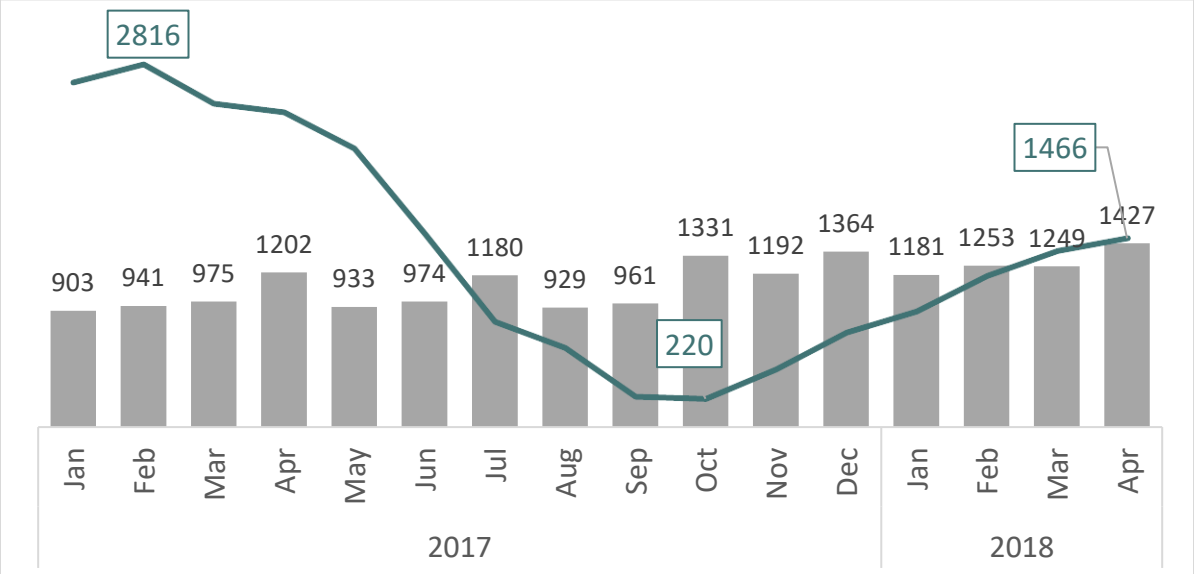
Home Care Wait Times

Lagging by one quarter, the home care wait time indicators in this report refer to the results from the fourth quarter of 2017-18. Two indicators remain far from target, and a third indicator with no target (90th percentile wait time for first home care from hospital discharge) worsened from 8 to 10 days over the previous quarter.

Overall, current performance is better than it was in early 2017-18 thanks to increased home care funding. After ramping up services from January through September 2017, and serving a number of patients who had been waiting, service provider capacity limits, personal support worker shortages, and increased referral levels resulted in a growing personal support wait list since October.

The number of requests can vary due to a number of factors, including public perception of the availability of home care services at the time (Figure 4 below). Wait time performance might have improved even more if it were not for a 14% increase in requests (referrals) for personal support services beginning in October 2017 when the wait list for home care had hit a low of 200 people.

Figure 4: Monthly number of persons waiting for personal support services and monthly referral/request volumes, January 2016- April 2018



Despite a tenacious wait list and wait times for home care services that are still far from target, there is reason to be hopeful.

Since the previous reporting period, the LHIN had been able to slightly increase the number of weekly clients who could be seen from the wait list, at the same time as the number of referrals for home care returned to previous lower levels. As a result, the number of people waiting for personal support services has gradually decreased over the summer.

Additionally, because of the increase in stable funding the LHIN has received, it is unlikely that the wait list will reach previous levels seen in January and February of 2017. Further improvements in wait times will occur as Service Provider Organizations (SPOs) continue to build capacity and the supply of personal support workers (PSWs) grows.

The LHIN's current strategies relate to maximizing our existing service capacity through efficiency, and building long-term service capacity with partners. Efforts to re-align service geographies within particular sub-regions will reduce travel distances and save valuable personal support worker time. In addition, the LHIN is piloting "Client Partnered Scheduling", which allows for a window of time to provide service to clients rather than a specific time, when appropriate, to allow service to occur when a worker is available. The LHIN is communicating regularly and working with all contracted Service Provider Organizations who provide home care services, as well as colleges, paramedics and other non-contracted organizations to mitigate the impact of limited capacity. Continued funding over time and work to improve and stabilize personal support capacity should lead to further improvement in results beyond 2018-19.

