Queensway Carleton Hospital

Vision 2021

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PREAMBLE

Queensway Carleton Hospital (QCH) is a dynamic and expanding community teaching hospital. With a growing and an aging population placing ever increasing demands upon our organization in excess of our anticipated resources, we need to make choices in how and, which services we will provide.

Vision 2021 is a strategic direction-setting document, which will outline strategic themes and directions the hospital will follow as it prepares for an integrated role in the provision of health services within the Champlain Local Health Integrated Network (LHIN). The document will support and inform key discussions and decisions such as,

- regional role within the LHIN,
- long-term goals and objectives, which are to be achieved through leveraged actions contained in the QCH Balanced Scorecard, and
- other planning initiatives such as medical human resource planning, information technology plans, and educational and learning plans.

The document will also support a subsequent planning document – the Master Program. Based upon the Strategic Plan, the Master Program will reflect the projected program volumes, staffing and departmental space. Following completion of the Master Program, the architects will develop a Master Plan, which illustrates how our facility will be developed.

I. EXECUTIVE SUMMARY

The Queensway Carleton Hospital (QCH), situated in the western portion of the City of Ottawa, is a large community teaching hospital providing a comprehensive range of acute care services to Ottawa and the Ottawa Valley. Opened in 1976, the hospital has experienced significant changes due to a growing and aging population, adding new health service roles following system restructuring and capital expansion to accommodate growth.

Within the context of an evolving regional health system, QCH undertook a comprehensive strategic planning exercise in support of its Vision, Mission, and Values. Planning was guided by a review of the environment and a current Strengths, Weaknesses, Opportunity and Threats (SWOT) assessment.

A robust planning process was followed to ensure completeness and logical progression of decisions. A key element was the consultation process. Specifically, the consultation process was structured using a bottom-up approach to ensure that the priorities and the environment experienced at the front line level were reflected in the overall priorities for the organization. In addition, the consultation process was inclusive of the external stakeholders, which occurred in partnership with the Pinecrest Queensway Community Health and Resource Centre, with whom we jointly completed a number of external focus group sessions within our community.

The confirmation of the Vision Statement sets the overall direction. For QCH, the Vision is, "*We will be the community hospital of choice, recognized for our exemplary patient care, people and performance"*. This descriptor highlights a number of factors. First, QCH's role will be focused as the premier community hospital. In addition, the statement highlights three areas of excellence: patient care, people and performance.

The environment in which we propose to achieve this Vision is framed by the values of Accountability, Innovation and Respect.

Four strategic themes further guide the organization towards achievement of the Vision. These themes summarize the overarching directions/initiatives to which the hospital will devote time, energy and resources in support of the Vision. The four strategic themes each have short and long-term goals which clearly define desired end points during the horizon of this Plan for 2021. Exhibit 1-1 summarizes the strategic themes and related goals.

Vision

We will be the community hospital of choice, recognized for our exemplary patient care, people and performance

Mission

We are a patient-and-family-centered community hospital providing a broad range of acute care services to the people of Ottawa and the Western Ottawa Valley.

We provide care for all age groups – through inpatient and outreach programs and services, in partnership with other healthcare and community service organizations.

We actively promote a learning environment, in which our staff, physicians, students and volunteers are encouraged to be their best.

Our Cornerstone Programs are:

- Emergency Services
- Medical Services
- Surgical Services
- Geriatric Services
- Acute Rehabilitation
- Childbirth Services
- Mental Health Services

Values

Accountability
Innovation
Respect

STRATEGIC THEMES	GOALS SHORT TERM (FIVE-YEAR HORIZON)	LONG TERM (10 YEARS PLUS HORIZON)
I Operational & Clinical Excellence	Patient Safety – Fully compliant with all 'Safer Healthcare Now' initiatives – Fully compliant with all CCHSA patient safety standards Operational and Clinical Excellence – Clinical and operational performance is consistently rated good to excellent as confirmed through Accreditation and other benchmarking surveys (e.g. OHA Report Card) – Fully compliant with MOHLTC performance expectations (i.e. Hospital Accountability Agreement -Wait Times, readmission rates, ER time to admit, balanced budget etc.) and governance policies – Increased educational training opportunities and relationships (e.g. University of Ottawa, Algonquin College) Workforce Planning & Management – Recognized as a preferred workplace within the province – Required human resources are in place to enable us to fulfill our mission – Utilization of human resources is optimized (i.e. full use of scope of practice; top quartile performance for sick time)	- Recognized for providing an expanded and reconfigured range of clinical programs characterized by clinical excellence, patient satisfaction and meeting the evolving needs of our community. - New and creative Recruitment and Retention Strategies will be utilized to ensure that our Human Resources needs are anticipated and met in a labour market where the demand will exceed the supply. - Recognized as a learning organization successful in engaging and developing talent.
II Patient/Family Centered Care & Service	- All patient satisfaction scores will be at or above the Mean on the OHA Patient Satisfaction Survey - Staff, physicians, students and volunteers will have increased and Demonstrated knowledge of cultural and environmental needs of their clients and colleagues	- All patient satisfaction scores will be at or above the 25th percentile on the OHA Patient Satisfaction Survey. - QCH's environment and clinical programs will be responsive to its demographic and ethnic diversity.
III Integrated Care & Service	- A minimum of four clinical programs and two service programs achieve regional integration (e.g. cancer; dialysis; mental health; orthopedics; Lab; DI) as recognized by the LHIN. - Chronic disease management (e.g. COPD) is enhanced across the continuum of care through increased coordination and effective use of innovative technology with community partners. - Care for the frail elderly is enhanced across the continuum of care resulting in the achievement of benchmark levels of ALC patient days. - Clinical program configuration supports the achievement of optimal service delivery	- Care and service capacity is optimized through alternate models of care and/or settings (e.g. freestanding ambulatory care facilities). - A sustainable and appropriate clinical profile is maintained in the context of local and regional service needs and strategies. - Promote and partner to achieve appropriate capacity in the community to efficiently and effectively care for individuals with complex chronic conditions. - Partner with other stakeholders to deploy innovative technologies to enhance patient self-care management in the community to reduce or delay hospitalization
III Responsiveness to Care & Service Need Through Alignment with System Priorities	Facilitate the development and implementation of LHIN priorities to address local and regional health care needs – Access (Wait Times (efficiency, system-wide approach), ALC, Coordination of Transportation, Human Resources Planning, Services Closer to Home, Diversity and Special Needs) – Primary Health Services for Health Communities – Chronic Disease Prevention and Management – Addictions and Mental Health – Seniors with Complex and Chronic Conditions – e-Health - All drugs, diagnostic and lab tests are ordered electronically contributing to a basic electronic health record (e.g. minimum data set; DI & Lab results. - Clinicians refer and schedule patients electronically on site and remotely. - Community funding share required for capital redevelopment has been secured by the Foundation. - A comprehensive community engagement program will increase understanding and manage the community's expectations with the reality of limited healthcare resources.	- All QCH patients will have a comprehensive electronic health record that follows the patient through the system - Priority acute care needs of the catchment population are met in a timely and effective manner

The activities required to achieve the goals for each of the strategic themes, described as leveraged actions, are outlined within the hospital's annually renewed Balanced Scorecard.

Operating as a community acute care hospital requires that decisions be made to ensure the appropriate and complementary scope of services are being provided. Having considered the needs of the community and the roles other providers are playing within our integrated health system, QCH re-affirmed that for the foreseeable future the clinical program focuses would include:

- Emergency
- Medicine
- Surgery
- Acute Rehabilitation
- Mental Health
- Obstetrics
- Geriatrics

Of note, over the time horizon of this Plan, QCH anticipates adding oncology to its clinical programs, as a critical mass of patients and supporting resources and infrastructure can be developed following opening of the regional cancer centre on the QCH site.

For planning purposes the majority of programs are assumed to grow in line with natural aging and population growth in our community with no market share changes expected. The exception is the Maternal Newborn Program, for which we have assumed a decanting of primary and secondary deliveries from The Ottawa Hospital. Moving forward, planning assumptions will need to be revisited in the event that other factors affect the hospital's market share, such as additional "decanting" of other medical/surgical services from area hospitals.

As with all planning documents there is a need to have an ongoing monitoring process. First, the process needs to ensure the Vision is in keeping with the larger health system reform occurring under the direction of the Champlain LHIN. Second, through an annual review of the Strengths, Weaknesses, Opportunities, Threats (SWOT), the process needs to ensure that new internal or external factors are considered impacting the Strategic Themes or Vision.

Implementation

The Strategic Plan is just that….a plan. Ensuring the plan is executed requires the development of a number of activities in support of the plan. For the most part, the hospital has a proven infrastructure which will support the Strategic Plan. Notable infrastructure elements include:

1. A robust Balance Scorecard process, which links the hospital strategic short and long term goals to annual leveraged actions.
2. Leadership alignment with the key activities through the use of Accountability Agreements.
3. An automated monitoring system (PB Views) of actual versus plan involving Medical Staff, Board of Directors, and hospital leadership.

Other key success factors in maximizing the likelihood of achieving the Vision include:

1. Engagement of other health system providers in both knowledge of our plan along with actively participating in actions leading to goal attainment.
2. Linking other internal planning processes such as the Master Program and Master Plan with the Strategic Plan.
3. Linking the Strategic Plan with other unit plans such as Quality, Service/Program, and Human Resource Plans.
4. Communicating the plan to internal and external stakeholders.
5. Identifying areas where a more robust change management process may be required given the magnitude of change from the status quo.

II. PLANNING FRAMEWORK

In March 2007, the hospital embarked upon a strategic planning exercise to respond to a number of factors including:

- Determining its future role in a complex and evolving healthcare delivery system.
- Detailing some specific strategic initiatives to address the patient care needs of the residents of West Ottawa and area.
- Setting the context for a new Master Program and Master Plan.
- Creating a longer term focus for the successfully deployed Balanced Score Card.
- Enabling the hospital to articulate its Vision and strategies when operating within the context of the Champlain LHIN.

Undertaking a strategic planning exercise is complex and time consuming. A successful plan will only occur with a comprehensive approach to planning along with the support of dedicated individuals. The hospital adopted the definition from Joseph Peters:

> *Strategic planning is a process that directs an organization's attention to the future, thereby enabling it to adapt more readily to change and to determine the direction in which the organization chooses to move.* [1]

The approach adopted by the Queensway Carleton Hospital incorporated a number of processes as illustrated below, which led to this report.

1. Planning Model

Queensway Carleton Hospital adopted a planning process which incorporated a number of key success factors:

- Comprehensive in approach and analysis.
- Delineated the roles of management and hospital Board.
- Provided a process for ongoing monitoring and evaluation.

Exhibit 2-1

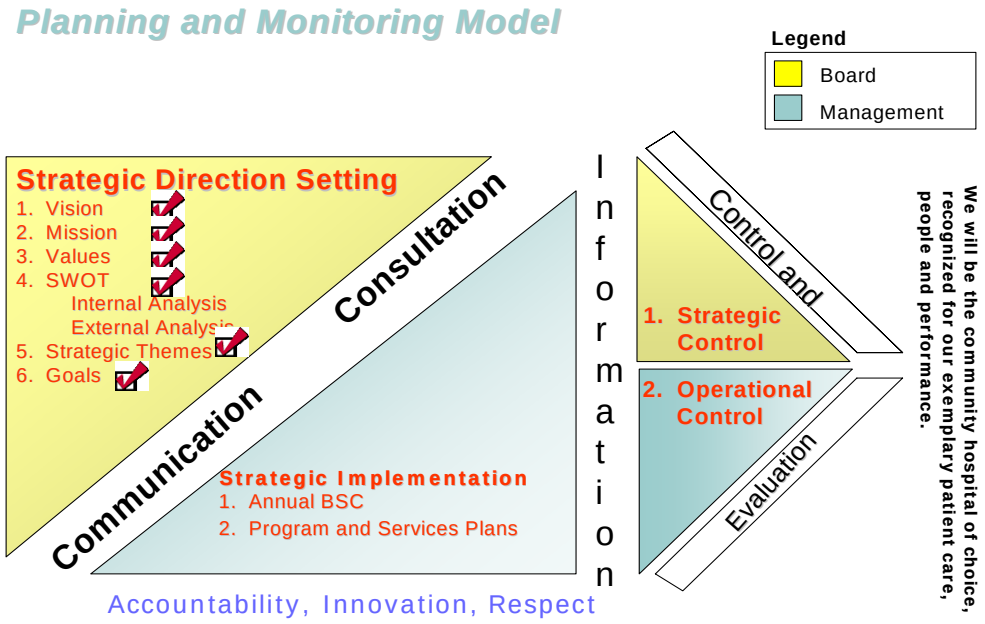

Exhibit 2-1 illustrates the policy/governance framework adopted by the QCH Board, wherein a clear delineation exists between policy setting and operations. The triangle on the top left shows the Board's role while the lower triangle reflects the Management Team's role.

The Board has confirmed the strategic directions including Mission and Vision, where as Hospital Management has set in place an implementation framework utilizing the Balanced Scorecard.

This particular exercise of the strategic planning cycle focused upon steps numbers 1-6 of the Strategic Direction Setting. The components illustrated under Strategic Implementation and Control and Evaluation represent the next steps of the strategic planning cycle - moving from direction setting to action and implementation.

2. Oversight

The hospital's Senior Management Team provided overall oversight and direction with respect to the completion of the Strategic Plan. Members included:

- Tom Schonberg, President and CEO
- Dr. Mary Brown, Chief of Staff
- Eric Hanna, Vice President, Corporate Services
- Maureen Taylor Greenly, Vice President of Patient Care and Chief Nursing Officer
- Judy Brown, Director, Communications

- Gary Earles, Vice President of Human Resources and Organizational Effectiveness.
- Eric Dean, Executive Director, Foundation

The Planning Committee was supported by Decision Support who collected and analyzed data, which helped participants to identify key issues facing the hospital.

3. Staff Engagement

A key and integral part of the planning process involved the engagement of medical staff leadership, management team, and external partners. Staff were engaged in a structured format such that key issues and related strategies could be ascertained for each clinical program. Results of these deliberations are outlined for each program in the Strategic Plan Addendum.

Each cornerstone program and/or major service confirmed their respective directions consistent with the overall hospital direction.

4. Community Engagement

A. Working in Partnership

The Queensway Carleton Hospital (QCH) and Pinecrest Queensway Health and Community Services (PQHCS) have been engaged in a joint community consultation process. The two organizations were in the process of updating their respective Strategic Plans. Recognizing that there was overlap in the catchment areas, and building on the strong partnerships between the two organizations, a plan was developed to work together to engage the community in consultations that would contribute to the strategic planning process of both organizations. Community input is central to strategic planning; it enables stakeholders to contribute to the process.

Pinecrest Queensway Health and Community Services is a large community health centre offering primary care, health promotion, primary prevention and a wide range of social services. The Centre provides a range of core programs within the catchment area in the west end of Ottawa, and it provides a number of programs that cover the City of Ottawa (pre-school speech and language, multi-cultural intensive case management, employment programs) and services that extend outside of the City limits, in some cases covering the Champlain region (Assertive Community Treatment Team which covers the City and the northern corridor of Lanark County; the Infant Hearing Program and the pre-school Blind Low Vision Programs covering the Champlain region). Employing over 160 staff, the Centre offers core services in the areas of: primary health care, health promotion, children's services, mental health, youth programming and community services.

The joint consultation process was specific to the shared portion of the catchment area for the two organizations (detailed below). It is recognized that QCH's catchment area also includes the City of Ottawa and

the Champlain region for its regional programs; and the catchment area for QCH also extends far beyond the shared west end area. Because of this, some of the information will be specific to this particular community; some of the input is also reflective of broader health and social issues that are representative of the City and Champlain region.

In the previous environmental scan, the data was aggregated at a city and county level. A focused analysis of the population in close proximity to the hospital identified a significant variation in comparison to the overall profile of the city.

When the catchment area is compared with Ottawa, it is, on average:

- lower income
- much more diverse - This area has the highest number of immigrants in Ottawa
- lower education

and has:

- fewer people working
- more women
- more lone parent families
- more seniors
- slightly fewer children

B. What Our Stakeholders Say: Results from Community Consultations

1. Results from Community Consultations

During February and March 2007, consultation sessions were held with stakeholders to gather information to assist in establishing the key strategic directions for both PQHCS and QCH.

In total, 25 focus groups were held involving 152 community members and 20 service providers.

The sessions were designed to gather information based on the following three questions:

a) What are the strengths that you think QCH/PQHCS should keep/build upon?
b) What are the challenges/emerging issues that the organizations should pay attention to?
c) What are the top three issues you feel are most important over the next five years?

What became very clear, very quickly, during the sessions is that the both QCH and PQHCS are highly respected in the community.