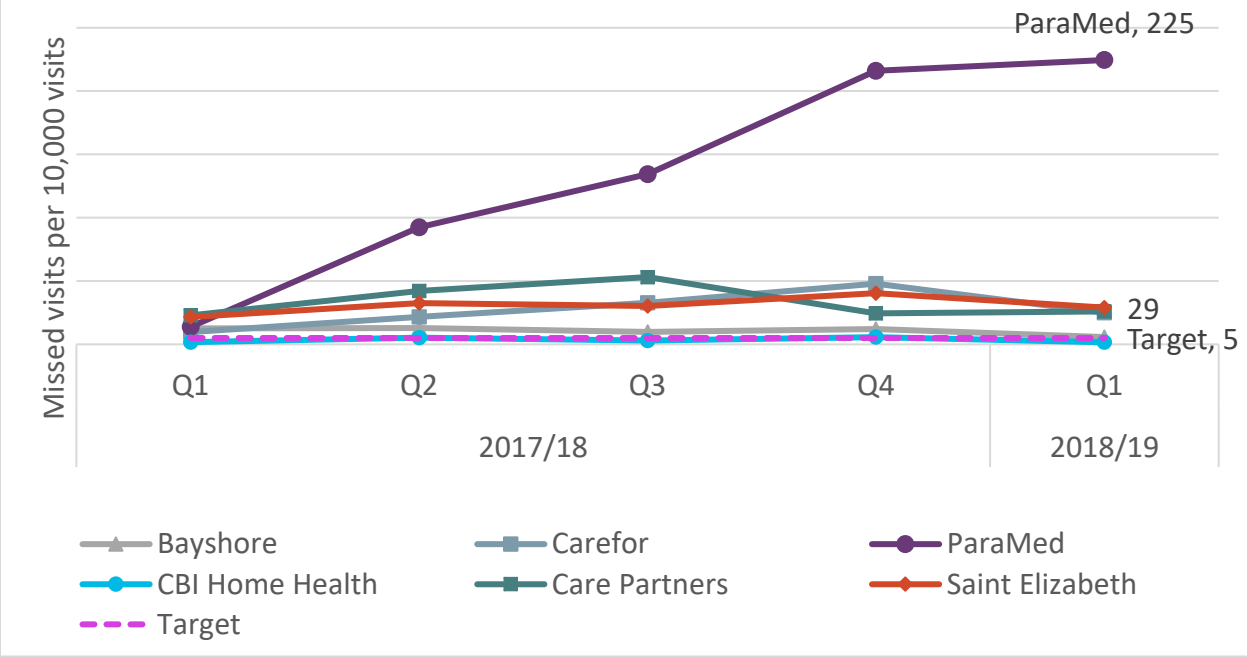
Missed care

In the 2017-18 fourth quarterly report, we reported that capacity shortages were influencing another home care quality indicator, "missed care", which is a provincial indicator that is monitored regularly by the LHIN Board's Quality Committee. Contracted service providers are required to self-report to the LHIN instances when they are unable to send a worker to visit a patient as previously scheduled to do so. Missed patient care may lead to poorer patient outcomes and affect overall patient experience. The provincially set target for missed visits is 0.05% or 5 in 10,000 visits.

Over 2017-18, the rate of missed visits for personal support services in Champlain increased from 0.13% in the first quarter to 0.90% in the fourth quarter, but has improved to 0.79% as of the first quarter of this year .

Figure 5 depicts the missed care rate per 10,000 visits over time for personal support services by contracted service providers that account for the majority of services provided in Champlain. A number of providers are not close to meeting the target of less than 5 of 10,000 visits, and one provider – ParaMed—continues to be particularly far from target. In addition to working with all partners to mitigate the personal support shortage and minimize impact on patients, the LHIN has followed additional steps in the performance management process as outlined in its contract with the provider to address this concern.

Figure 5: *Missed personal support care (missed visits per 10,000 visits) in Champlain, by Service Provider Organization, 2017-18 Q1 to 2018-19 Q1*

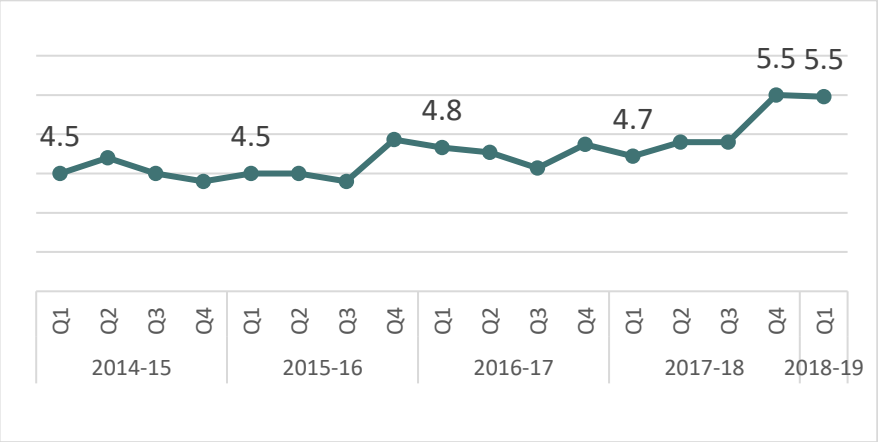


SPOTLIGHT: Emergency Department Challenges and Opportunities

Emergency department length of stay is the total time from registration at the emergency department to discharge from the emergency department.