The following represent those areas identified most often during the sessions:

STRENGTHS (COMMUNITY and PROVIDER FEEDBACK)

- The staff of the organizations
  - friendly/welcoming
  - supportive, flexible in their approach
- Partnerships
  - broad range of partnerships supported and fostered by both organizations
  - ongoing collaborative communications with elected representatives
  - positive relationship between QCH and PQHCS
- Outreach
  - strong outreach to communities from PQHCS
  - leadership, youth, playgroups, community programs offered on an outreach basis through PQHCS
- Services
  - services for all ages available at both PQHCS and QCH
  - Physiotherapy Program at QCH
  - expansion of Emergency Department at QCH
  - referral system to/from CCAC and Emergency Department at QCH
  - linkages/referrals from QCH and PQHCS to other supports in the community
  - range of services for mental health; hospital services for acute conditions, ACTT and multi-cultural case management services, range of other community based mental health supports at PQHCS
  - access to Regional Type II Diabetes Program at PQHCS
  - housing supports
  - children and youth (parent supports)
  - access to services for non-insured residents through PQHCS's primary care program
  - access to services for clients of both QCH and PQHCS
  - family centred organizations
  - diagnostic services at QCH
  - good co-ordination/communication with primary care at PQHCS and consultants at QCH
- Multicultural programs at PQHCS
  - range of multi-cultural programs at PQHCS
  - Somali youth project
  - annual diversity event

- cultural interpretation/ access of primary care for multi-cultural clients
- ethnic specific programs

2. Challenges (Community and Provider Feedback)
   - safety
   - gangs
   - violence
   - physical environment
   - accessibility (reducing barriers)
   - access to food bank
   - shortage of Family Physicians/Nurse Practitioners
   - transportation to services outside of catchment area
   - services for youth
   - services for seniors including alternative housing strategies, outreach programs, health promotion/quality of life focus, enhanced utilization of Nurse Practitioners including outreach to retirement homes, management of chronic health conditions, prevention of admission to Emergency Department)
   - ensuring all services are accessible for multi-cultural population: signage at QCH; access to cultural interpretation at QCH; translation of documents in other languages
   - ensuring access for people with disabilities
   - increase public awareness of programs/services and how to access
   - Increase mental health/addiction services
   - more services/supports to increase skills/coping strategies for residents (e.g. anger management, stress management)
   - ensuring continuity of care between hospital and community services for individuals with mental health challenges
   - increase in challenges related to addictions (gangs/ youth access to drugs/ safety issues
   - need more advocacy/education for providers and consumers common assessment tools between health/social service agencies
   - treatment of mental health and addictions as concurrent disorder
   - prevention strategies (programs/initiatives to deal with root causes)
   - supports for parents
   - parenting programs for parents with youth/teens
   - access to child care
   - waiting lists for services at PQHCS and QCH; more funding for services
   - poverty
   - individuals on fixed incomes

- challenges of residents/families living in poverty
- enhance nutrition services/programs at PQHCS (including focus on health weight/ food security/ obesity/ exercise)
- increase in housing supports; need for more transitional housing and adequate social housing
- more awareness of QCH/PQHCS services for newcomers
- perinatal services: ensuring services support breast feeding/ linkages between hospital and community perinatal services
- reaching children of lower income, vulnerable families, single moms, mental health, isolated
- workload pressures for staff in health care/social services
- employment for new Canadians
- access to secondary/tertiary services for people without health insurance
- Chronic disease prevention and management
- co-ordination of services between QCH and PQHCS: E-health opportunities
- enhance discharge planning from hospital to community

3. Priorities

- Safety
- Accessibility (reducing barriers)
  - access to food bank
  - shortage of Family Physicians/Nurse Practitioners
  - transportation
  - services for youth
  - ensuring all services are accessible for multi-cultural population: signage at QCH; access to cultural interpretation at QCH; translation of documents in other languages
  - ensuring access for people with disabilities
- Services for seniors including alternative housing strategies, outreach programs, health promotion/quality of life focus, enhanced utilization of Nurse Practitioners including outreach to retirement homes, management of chronic health conditions, prevention of admission to Emergency Department
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  - increase in challenges related to addictions (gangs/ youth access to drugs/ safety issues
  - need more advocacy/education for providers and consumers
  - common assessment tools between agencies
  - treatment of mental health and addictions as concurrent disorder

  - prevention strategies (programs/initiatives to deal with root causes)
- Poverty
  - individuals on fixed incomes
  - challenges of residents/families living in poverty
  - addressing determinants of health
- Chronic disease prevention and management

III. WHO ARE WE?

A. Vision

In order to set the strategic direction for an organization a clearly defined Vision must be articulated and communicated to all impacted stakeholders. The existing QCH Vision Statement was reviewed and validated as being an appropriate statement having considered the current environment.

The current Vision Statement for Queensway Carleton Hospital is audacious, yet it represents an achievable position in our integrated healthcare system. As such, the Vision is inspiring and motivating such that it creates excitement yet poses a challenge. In addition, the Vision will provide a sense of purpose to those in the organization so that they can be focused upon achieving a desired end point.

"We will be the community hospital of choice, recognized for our exemplary patient care, people and performance."

B. Mission

The Mission Statement of QCH should clarify the organizations purpose and why it should be doing what it does. When reviewing the Mission Statement for Queensway Carleton Hospital, a number of questions were asked including:

- Who are we?
- What are the basic needs we must fill and for whom?
- What do we want to do to respond to these needs?
- How should we respond?
- What makes us distinctive and unique?

"We are a patient-and-family-centered community hospital providing a broad range of acute care services to the people of Ottawa and the Western Ottawa Valley.

We provide care for all age groups – through inpatient, outpatient and outreach programs and services, in partnership with other healthcare and community service organizations.

We strive to respond to the needs of our patients and their families through an interdisciplinary team approach. Our team is progressive, responsive and committed to exemplary performance and accountability.

We actively promote a learning environment, in which our staff,

physicians, students and volunteers are encouraged to be their best.

Our Programs are:

- **Emergency Services**
- **Medical Services**
- **Surgical Services**
- **Geriatric Services**
- **Acute Rehabilitation Services**
- **Childbirth Services**
- **Mental Health Services**
- **Allied Health Services**

In the future, the hospital intends to add Oncology as a Cornerstone Program.

C. Values

The Values of an organization represent enduring, passionate and distinctive core beliefs. When acting in pursuit of the Vision, the Values form the foundation of how we will behave and operate. For employees, physicians, the Board, students and volunteers at the QCH, the Values frame the way of life within the hospital such that we can achieve our Vision of being the "community hospital of choice".

In 2002, the hospital conducted an extensive exercise in redefining its Values. Based upon a review of leading practices, it was determined that the Values of the organization should be small in number (ideally 3) each with descriptor behaviors. Our Values, commonly referred to as the acronym "AIR", are described below.

ACCOUNTABILITY:

"We will demonstrate our accountability by:

1. Doing what we say we will do.

2. Acting responsibly in accordance with our defined roles and applicable standards.

3. Using and monitoring our resources effectively and efficiently in support of patient needs.

4. Measuring our progress and accomplishments against planned outcomes.

INNOVATION:

We will demonstrate our commitment to innovation by:

1. **Striving to make things better for our patients and team members.**

2. **Developing and applying personal and professional knowledge in support of our Mission.**

3. **Seeking new ways and best practices to strengthen our commitment to patient-centered care.**

4. **Recognizing and rewarding the achievement of excellence in the pursuit of our Vision.**

RESPECT:

We will demonstrate our respect by:

1. **Engaging in open, honest, courteous two-way communication and listening in a non-judgmental manner.**

2. **Acknowledging the needs of others by involving them in decisions that affect their well-being and role within the Hospital.**

3. **Openly acknowledging the contribution that every team member makes in delivering quality patient care and services.**

4. **Providing a safe, caring and secure environment for our patients, visitors and team members.**

D. Description of our Programs and Services

Program: Emergency

The Emergency Department is the gateway to the hospital for the majority of our patients with over 80% of hospital admissions through the ED. The Department provides care on an emergency, urgent and non-urgent basis to meet the diverse needs of the individual patient and his/her family. Each patient is triaged on entry to the ED by a Triage R.N. using the Canadian Triage Acuity Scale (CTAS), and then assessed and treated by the ED team. The triage process prioritizes patients for treatment

according to their presenting symptoms. Depending on their care and treatment requirements, patients may be admitted to an inpatient bed, discharged or transferred to other health care facilities. The new, state of the art ED has a resuscitation room with 2 stretcher bays, an observation area comprised of 10 bays with cardiac monitors and 10 non-monitored bays, and a 12 room cubicle area for patients who do not require a stretcher or acute monitoring. The ED at the QCH has the highest patient volumes in the city serving in excess of 65,000 visits per year. The ED Care Team is continually exploring ways to better serve this patient population whether through improving patient flow through the department or through quality care improvement initiatives.

Program: Childbirth Program

Queensway Carleton Hospital's Childbirth Program provides family centred care for over 2,700 births each year and offers a full complement of services. These services include prenatal classes, a Childbirth Centre of which there is a 'virtual' tour available through the QCH's website and in physicians' offices, an outpatient maternity assessment clinic offering non-stress testing and clinic appointments with R.N.s, a triage area for the assessment of patients for labour and delivery, birthing and immediate recovery care in private Labour and Birth Rooms, complete with hydrotherapy bathtubs and pain management options.

In addition, the Childbirth Program offers a special care nursery for newborns who need closer observation, treatment, and care. Mother and baby are kept together in mother's room (combined care and rooming in) as part of the family-centred care model. The program also offers a breastfeeding support drop-in clinic for new moms and babies (open 6 days a week) staffed by R.N's who are certified lactation consultants. The Childbirth Program at QCH has a high breastfeeding initiation rate and, most importantly, a high breastfeeding continuation rate after discharge.

QCH's Childbirth Program staff liaize with the Ottawa Health Unit and other regional agencies. QCH is an active participant in the MORE ob Program. This nation-wide program focuses the interdisciplinary team involved in labour and delivery care with the goal of improving patient safety and quality of care.

QCH is participating in regional discussions led by the Champlain LHIN and the Perinatal Partnership of Eastern Ontario (PPESO) regarding future distribution of maternal newborn care in our region. It is very likely that this program will grow in the future, which would require significant planning for appropriate space and human resources. Additional volume would require our Special Care Nursery to become a Level II nursery, with the associated supports and resources to care for newborns with a higher

level of acuity than what we are for presently.

Program: Medicine

The inpatient medical units provide coordinated multi-disciplinary care to patients admitted through the Emergency Department. A telemetry program allows for remote cardiac monitoring. Aggressive utilization initiatives such as care mapping and concurrent utilization review have been incorporated into the Medicine Program and are front-line tools for improving patient care. Patients have a wide variety of diagnoses, the most common ones relate to combinations of problems with heart, lungs, high blood pressure and diabetes. Limited outpatient services are provided through the Medical Day Care Unit. Most patients have follow-up in private physicians' offices.

Typically, medical patients have multiple co-morbidities and often have more than one chronic disease. Implementing best practice models for managing chronic diseases has become a priority for QCH and will continue to be a focus for the Medicine Program. These models will require extensive coordination and integration of care with community/primary care stakeholders. Outpatient services exist for diabetes and chronic heart failure (CHF) and a new comprehensive model for managing chronic obstructive pulmonary disease (COPD) is currently being implemented.

The new 12-bed Intensive Care Unit, provides both medicine and surgery patients with sophisticated, contemporary care. The ICU has also implemented an Intensivist model of medical coverage – a core team of physicians manage these patients on a rotating basis. The ICU Team also has a program for early intervention in hospitalized patients whose condition acutely deteriorates. The ICU Outreach Team can be contacted by any nurse if a patient has a sudden change in condition. The Outreach Team will respond, assess and intervene as appropriate. The goal is to achieve early intervention to decrease cardiac arrests, decrease ICU length of stay and also to prevent readmissions to ICU.

The Alternate Level of Care (ALC) designation is applied to patients who are ready for discharge from acute care and are awaiting another level of care such as placement in a chronic or long-term care facility. This is a designated unit with staff and programs designed to meet the needs of this patient population.

ALC's will continue to be a challenge to the Hospital, creating risks in areas such as cancelled surgeries, higher case costs, overloaded Emergency Department and poor staff morale.

Program: Surgery

The Surgery Program serves a combination of inpatients and outpatients, providing assessment, teaching and consultations.

The following services are provided:

The Preoperative Assessment Clinic (POAC) sees all elective surgical patients. Consults for anesthesia, medical support, physiotherapy, occupational therapy, and social work are scheduled at this time. The clinic serves to prepare and educate patients about their upcoming surgery prior to admission.

The Day Surgery Unit provides pre-operative care for the same day admission patients (patients having surgery and staying in an inpatient bed after surgery) and pre and post-operative care for all patients who have their surgery and go home the same day. The unit also provides pre and post-procedure care for a number of non-surgery patients.

The Operating Rooms provide surgical intervention and selected diagnostic procedures to inpatients and outpatients on an elective and emergency basis. Surgical specialties include: general surgery, gynecology, orthopedics, urology, plastics and ENT (ears, nose and throat). There is a strong focus on endoscopic (minimally invasive) procedures.

The Post-Anaesthesia Care Unit (PACU) provides direct primary patient care during the immediate post-operative period. PACU is also a critical care environment that provides advanced life support measures following surgery.

The Surgery Inpatient Units provide coordinated multi-disciplinary care to patients undergoing elective or emergency surgical procedures. Care maps are a major focus to ensure progressive, consistent high quality care standards and patient education is an integral component of care. A four-bed surgical constant care unit provides enhanced nursing care and monitoring for selected surgical patients.

Ambulatory Care - Medical and Surgical Clinics:

The Ambulatory Care Department provides assessment and treatment on a referral basis for patients in an outpatient setting in a variety of medical and surgical clinics including orthopaedics, haematology, endocrinology, general surgery, plastic surgery, otolaryngology, urology, and neurology. Minor surgical services, follow-up care, consultations, and counseling are provided by appropriate medical, nursing, and allied health professionals. In addition, there are several multidisciplinary clinics that have both a treatment and education focus. These include diabetes, impaired glucose

tolerance, congestive heart failure, gestational (pregnancy related) diabetes, and lipid programs.

Access and Wait Times - Improving access to surgical care and decreasing wait times will continue to be a major focus for the surgical program in response to system priorities. The Total Joint Assessment Clinic (TJAC) is an example of an innovative interdisciplinary approach to care that has been implemented to respond to this challenge. Referrals for potential knee and hip replacements from family physicians are sent directly to the clinic. The patient is seen within two weeks by either an advanced practice nurse or a physiotherapist and following a detailed assessment is placed into a conservative management program or a surgical stream. The patient is then seen by a surgeon and within three to six months is scheduled for surgery, versus the previous wait time of 18 months.

The Surgery Program will continue to focus on innovative models to improve access. Currently the program is exploring the feasibility of developing cancer assessment centres using the same principles that have been developed by the Regional Cancer Program, in order to improve access and decrease wait times for those patients in our catchment area who require surgery for breast, colorectal or prostate cancer.

Program: Mental Health

The Mental Health Program provides coordinated multidisciplinary care. QCH is a Schedule 1 facility (under the Ontario Mental Health Act), providing the full range of services: inpatient, day treatment, outpatient, and emergency/crisis services meeting the criteria of providing a therapeutic and safe milieu for all patients.

The Inpatient Mental Health Unit provides acute care inpatient services with short term assessment, treatment, discharge planning and coordination of follow-up.

The Assertive Community Treatment Team is a community based program for patients with long term psychiatric needs and QCH supports the ACTT as the acute care hospital-based component.

The Day Treatment Program provides treatment to patients who require help and support in the management of psychiatric illness or disorder. This program provides a supportive milieu for patients to develop their strengths through specific therapeutic activities that can be assimilated into their own lifestyle. The Day Treatment Program emphasizes the development of skills, which will promote socialization and integration within the community.

Outpatient care is provided for those requiring multi-disciplinary hospital based out patient treatment.

Outreach services include assessment, consultation and follow up clinics in Arnprior and Carleton Place.

Emergency consultation services are provided to the Emergency Department 24/7 including urgent assessment and follow-up.

Consultation/liaison services are provided to other QCH inpatient units and to local agencies as required

Psychology

Psychologists use various forms of intervention for persons suffering debilitating psychological disorders and/or serious psychiatric illness. The interventions include: *Psychodiagnostic Assessment/Consultation*; and *Psychotherapy* for individuals, couples, families and groups. Psychologists are required to have a Ph.D. in clinical psychology and this level of training also enables them to contribute to the design and the interpretation of assessment techniques for patient satisfaction, treatment outcomes, etc. The Department of Psychology provides service to Inpatient, Outpatient and Day Treatment Programs in the Mental Health Program.

Program: Geriatric Services

The components of the Specialized Geriatrics Services include;

Geriatric Evaluation Unit is an inpatient service where specialized geriatric assessment and treatment is provided by a multidisciplinary team to inpatients following an admission for an acute illness.

The Geriatric Day Hospital operates at a satellite site in Bells Corners. The Day Hospital provides rehabilitation psychogeriatric consultation and treatment to geriatric patients with multiple medical conditions. Patients are referred from the Geriatric Assessment Outreach Team, inpatient units at the hospital or family physicians.

The Geriatric Assessment & Outreach Program is a component of the Regional Geriatric Assessment Program and provides comprehensive, multi-dimensional screening assessment for people over 65 in their homes. Program goals include;

- improving quality of life,
- promoting functional independence and autonomy, and
- preventing or delaying institutionalization unless appropriate.

Program: Rehabilitation

Rehabilitation Services consist of Physiotherapy, Occupational Therapy and Speech and Language Therapy provision throughout all areas of the hospital, as well as a specific acute Inpatient Rehabilitation Unit.

Physiotherapists provide assessment, treatment and education to in-patients and out-patients with movement dysfunction. Therapeutic intervention includes manual and electrotherapy, exercise instruction, traction, acupuncture, whirlpools, wax, heat and ice. A Parkinson's exercise class is conducted weekly. Classes for patients who have had total joint replacements are held in the Physiotherapy Department and on the Inpatient Unit. Therapy focuses on attaining the maximal level functionally possible through pain control, enhancement of strength and balance, and gaining range of motion. The department is also instrumental in teaching safe lifts and transfers and conducting strength and flexibility testing with new staff during nursing orientation. Treatment of injured employees is also a function of the department.

Patients experiencing difficulty with functional activities are seen by Occupational Therapy staff. Occupational Therapists (OT) consider the interaction between the person, the environment and the occupation when identifying problem areas in the performance of daily activities. Together with the patient and their family, OT's complete assessments, interventions and education, while maintaining a holistic and client centered approach. Therapeutic intervention is activity-based and goal-oriented, working on performance in the areas of self-care, productivity and leisure. Occupational therapy services are provided on an inpatient and outpatient basis. Patients booked for Total Joint Replacement are seen pre-operatively for education and equipment requirements. Resting and dynamic splints are provided to patients.

The Speech and Language Pathology Team provides assessment, treatment, and education to in- and outpatients. Services are aimed at maintaining, rehabilitating, or augmenting oral motor, communication, and swallowing functions. Video-fluoroscopic swallowing assessments for in- and outpatients are completed in conjunction with the Diagnostic Imaging Department. A physician's referral is required for outpatients who are seen for swallowing, neurogenic language, and neurogenic motor speech disorders.