For patients with uncomplicated needs, the 90th percentile target is 4 hours.

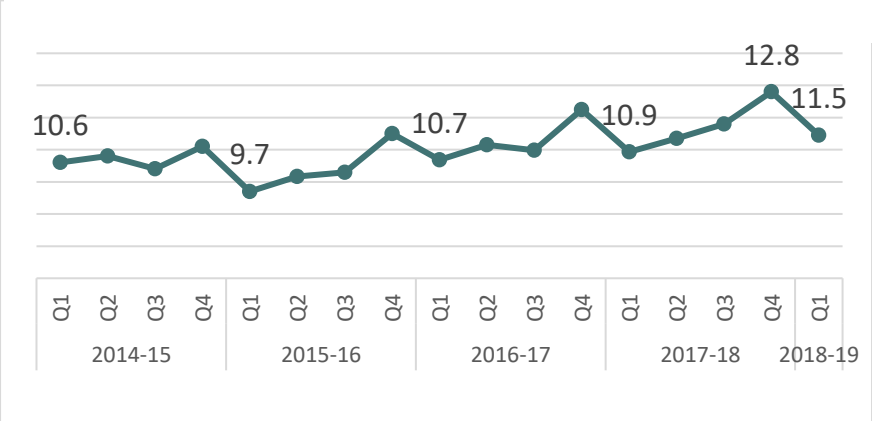
Figure 6: 90th percentile emergency department length of stay for patients with uncomplicated needs, 2013-2018, Champlain



Though the 90th percentile length of stay in the emergency department for people with uncomplicated needs has hovered between 4.6 and 4.9 hours over the last few years, it worsened substantially to 5.5 hours in these past two quarters (Figure 6), and ranked Champlain last among the other 14 LHINs.

Patients with complex needs require more time in the emergency department as they undergo assessments and tests, and receive treatments. The Ontario target is that 90% of patients with complex needs have stays of 8 hours or less. For patients with complex needs (CTAS 1-3), the 90th percentile time in emergency department has gradually worsened over the last 3 years from 9.7 hours in the first quarter of 2015-16 to 11.5 hours in 2018-19 (Figure 7). In the past year, it has been as high as 12.8 hours. For patients with complex needs, the Champlain LHIN ranks 12th of 14 LHINs in Ontario.

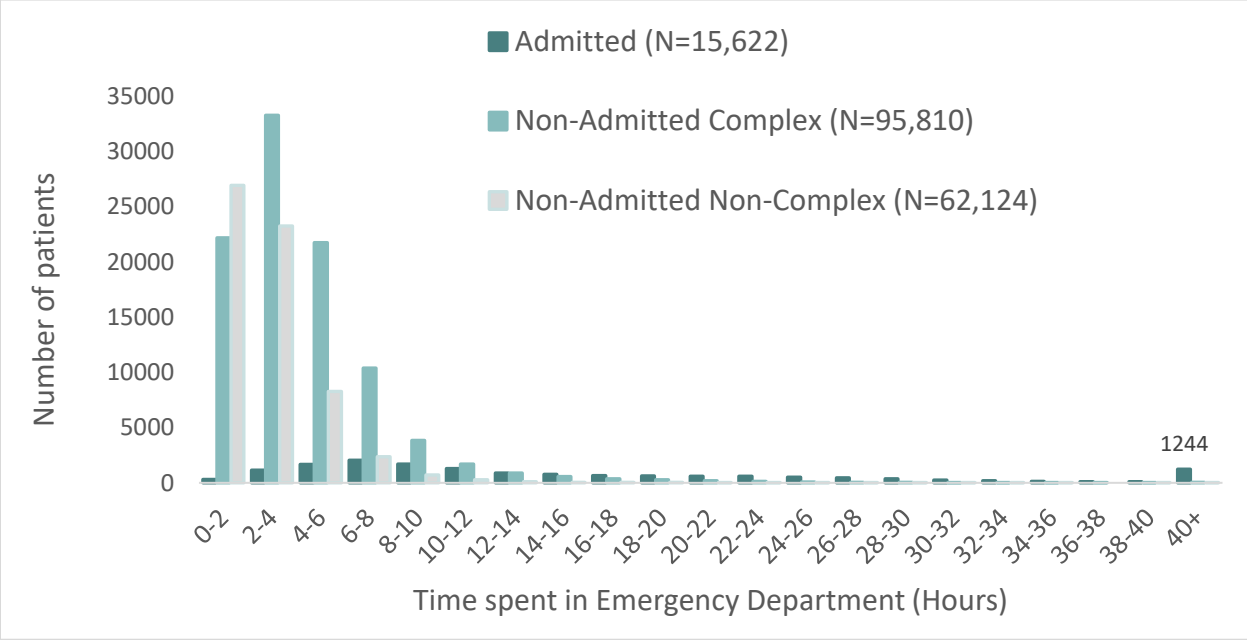
Figure 7: 90th percentile emergency department length of stay for patients with complex needs, 2013-2018, Champlain