The 25 bed Inpatient Rehabilitation Unit provides rehabilitation for patients recovering from orthopedic surgery, stroke, fractures, respiratory and neurological disorders and other conditions. Patients are cared for in an environment, which enables them to prepare for discharge, working with

the interdisciplinary team to fulfill their goals. The team includes medical and nursing staff as well as allied health professionals. The unit has a gym, dining room, and teaching kitchen and bathroom so that patients can work on all areas of need to be able to return to their optimum level of function. Discharge planning, including links to community services and resources, is an important part of the care planning.

Recreation Therapy

This program provides assessment, recreation activities and education to patients of the Geriatric Day Hospital and the Mental Health Inpatient Unit, and to patients awaiting placement to chronic care and long-term facilities institutions. Patients are seen individually or in groups. The focus of the therapy is to provide activities, which fulfill and develop leisure interests and skills as well as prepare patients for participation in community programs and activities.

Diagnostics, Therapies, and Support Services

Laboratory

The Laboratory is an essential component of the diagnostic and treatment process for patient care, offering a complete onsite testing menu in the medical laboratory disciplines of Biochemistry, Hematology, Transfusion Medicine, Microbiology and Pathology. The testing referral service works in coordination with the Eastern Ontario Regional Laboratory Association (EORLA). The Laboratory responds to 24/7 requests for urgent and routine testing for the areas of inpatient, outpatient, ED, clinics and clients.

The Laboratory is integrated with a number of external programs including: Valley Hospitals – contract laboratory services to Arnprior and District Hospital; Carleton Place and District Hospital; Kemptville District Hospital. The hospital is currently finalizing a joint venture with 16 other Eastern Ontario hospitals (EORLA).

The lab provides high quality and safe services by:

- Responding to our clients' needs and initiatives
- Continually evaluating and assessing policies, procedures and processes
- Complying with regulatory and accreditation standards
- Promoting professional development
- Monitoring and benchmarking peer groups

Diagnostic Imaging

Radiology:
The Diagnostic Imaging Department provides diagnostic radiology, fluoroscopy and nonvascular interventional services to inpatients, outpatients, emergency patients and patients from other hospitals.

Radiological technology is the production of images of internal organs and structures by passing a small, highly controlled amount of radiation through the human body, and capturing the resulting image on an image recording device. When x-rays penetrate the body, they are absorbed in varying amounts by different parts of the anatomy. Bones, for example, will absorb much of the radiation and, therefore, appear white or light gray on the image, whereas soft tissue absorbs little radiation and appears dark.

Mammography:
The Diagnostic Imaging Department provides imaging of the breasts using specialized equipment and techniques in the form of low dose radiation. In addition to routine breast imaging, specialized breast imaging such as wire localization and digital stereotactic needle biopsy are available.

Mammography is the process of using low-dose X-rays to examine the human breast. It is used to look for different types of tumors and cysts. Mammography has been proven to reduce mortality from breast cancer.

Bone Densitometry:
Bone mineral densitormetry provides information regarding the patient's bone mineral density. The results provide specific information relating to fracture risk of the lumbar spine and the femoral neck of the hip. Bone mineral densitometry diagnose osteoporosis by measuring a patient's bone mineral density (BMD). Bone mineral density measures the amount of calcium in regions of the bones. Most methods for measuring BMD (also called bone densitometry) are fast, non-invasive, painless and available on an outpatient basis. Bone densitometry can also be used to estimate a patient's risk of fracture.

Ultrasound:
Ultrasound is an imaging technique that uses high-frequency sound waves reflecting off internal body parts to create images for medical examination. Most commonly used in obstetrics and gynecology, ultrasound is also used to image superficial structures and internal structures such as the abdomen and the vascular system.

Nuclear Medicine/Nuclear Cardiology:
Nuclear Medicine Imaging documents organ function and structure, in contrast to diagnostic radiology, which is based upon anatomy. It is a way

to gather medical information that may otherwise be unavailable, require surgery, or necessitate more expensive diagnostic tests.

It uses substances, called radiopharmaceuticals, that are attracted to specific organs, bones, or tissues and which can be inhaled, injected or taken orally.

CT Scan:
Computed tomography (CT) is a medical imaging method employing tomography where digital geometry processing is used to generate a three-dimensional image of the internals of an object from a large series of two-dimensional X-ray images taken around a single axis of rotation. The CT service performs all types of brain, spine and body imaging as well as specialized imaging such as biopsies and drainages for outpatients, in-patients, emergency-patients and other hospitals/nursing home patients.

MRI:
Magnetic Resonance Imaging (MRI) is a procedure that creates images of the body using powerful magnets and radio waves.

The MRI service performs all types of brain, spine and body imaging as well as specialized imaging such as biopsies for out-patients, in-patients, emergency-patients and other hospitals/nursing home patients.

Cardiopulmunary Services & EEG Unit

Cardiopulmunary service includes a full range of access on both an impatient and outpatient basis. Specialties include:

- *Electroencephalography: (EEG)*
- *Electrocardiograph: (ECG)*
- *Carotid Doppler:*
- *Cardiac Echo and Doppler:*
- *Cardiac Holter Monitor and Scanning:*
- *Pulmonary Function Laboratory:*
- *Cardiac Exercise Treadmill Testing:*
- *Sleep Laboratory Services (Polysomnography)*
- *ECG Loop Recorder Services:*
- *Respiratory Therapy Services:*

Pharmacy

The Pharmacy staff ensures safe, timely medication practices. Pharmacists are assigned and located on patient care areas during regular weekday operation hours. The pharmacist service is centralized during evenings and

weekends. There is twenty-four hour coverage provided by an on call pharmacist roster. The distribution system is a unit dose PAC MED computerized supported service. Functions include purchasing, drug distribution, patient pharmaceutical monitoring, patient counseling and teaching, drug information, drug utilization review, pharmacokinetic monitoring, adverse drug reaction reporting, medication incident prevention and analysis, total parenteral nutrition, and student training program.

Clinical Nutrition

Nutritional assessment and counseling is provided by Clinical Dieticians, supported by Technicians who complete non complicated meal/diet plans, as requested by physicians, nursing staff, paramedical staff, patient and/or family. Service is provided to patients in Mental Health, Geriatrics, Medicine, Surgery, ICU/CCU, Enteral and Parenteral nutrition, Palliative Care and Outpatients with a physician's referral.

Social Work and Discharge Planning Services

The Social Work Department provides assistance to enhance the best psychosocial functioning of patients and their families. The department promotes early identification and assessment of patients needing help with psychosocial needs and discharge planning. Through consultation and liaison with community programs and services, social workers facilitate patient and family access to appropriate community resources. Timely plans for discharge ensures efficient bed utilization, continuity of care and effective use of hospital and community resources.

Spiritual Care

The Spiritual Care Department provides multi-faith, inter-denominational, and non-religious spiritual care to patients, families, caregivers and staff both directly and through the coordination of community clergy and trained lay volunteer programs. The intent is to enable people to identify and draw upon personal and community spiritual resources to assist them in coping with traumatic events, life and lifestyle changes, and the stress of illness and hospitalization and thereby facilitate the fullest and timeliest recovery or adjustment.

E. Academic Teaching Responsibilities

QCH is a clinical teaching partner with the University of Ottawa Faculty of Medicine, providing core clinical placements and teaching for undergraduate and postgraduate medical students. QCH also offers a

broad scope of elective opportunities to non-medical students/residents and from numerous Universities and Colleges. The ongoing development of these clinical teaching partnerships is viewed as key success factors to the recruitment and retention of health care professionals.

F. Partnerships and Joint Ventures

QCH has developed a comprehensive array of strategic partnerships with other healthcare organizations to enhance care in the communities we serve. Examples of our partnerships include:

1. Champlain Local Health Integration Network (LHIN)
2. West Ottawa Valley hospitals (Arnprior, Carleton Place, Kemptville, Almonte Hospitals)
3. The Ottawa Hospital
4. Royal Ottawa Hospital
5. SCO
6. Childrens Hospital of Eastern Ontario
7. Champlain Community Care Access Centre
8. Pinecrest Queensway Health and Community Services
9. West Ottawa Community Resource Centre
10. Nepean Community Resource Centre
11. Area residential homes and long term care facilities
12. Family Health Teams
13. Ottawa Public Health Department
14. Perinatal Partnership Program of Eastern and South Eastern Ontario
15. Champlain Mental Health Network
16. Rehabilitation Network
17. Regional Geriatric Program
18. Convalescent Care Partnership
19. Seniors' Support Groups
20. Assertive Community Treatment Team
21. Regional Cancer Program
22. Eastern Ontario Regional Laboratory Association
23. Regional Materials Management
24. QCH Community Advisory Committee
25. City of Ottawa
26. Ambulance/transportation services
27. Algonquin College
28. University of Ottawa
29. Queens University

The organization's linkages and partnerships extend across the continuum including other sectors, e.g. education, housing, social services, and government, e.g. municipal, provincial and federal.

G. Physical Facilities

Queensway Carleton Hospital is located on 50 acres of land, leased from the National Capital Commission (NCC). The buildings occupied include those constructed initially in 1976 through to recent construction in 2004. Current plans include construction of a Cancer Centre, parking garage and additional space for current programs and services. The current Master Program and Master Plan reflects trends in facility design to address new integrated services delivery models, infectious diseases, and factors influencing recruitment and retention of staff. Over the foreseeable future it is anticipated that the current Baseline Road site will reach capacity, and strategies to decompress the campus will need to be adopted.

IV. SWOT

Developing an effective organizational strategy will result from the careful consideration of alternatives and making a choice as to the direction the organization wishes to move. A good strategic decision will be one that optimizes the fit between the organization (its strengths and weaknesses) and the environment (opportunities and threats) in which it operates.

Strengths are internal positive characteristics of the organization that already exist. When identifying potential strategies in light of ones strengths, one should ask the question – How can we capitalize upon these characteristics?

Weaknesses are negative characteristics within the organization that already exist. When developing strategies, one should ask – How can we minimize or eliminate these?

Organizing the characteristics of the external environment is assisted with two classifications:– opportunities and threats. The external factors can often be identified when considering Political, Economic, Social, or Technological factors. (PEST).

Opportunities are positive events (external to the organization) that could occur, but have not yet. In assessing the strategies the organization may wish to undertake, ask the question - How could we take advantage of this if it were to occur?
Threats are negative events (external to the organization) that could occur, but have not yet. In assessing the strategic options, ask the question – How can we prevent or minimize the impact of this event upon our organization?

STRENGTHS

Our Community & External Relations:

- Attractive growing community characterized by a higher than average socioeconomic and health status
- Excellent community reputation as evidenced in part by a strong history of philanthropic support
- Commitment to partnering with other organizations to achieve health system transformation
- Excellent media relations and strong/positive government relations
- Established partnerships with academic/clinical teaching facilities

Our Patients:

- Strategic focus on patient safety and evidence based leading practice
- Our patients report we provide good to excellent care in OHA Report Card
- Additional select capacity/access to service (e.g. OR expansion, Endo)
- Nationally and provincially recognized Accreditation excellence (e.g. CCHSA, DI & Lab, Physio etc.)

Our Culture:

- Focused organizational values/behaviours
- Strong financial performance
- Progressive, innovative and involved leadership
- Leadership (Board, medical leadership and management) aligned in achieving successful strategic outcomes
- Strategic commitment to investment in Learning and Growth to achieve our Mission
- Recognized as a preferred workplace by our employees, physicians and volunteers
- Corporate collegiality resulting in a strong sense of community
- BSC methodology and accountability framework aligned with MOHLTC strategic approach

Our People:

- Collaborative and engaged labour management relations
- Strong historical ability to recruit and retain staff, physicians and volunteers to accomplish our Mission
- Commitment to collaborative problem-solving leveraging external expertise
- Volunteer program which is committed, vibrant and dedicated

WEAKNESSES

- Communications gaps (e.g. intra & inter-disciplinary and departmental)
- Negative working capital
- Lack of select clinical and support space pending completion of further development (e.g. Phase III)
- Significant cohort of retirement-eligible staff and medical staff
- Areas of sub-optimal strategic alignment and accountability amongst staff and physicians
- Limitations in integrated information to make clinical and business decisions
- Limited resources to fund renovations and equipment
- Lack of information and understanding of our multi-cultural patient population
- Compromised access to acute care services as a result of increasing ALC
- Declining availability of human resources (e.g. clinical professionals)

OPPORTUNITIES

- Improve capacity/access to service
- Enhance patient/family centered care
- Improve clinical management/integration of care
- Innovations in clinical practice (new technology, interventions, best practices)
- Increase engagement with the community
- Develop a culture of philanthropy internally, to succeed in a competitive fundraising environment
- Secure additional resources for targeted initiatives and government priorities
- Promote and facilitate mutually beneficial linkages and partnerships to improve population health
- Expand clinical teaching opportunities
- Enhance integration of internal and external information systems
- Selective opportunities to improve and optimize the use of human resources (i.e. sick time, overtime, full time nursing ratios and appropriate skill mix)
- Develop magnet environments to better recruit and retain physicians, staff and volunteers
- Develop further as a learning organization

THREATS

- Loss of targeted MOHLTC funding (e.g. Wait Time, PCOP)
- Increasing care/service demands (demographics, growing pockets of poverty, technologies, infectious diseases) with uncertain and constrained resource availability
- Inadequate and fragmented alternate provider (e.g. LTC, community) capacity and coordination
- Increasing burden of mandated policy/regulation/legislation requirements
- Increasing complexity of medical/legal/ethical issues
- Increasing difficulties in balancing resources with complex consumer expectations
- Difficulties in staff and medical staff retention/recruitment to fulfill Human Resources Plans
- Inability to raise targeted community share funds consistent with redevelopment timelines and demands
- Uncertainty of government, LHIN and other provider priorities labour settlements and associated resource requirements

V. Demographics and Health Needs

A. Population Projections

Overall population changes over the course of the next 15 years are expected to be similar to growth projections for the province as a whole. This represents a change from the previous census (1996) in which the influence of the "technology bubble" suggested higher growth due to a significant influx of workers which has since subsided. From a planning perspective, the following factors will significantly impact the Queensway Carleton Hospital and require the cornerstone programs to develop mitigation strategies to adapt and tailor services accordingly:

- The relative proportion of seniors in our region will increase at a higher rate than is expected in the province as a whole. This will increase demand in acute services and apply increasing pressure on the Emergency Department. In addition to adding capacity to these programs, the hospital will need to consider additional strategies to improve continuity of care into the community and increase partnerships with community based primary care to respond appropriately to service demand, especially with respect to chronic disease management.
- The aging population in the region will also affect the available pool of qualified staff to work at the hospital. Recruitment and retention strategies will need to be developed to address expanded programs and a decreasing availability of physicians, nurses and other care and support workers.
- There is an expectation of a decreasing fertility rate as well as a shrinking proportion of women in childbearing years. Maintaining and/or expanding maternity care/women's health may require new partnerships to be formed and/or patriation strategies to be developed in order to increase market share within the region.
- Along with an aging population, it is expected that the demand for oncology services will similarly increase and offer the potential to adopt oncology as a "stand-alone" cornerstone program.
- It is expected that life expectancy will continue to increase in the region to 2021. This will potentially increase growth in the elderly population over the current projection and increase the need to develop mitigation strategies for dealing with volume pressures, ALC and availability of other community resources.

Exhibit 5-1 shows a breakdown of the growth estimates for the 3 major census divisions that comprise the Champlain LHIN:

Exhibit 5-1

Ottawa - Census Division Population Projections - 2005-2021						
Census 2001.	Age Groups					
Year (July 1)	0-19	20-64	65-74	75-84	85+	Total
2005	200,700	533,960	51,030	35,180	11,680	832,550
2006	200,260	540,570	51,800	35,720	12,550	840,890
2007	200,070	547,250	53,120	36,150	13,410	850,000
2008	200,270	554,570	54,740	36,620	14,210	860,400
2009	200,160	561,990	56,790	36,940	14,910	870,760
2010	199,750	569,830	58,670	37,330	15,520	881,110
2011	199,140	577,210	61,170	37,860	16,080	891,450
2012	198,840	582,650	65,350	38,390	16,560	901,770
2013	198,770	587,980	69,300	38,960	17,070	912,060
2014	198,940	593,570	72,760	39,630	17,540	922,430
2015	198,950	599,570	76,100	40,250	17,980	932,850
2021	205,340	625,970	95,540	49,550	19,930	996,310
Percent change 2005-2021	2.3%	17.2%	87.2%	40.8%	70.6%	19.7%
Percent change 2005-2021	3.0%	17.9%	77.7%	35.7%	72.1%	19.9%

Overall, growth in Ottawa closely reflects that which is expected for the province as a whole. However, breaking down the overall population by age group, Ottawa's differences emerge in the pediatric population that is expected to grow at a lower rate than the provincial average, and in the 65-74 age group that is expected to increase disproportionately higher than the provincial average.

Exhibit 5-2

Lanark County - Population Projections - 2005-2021						
Census 2001	Age Groups					
Year (July 1)	0-19	20-64	65-74	75-84	85+	Total
2005	16,630	40,790	5,320	3,450	1,130	67,320
2006	16,440	41,590	5,430	3,530	1,190	68,150
2007	16,250	42,300	5,620	3,590	1,230	68,980
2008	16,180	42,850	5,910	3,620	1,270	69,820
2009	16,000	43,520	6,130	3,690	1,310	70,640
2010	15,810	44,170	6,360	3,730	1,380	71,450
2015	15,360	45,970	8,380	4,090	1,530	75,330
2021	15,680	46,280	10,820	5,170	1,710	79,660
Percent change 2005-2021	-5.7%	13.5%	103.4%	49.9%	51.3%	18.3%
Percent change 2005-2021	3.0%	17.9%	77.7%	35.7%	72.1%	19.9%

While similar to Ottawa in overall population increase, growth in the 65+ age group is expected to be higher that in Ottawa. By 2021, the over 65 population will be comprised of over 18% of the Lanark population compared to just under 15% of the Ottawa population. Also, the decline in the proportion of residents under the age of 20 yrs is expected to be more significant than in Ottawa.