In the fourth quarter of 2017-18 and first quarter of 2018-19, the time patients spent in the emergency department was unusually long in hospitals in Hawkesbury and Cornwall, in particular. The results at those two hospitals contributed significantly to the LHIN's poor results in the most recent quarters.

The experience and factors associated with patients spending a long time in the emergency department are different for patients who are admitted to hospital, for patients with complex needs who are not admitted, and for patients with uncomplicated needs (Figure 8 below). For the subset of patients with complex needs who do not end up admitted to an inpatient ward, the 90th percentile wait time was very close (8.1 hours) to the provincial target, but patients who are admitted waited more than 34 hours at the 90th percentile. The LHIN's understanding of emergency department challenges and opportunities has broadened as a result of data analysis of all emergency visits in Champlain in the fourth quarter of 2017-18 and consultation with members of the Champlain Emergency Services Network. Factors driving the long lengths of stay include an increased numbers of visitors, high inpatient occupancy rates, space constraints, access to diagnostics, specialist and community resources, and medical staff shortages.

Figure 8: Time in Emergency by Patient Type (Champlain LHIN, 2017-18 Q4)



In Champlain, overall Emergency department patient volumes have increased by 6.7% from 2013-14 to 2016-17, outstripping the average increase in non-physician staffing in emergency departments of 2%. In 2017-18, there were 25,000 more visits to the emergency department – the highest in 10 years. Some hospitals have seen more growth in volumes than others. For instance, the Hawkesbury General Hospital has seen a 46% increase in volumes, and a 67% increase in patients from Quebec, over the last four years. This hospital accounted for 30% of all of Champlain's long-wait patients with uncomplicated needs in the fourth quarter of 2017-18.

Hospitals in Champlain, particularly in Ottawa and Eastern Champlain, have been reporting very high occupancy for a number of consecutive quarters. The number of patients who were admitted to Champlain hospitals increased by 11.2% over the past four years. Hospital occupancy, and delayed flow of patients to inpatient beds, when they require them, can cause a significant

bottleneck in the emergency department, and create delays in patient assessment and overall flow. People waiting in emergency room beds also create additional workload for staff, and risk for patients as a result.

The time to physician assessment is an important factor in emergency quality and safety – it is the time a patient waits to have their concerns assessed and for care decisions to begin. For patients who are not admitted to hospital, the bulk of time is spent waiting for an initial assessment by a physician. Truly emergent patients are seen almost immediately – the average time it takes to be assessed by a physician for the highest priority life threatening concerns is within 20 minutes. For the rest of patients in the emergency department, the average time to assessment is between 1.5 to 2 hours. For the longer waiting patients, this time can be as long as 4 hours. The time that these patients spend before being assessed is influenced by how many physicians are present to see the volume of patients at the time.

At night (and on holidays and weekends), there is less physician coverage in emergency departments. There is also less access to diagnostic testing and interpretation, and specialist consultations. Everything takes longer, and much of the testing, consultation, and inpatient admission waits until the morning.

Some hospitals are having particular difficulty recruiting medical and emergency department staff, especially French-speaking staff. This is particularly challenging as those hospitals are also experiencing dramatic volume increases at the same time.

CTAS level 3 patients (described as having urgent, potentially serious concerns) are the largest group of patients using the emergency department. They tend to be complex to assess and diagnose, compared to the more urgent and emergent patients whose symptoms are usually much clearer. Diagnoses require more time, access to diagnostic testing, consultations with specialists and primary care, and patients often require community referrals and follow up upon discharge.

There seems to be a particular shortage of psychiatry and resources for patients who present to the emergency department with mental health and substance use concerns, and this issue is exacerbated at night. Patients with mental health crises can end up waiting all night in the emergency room – an inappropriate care setting for people in distress.

What's working

To help reduce continuing occupancy challenges and the resulting impact on the emergency department length of stay, hospitals in Ottawa and Cornwall received funding for 128 additional beds in November 2017 through January 2018. Though the length of stay for admitted patients was still long, the hospitals receiving the additional funding reported improved flow.

The provincial "pay-for-results" program encourages hospitals to improve their length of stay in the emergency department with funding directed toward quality improvement initiatives.

The Community Paramedic Program and Nurse-led Outreach Team helped to prevent and reduce visits to the emergency department, especially from seniors and residents of long-term care homes.

Geriatric emergency medicine (GEM) nursing is invaluable in the emergency department because they help to ensure older patients (often CTAS 3 level mentioned earlier) receive an early specialized assessment and the care, and follow up they need.

The number of visits to the emergency department that could be managed elsewhere have been declining over the past three years. This positive change could relate to primary care access, emergency department diversion efforts (discussed above), community surge planning and education, among other factors.

HEALTH QUALITY ONTARIO'S EMERGENCY DEPARTMENT RETURN VISIT PROGRAM

Health Quality Ontario has been working with hospital emergency departments to review reasons for return visits to the emergency department and to make improvements to the quality of care provided.

Though the time spent in emergency is not the only indicator, many of the opportunities highlighted here are well aligned with the findings of a provincial review of return emergency department visits. The provincial report can be found here:

http://www.hqontario.ca/Portals/0/documents/qi/ed/report-ed-return-visit-program-2017-en.pdf

Looking ahead

A number of opportunities to improve emergency department length of stay, and quality, have become clear.

We need to improve flow from the emergency department to inpatient beds. This may mean more funding for beds but it also may mean identifying barriers to flow at night, on weekends and holidays. Improved medical coverage and access to diagnostics at night would improve quality of care and shorten the region's 90th percentile length of stay. Continued and increased geriatric assessment, diversion, care and follow up for older patients with complex concerns would reduce length of stay, reduce re-visits, and improve outcomes. Improved access to mental health and substance use specialists and community resources would reduce about 2% of Champlain's longer waiters in the emergency department and provide more appropriate mental health care. Finally, continued "surge planning" for higher volume seasons, and community education about alternatives to the emergency for non-urgent concerns, especially during influenza seasons would continue to divert unnecessary visits to already busy emergency departments at peak times.

Patients waiting in hospital for an alternate level of care

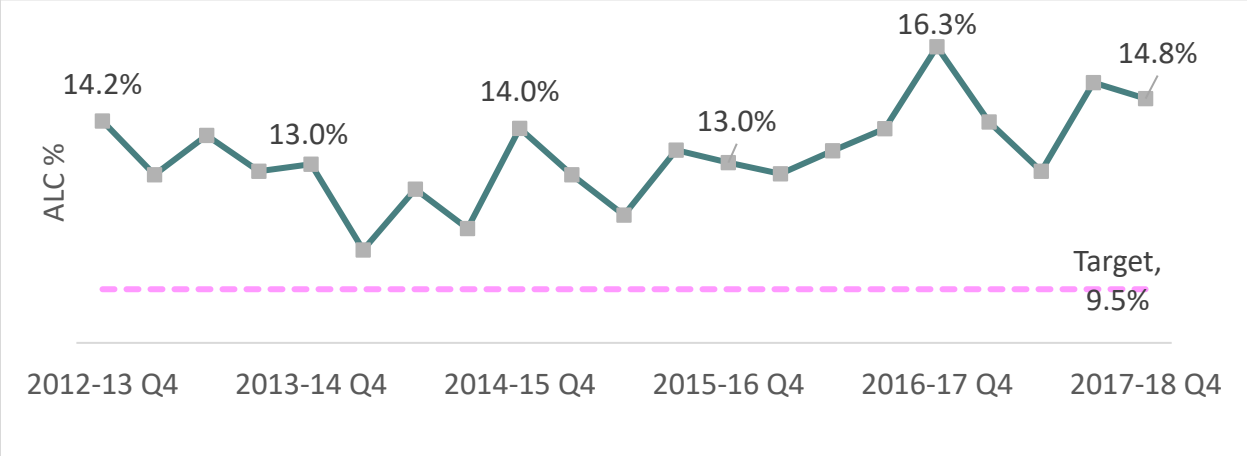
The alternate level of care (ALC) indicators reflect the number of patients waiting in hospital for care in a more appropriate and less costly setting. The number (and proportion) of people waiting for an alternate level of care, is influenced by capacity and performance in multiple sectors (i.e. community services, long term care, acute care, rehabilitation, palliative care, mental health, supportive housing, home care) and is a measure of health system performance, capacity, and integration.

The "% ALC" indicator counts the number of total days waited in an acute bed at the time a patient is discharged. A few patients waiting a long time and then being discharged in the same quarter can influence the result substantially. After a spike in the previous quarter (15.3%) related to the discharge of a high number of patients who had been waiting for an alternate of care for a long time, the rate was lower again in Q4 (14.8%). Though still much worse than the 9.5% target, this fourth quarter result was much better than the 16.6% we had forecast in our previous report and was lower than in the same quarter one year earlier. Champlain's results are 5th best of 14 LHINs. Recognizing that influenza related admissions peak during the fourth quarter of the year, the Champlain LHIN hospitals faired very well this year.

The proportion of days that patients wait in acute hospital beds for an alternate level of care has been elevated since the beginning of 2016-17 (Figure 9).

Patients spent the longest waiting in acute beds for long-term care (30% of ALC days), home care support (18%), and for supported or assisted living (15%). Patients also waited for rehabilitation, complex continuing care, home with community or no services, or convalescent care.

Figure 9: Proportion of days patients waited in acute hospital beds for an alternate level of care, Champlain LHIN, 2012-2017



The LHIN continues to work with hospital and community partners to ensure patients receive care in the right location, outlined in a January presentation- "Pathways to Appropriate Levels of Care" to the LHIN Board of Directors.

A board-approved sub-acute[5] capacity plan proposes to re-align the region's resources to provide services earlier to help people recover from acute illnesses and restore their functioning so that they can return home and increase their chance of remaining in their home. More specifically, the plan's key recommendations propose to:

- Convert a minimum of 43 complex medical management, 28 general rehabilitation and 14 transitional care beds to specialized, stroke and geriatric rehabilitation beds.
- Test the impact of increased intensity of inpatient rehabilitation by offering therapy 7 days per week and increasing daily hours of therapy.
- Increase availability of outpatient and in-home rehabilitation to reduce use of in-patient beds through the creation of integrated hubs of service in 3 geographic locations.
- Add community based housing supports to expedite discharges out of sub-acute care.
- Make better use of existing sub-acute beds by standardizing care: reducing length of stay, standardizing admission criteria and coordinating access to beds.

The outcome will be the right mix of rehabilitative beds, available when needed (for example, fewer low occupancy complex continuing care beds and more high demand stroke beds) and improved community-based supports to better meet the needs of Champlain's aging population.

An ambitious step in the plan's implementation is the integration decision in consideration in this month (October 2018) by the Board of Directors. The integration decision would require hospitals providing rehabilitative services to convert the mix of beds, increase the intensity of services received by patients, refrain from making changes without approval of the LHIN, and establish a regional program to ensure ongoing planning and improvement initiatives.

If the plan is successful, there will be higher quality care and fewer delays to the most appropriate rehabilitative care setting for patients, improving their chances for optimal function and to remain at home. It will also make the best use of the region's scarce resources, reduce the number of costly days patients spend in acute beds, and reduce backlog in the region's acute and emergency services.

To reduce time waiting for long-term care, the LHIN is facilitating hospitals to provide a preferred accommodation supplement to expedite transfer to long-term care. In addition, a new

[5] Sub Acute Services include: All rehabilitation, complex medical management, convalescent and sub-acute palliative care beds, and all publicly-funded community restorative care services. These services benefit patients such as stroke survivors, those with acquired brain injuries, amputees and older people who have become deconditioned following illness or injury.

enhanced assisted living model to divert patients from long-term care to a supported community option is underway, with two of three new locations currently "rolled out".

Further, work is underway to support a regional approach to implementing leading practices in discharge planning. These efforts will reduce the time that 53% of patients-- waiting less than 8 days – wait for an alternate level of care.

Conclusion

The Champlain LHIN sits mid-pack amongst LHINs in terms of its overall performance for health system accountability indicators. Champlain is a top performer, and has worked diligently over many years to improve readmissions for chronic conditions, and hip and knee replacement wait times.

Over 2017-18, the Champlain LHIN's home care wait time indicators have mostly recovered from the dramatic wait list growth in the previous year, as a result of swift and thoughtful implementation of new funding to address the need. However, results have reach a plateau due to capacity challenges in Champlain for personal support and therapy. Strategies to maximize existing and build long-term service capacity will contribute to performance improvements going forward.

Despite a number of Ministry and LHIN initiatives with positive outcomes to improve hospital occupancy and reduce or divert emergency visits, the time patients stay in the emergency department continues to be one of the poorest in the province, and to worsen year-over-year. The LHIN has gained an improved understanding of the factors and issues affecting emergency department flow and quality. Additional initiatives have been identified for action.

The systemic and worsening challenge of patients waiting in hospital beds (especially acute hospital beds) for an alternate level of care is shared by many other LHINs. The sub-acute capacity plan, when successfully implemented, aims to improve the mix of services provided to meet population needs, and because of that, will improve the time patients spend waiting for an alternate and more appropriate level of care.

Corporate Performance

Financial Summary (First Quarter)

In the first quarter of 2018-19, the Champlain LHIN spent 71.2 million dollars, which was 0.5% in excess of the 70.8 million dollars that were budgeted. This represents a 9% increase in spending of over the same period in 2017-18.

Part of the way through the first quarter, the LHIN was notified by the Ministry of Health and Long-Term Care of $16.0 million in additional funding to support services to patients. Considering the 0.5% first-quarter variance, the additional funding will be used to support personal support services, therapy services and nursing services. This budget refresh will be integrated into the Q2 financial results.

Progress on the Annual Business Plan (Second Quarter)

The Annual Business Plan is the yearly plan that maps out how we are fulfilling the strategic goals articulated in the Integrated Health Service Plan and forms part of the Ministry-LHIN Accountability Agreement.

In 2018-19, priorities include:

- Support scaling of Health Links to significantly increase the number of people with complex health conditions receiving coordinated care.
- Expand sub-regional planning efforts to focus on strengthening, coordinating and integrating primary care, and home and community care for people who need those services.
- Ensure coordination and integration of community mental health and addictions services and palliative care.
- Deliver coordinated care based on community needs and improve equitable access to services through sub-regional planning.

Overview of status and mitigation

Of the 58 interventions identified in the Annual Business Plan (ABP), 45 are forecasted to be on-track to achieve their planned deliverables by the end of the fiscal year. There are 13 interventions forecasted to be off-track at the end of the year.

Of the 13 interventions forecasted to be off-track, 11 are related to funding availability and/or expenditure constraints. Some of these interventions may receive a favourable forecast later in the fiscal year, should the constraints be lifted and resources become available (e.g. future

Ministry funding announcements or approval to reallocate resources within the system). These interventions involve resources to:

- Enhance community support services (e.g. attendant services, homemaking and transportation)
- Enhance chronic disease prevention and management services (e.g. chiropody, stroke rehab, culturally appropriate health promotion activities)
- Support effective communication and engagement of primary care practitioners
- Review and enhance services for Indigenous Peoples (e.g. development of an Equity Framework; needs assessment related to Indigenous seniors healthcare; system navigation and outreach services related to complex mental health issues; addictions services)
- Establish six residential hospice beds in Hawkesbury
- Implement several recommendations of the regional sub-acute capacity plan

Risk Assessment (First Quarter)

Enterprise Risk Management (ERM) is a continuous, proactive and systematic process to understand, manage and communicate risk from an organization-wide perspective. The Champlain LHIN's ERM program reflects a best practice of well-governed organizations.

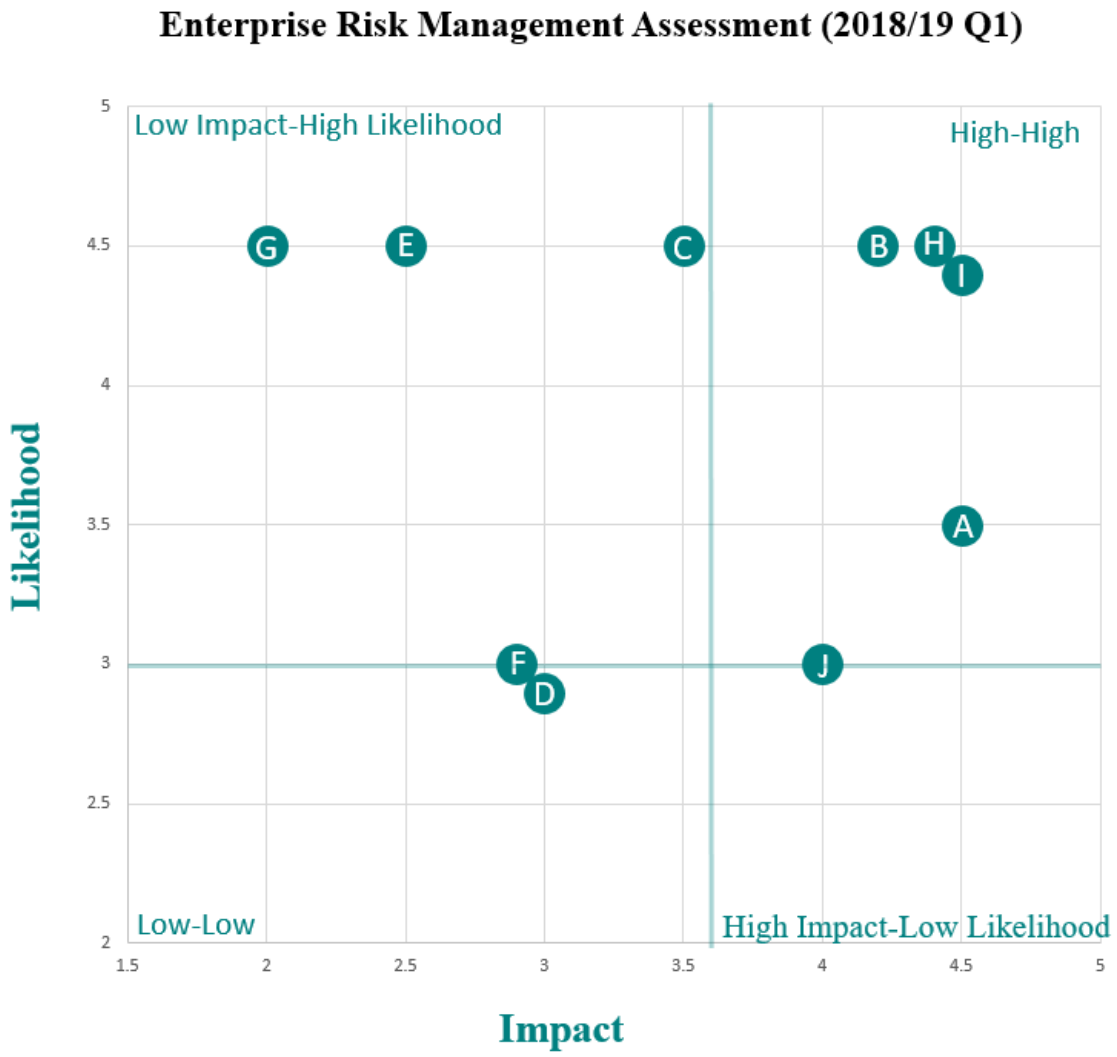
In light of the proposed Patients' First legislation and Integrated Health Services Plan for 2016-19, the Champlain LHIN revised its risk register for 2018-19, identifying risks that are most significant to the LHIN. The revised risk register was approved by the Board of Directors in September 2018.

Below is a summary of the organization's revised risk profile as of the end of the first quarter of 2018/19, organized into the following risk categories - strategic, financial, leadership, operational, and external. The LHIN's risks are generally reviewed and re-assessed each quarter in this report. For the purposes of assessing and mapping the risks, each risk has been assigned a label (A through J) in the table below.

	Risk Description
Strategic	
A	**Strategic Implementation** An inability to sufficiently and/or effectively deploy initiatives central to the strategic plan to have a positive impact on the health system, possibly aggravated by competing priorities.
B	**Health Service Provider Organizational and Leadership Capacity** Organizational challenges within service providers impact performance of the health system and detract from the LHIN's ability to effect transformational changes.
Financial	
C	**Fiscal and Statutory Capacity to respond** The LHIN's limited flexibility to allocate or reallocate funds where needed and a lack of authority and/or statutory powers could detract from its ability to achieve health system performance improvements and to fulfill our transformational mandate.
Leadership	
D	**LHIN Organizational Capacity** Insufficient breadth and depth of skills and experience within the LHIN impacts the LHIN's ability to meet both the transformation and operational requirements of its expanded mandate.
Operational	
E	**Technology** The slow pace of technology implementation limits the integration of health services as observed through challenges in connecting every Ontarian to an electronic health record. Delayed deployment leads to compromises in safe and effective patient care, and a reduction in efficiencies that could be realized through integrated electronic records.
F	**LHIN Instability** Though the LHIN has officially merged, stabilization after a merger takes many years. There remains a risk that organizational instability will detract from meeting all existing obligations.
G	**Deficiencies in needed information to fulfill our responsibilities** The LHIN does not always have access to all the information/data required to make informed decisions or to fulfill our responsibilities.
H	**Service delivery capacity** A deficiency in the quality, number or availability of health human resources available to contractors and/or the LHIN could prevent the LHIN from meeting the demand for home care services.
External	
I	**Policy and economic uncertainty** Due to the uncertain policy direction from the new provincial government, the risk of restructuring in the health care system and the potential for global economic instability, the availability of health care funds may be constrained and the organization of health services disrupted.
J	**Unanticipated population change** Unanticipated changes in demographic characteristics and health needs of the Champlain population may overwhelm existing health service capacity.

Q1 Risk Assessment

Each of the ten risks were assessed for the potential impact and likelihood of the risk occurring. For comparative purposes, the chart below illustrates the current quarter (Q1) risk assessment.



Risk Mitigation Strategies

The LHIN has put in place mitigation strategies for all ten of the identified risks. The LHIN management team reviews the risks and the mitigation strategies on a quarterly basis and as circumstances change.