Exhibit 5-3

Renfrew County - Population Projections 2005-2015						
Census 2001	Age Category					
	0-19	20-64	65-74	75-84	85+	Total
2005	26,135	59,520	8,510	5,650	1,740	99,550
2006	25,696	59,690	8,620	5,760	1,830	99,580
2007	25,297	59,960	8,770	5,860	1,890	99,770
2008	25,008	60,210	9,010	5,950	1,970	100,130
2009	24,729	60,560	9,230	5,950	2,080	100,520
2010	24,380	60,980	9,430	6,020	2,150	100,950
2015	23,405	61,560	11,670	6,370	2,450	103,440
2021	23,471	60,700	14,420	7,500	2,720	106,770
Percent change 2005-2021	-10%	2%	69%	33%	56%	7%
Percent change 2005-2021	3.0%	17.9%	77.7%	35.7%	72.1%	19.9%

Among the three regions, Renfrew county shows the largest decline among residents <20 yrs of age. In addition, overall growth in the Renfrew region is expected to be well below the provincial average growing only 7% over the 16-year period.

Summary:

Overall growth across the Champlain LHIN is expected to be similar to the provincial average. However, Chaplain should experience decreases in the proportion of residents below the age of 20 over the 16-year period. This is generally linked to a decline in the late adolescent and early teen age groups. Increases in residents over the age of 65 are expected to be larger in Ottawa and Renfrew compared to the province as a whole.

B. Market Share

For the majority of clinical services we have assumed that growth will occur as a result of aging and population growth only. Above these factors, no major market share changes are proposed, other than for the Maternal Newborn Program for which we expect decanting of primary and secondary cases from area hospitals. Moving forward, the planning assumptions will need to be revisited in the event that other factors affect the hospitals market share, such as additional “decanting” of other medical/surgical services from area hospitals or community agencies.

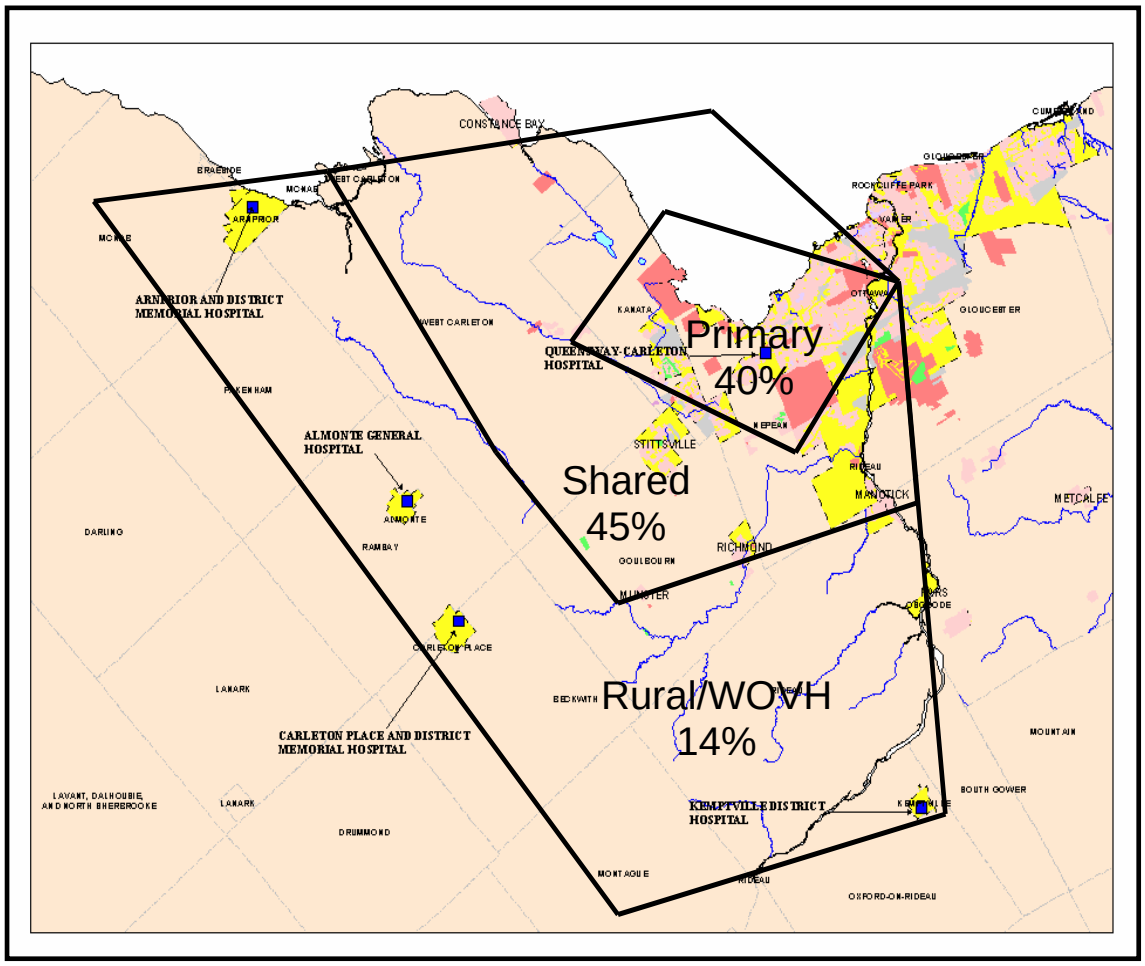
1. Primary Catchment Area

The primary catchment area is comprised of three communities consisting of Kanata, Nepean and West Ottawa. For analysis purposes these areas are defined in terms of 4 forward sortation area (FSA) codes: K2B, K2C, K2H, and K2A.

Exhibit 5-4
Primary Catchment Area

Inpatient Services		Primary		
Program Cluster	Service ID	QCH	Other Hospitals	Market Share
Neurology	Medical	203	269	43%
Neurosurgery	Medical	0	111	0%
Rheumatology	Medical	8	18	31%
Dermatology	Medical	9	10	47%
Trauma	Medical	272	506	35%
Nephrology	Medical	56	94	37%
Cardiology	Medical	778	566	58%
Haematology	Medical	47	100	32%
Endocrinology	Medical	120	126	49%
Gastro /Hepatobiliary	Medical	456	509	47%
General Medicine	Medical	226	501	31%
Not Generally Hospitalized	N/A	17	71	19%
Neonatology	Newborn	1443	1814	44%
Obstetrics	OBS	1589	2033	44%
Psychiatry	Psychiatry	308	630	33%
Rehabilitation	Rehabilitation	99	49	67%
Orthopaedics	Surgical	294	643	31%
Urology	Surgical	236	379	38%
Gynaecology	Surgical	205	395	34%
Otolaryngology	Surgical	54	137	28%
Dental Surgery	Surgical	0	4	0%
Thoracic Surgery	Surgical	35	724	5%
Ophthamology	Surgical	1	25	4%
General Surgery	Surgical	567	868	40%
Vascular Surgery	Surgical	10	130	7%
Plastic Surgery	Surgical	17	27	39%
Total		**7050**	**10739**	**40%**

Exhibit 5-5
FSA – Ottawa



2. Secondary Catchment Area

The hospital's secondary catchment area extends into the west and encompasses West Carleton, Goulbourn Township and Rideau.

Exhibit 5-6
Secondary Catchment Area

Inpatient Services		Shared Service Area		
Program Cluster	Service ID	QCH	Other Hospitals	Market Share
Neurology	Medical	25	26	49%
Neurosurgery	Medical	0	11	0%
Rheumatology	Medical	1	1	50%
Dermatology	Medical	0	1	0%
Trauma	Medical	23	46	33%
Nephrology	Medical	7	14	33%
Cardiology	Medical	90	40	69%
Haematology	Medical	4	6	40%
Endocrinology	Medical	14	7	67%
Gastro /Hepatobiliary	Medical	55	43	56%
General Medicine	Medical	24	29	45%
Not Generally Hospitalized	N/A	1	6	14%
Neonatology	Newborn	145	136	52%
Obstetrics	OBS	153	149	51%
Psychiatry	Psychiatry	11	29	28%
Rehabilitation	Rehabilitation	9	1	90%
Orthopaedics	Surgical	45	63	42%
Urology	Surgical	37	40	48%
Gynaecology	Surgical	19	55	26%
Otolaryngology	Surgical	3	19	14%
Dental Surgery	Surgical	0	0	0%
Thoracic Surgery	Surgical	7	69	9%
Ophthamology	Surgical	1	2	33%
General Surgery	Surgical	57	92	38%
Vascular Surgery	Surgical	1	14	7%
Plastic Surgery	Surgical	5	1	83%
Average		**737**	**900**	**45%**

3. Other Regions Served by QCH

Other regions served by the hospital include communities within the Ottawa Valley, referred to as the Rural/WOVN area. Several FSA boundaries overlap between the shared service area and the Rural WOVN area – market share results are presented for the Rural WOVN and the Shared/WOVN distinctly:

Exhibit 5-7
Rural WOVN Catchment Area

Inpatient Services		Shared/WOVN		
Program Cluster	Service ID	QCH	Other Hospitals	Market Share
Orthopaedics	Surgical	68	531	11%
Neurology	Medical	34	284	11%
Neurosurgery	Medical	0	81	0%
Rheumatology	Medical	0	13	0%
Dermatology	Medical	2	16	11%
Trauma	Medical	53	409	11%
Urology	Surgical	34	321	10%
Nephrology	Medical	2	79	2%
Gynaecology	Surgical	48	300	14%
Obstetrics	OBS	382	1041	27%
Neonatology	Newborn	361	938	28%
Otolaryngology	Surgical	8	120	6%
Dental Surgery	Surgical	0	1	0%
Cardiology	Medical	81	976	8%
Thoracic Surgery	Surgical	4	434	1%
Haematology	Medical	4	78	5%
Endocrinology	Medical	7	79	8%
Psychiatry	Psychiatry	58	416	12%
Ophthamology	Surgical	0	17	0%
Gastro /Hepatobiliary	Medical	49	672	7%
General Surgery	Surgical	87	551	14%
General Medicine	Medical	22	461	5%
Vascular Surgery	Surgical	1	67	1%
Plastic Surgery	Surgical	7	28	20%
Rehabilitation	Rehabilitation	4	80	5%
Not Generally Hospitalized	N/A	3	42	7%
Average		**1319**	**8035**	**14%**

Exhibit 5-8
Shared/WOVN Catchment Area

Inpatient Services		WOVN		
Program Cluster	Service ID	QCH	Other Hospitals	Market Share
Neurology	Medical	2	169	1%
Neurosurgery	Medical	0	46	0%
Rheumatology	Medical	0	21	0%
Dermatology	Medical	0	10	0%
Trauma	Medical	17	185	8%
Nephrology	Medical	1	61	2%
Cardiology	Medical	9	615	1%
Haematology	Medical	1	58	2%
Endocrinology	Medical	0	66	0%
Gastro /Hepatobiliary	Medical	4	446	1%
General Medicine	Medical	6	258	2%
Not Generally Hospitalized	N/A	1	17	6%
Neonatology	Newborn	108	348	24%
Obstetrics	OBS	125	358	26%
Psychiatry	Psychiatry	28	234	11%
Rehabilitation	Rehabilitation	2	49	4%
Orthopaedics	Surgical	36	216	14%
Urology	Surgical	9	138	6%
Gynaecology	Surgical	7	101	6%
Otolaryngology	Surgical	1	45	2%
Dental Surgery	Surgical	0	1	0%
Thoracic Surgery	Surgical	0	188	0%
Ophthamology	Surgical	0	6	0%
General Surgery	Surgical	42	209	17%
Vascular Surgery	Surgical	0	48	0%
Plastic Surgery	Surgical	4	16	20%
Average		**403**	**3909**	**9%**

4. Outpatient Services – Emergency & Day Surgery (Main O.R)

Day Surgery:

Outpatient Surgery remains a key focus of our surgical disciplines and maintaining a high proportion of outpatient service relative to admitted surgical patients is a measure of efficiency and quality. Table 5-9 shows the market share for day surgery cases performed in an O.R. setting (Cost Centre 7134025):

Exhibit 5-9
Market Share for Day Surgeries:

Day Surgery - 7134025	QCH	Other Hospitals	Market Share
Primary	3579	11977	23%
Shared	502	1192	30%
WOVN	215	4530	5%
WOVN/Shared	777	9471	8%

Interestingly, the market share for day surgery for our primary and shared service areas is significantly lower than the share of inpatient services. A likely explanation for this is linked to the hospital's historical issues with availability of Operating Room time. Over the past 10 years, QCH surgeons have developed relationships with outlying hospitals to support their practice given the limited availability of operating room time at QCH. Most commonly, surgeons perform primarily day surgery at these outlying sites (Kemptville, Arnprior and Carleton Place), resulting in an "outflow", creating a market share imbalance between inpatient and day surgery services.

Emergency Department:

A key focus of the hospital's Phase 2 Redevelopment Project, the Emergency Department is the first point of contact in our hospital for a significant number of our patients. Numbers below reflect market share by catchment area which include visits to CHEO, FY 2004/05:

Exhibit 5-10
Market Share by Catchment Area

Catchment Area	QCH Market Share
Primary	33.7%
Shared	39.9%
Shared/WOVN	17.6%
WOVN	33.4%

C. Drive Time Analysis

Developing critical mass to ensure quality of services requires an assessment of the population within a reasonable driving distance from home. The following exhibits outline the populations within targeted travel times.

Exhibit 5-11
Drive Time

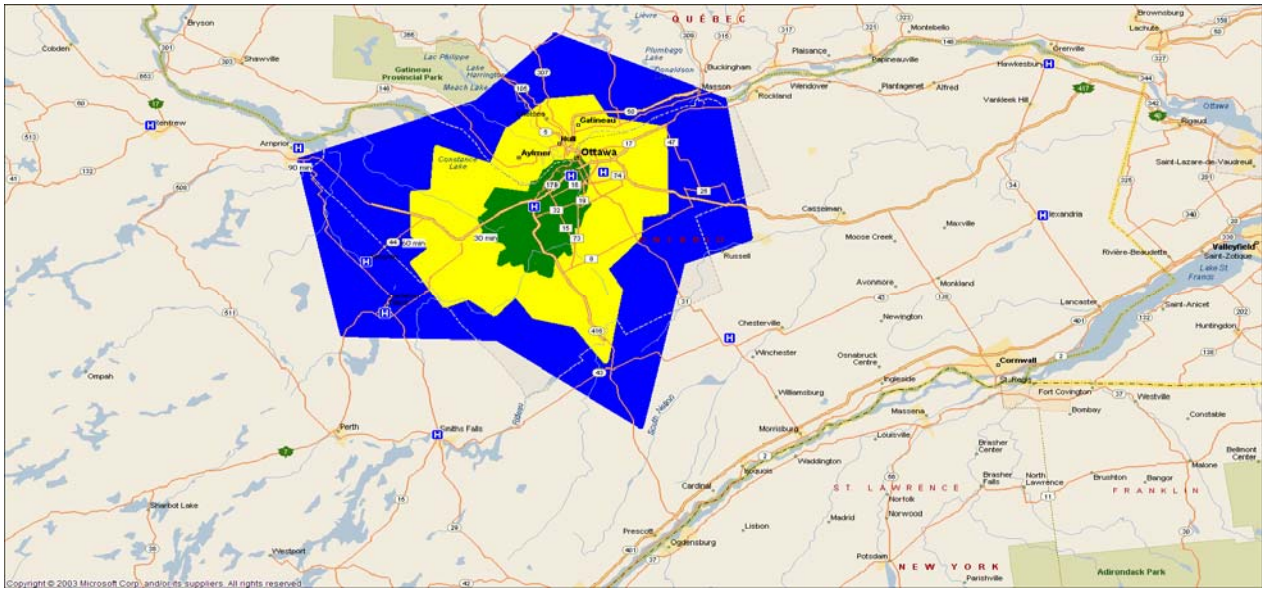


Exhibit 5-12

Summary of Populations Living Within 30, 60 and 90 Minutes of Selected Ottawa Hospitals

Non-Rush Hour Population Summary

		Total Population				Population 75+			
Time (Min)	**Hospital**	**2001**	**2006**	**2011**	**2016**	**2001**	**2006**	**2011**	**2016**
<30	**Queensway**	677,180	744,062	791,562	839,177	38,853	45,740	51,007	56,593
<60	**Queensway**	852,785	936,309	994,658	1,052,899	45,219	52,774	58,742	65,176
<90	**Queensway**	965,527	1,058,293	1,121,438	1,184,425	53,222	61,438	68,120	75,496
<30	**Ottawa-General**	722,427	793,777	844,462	895,285	39,261	46,229	51,554	57,200
<60	**Ottawa-General**	848,464	932,149	990,672	1,048,969	44,716	52,221	58,134	64,526
<90	**Ottawa-General**	943,460	1,034,945	1,097,341	1,159,470	51,343	59,415	65,896	73,074
<30	**Ottawa-Civic**	648,493	712,535	758,066	803,773	37,404	44,096	49,181	54,564
<60	**Ottawa-Civic**	822,114	903,454	960,672	1,017,721	43,368	50,764	56,566	62,802
<90	**Ottawa-Civic**	928,775	1,019,239	1,081,450	1,143,356	50,548	58,526	64,980	72,083

Rush Hour Population Summary

		Total Population				Population 75+			
Time (Min)	**Hospital**	**2001**	**2006**	**2011**	**2016**	**2001**	**2006**	**2011**	**2016**
<30	**Queensway**	252,534	277,470	295,201	313,005	15,877	18,724	20,884	23,169
<60	**Queensway**	660,900	726,173	772,540	819,030	38,400	45,219	50,429	55,950
<90	**Queensway**	796,272	874,736	930,168	985,578	42,599	49,916	55,624	61,716
<30	**Ottawa-General**	300,416	330,079	351,185	372,397	19,024	22,454	25,046	27,785
<60	**Ottawa-General**	674,142	740,721	788,033	835,499	38,047	44,825	49,992	55,464
<90	**Ottawa-General**	794,113	872,721	928,130	983,485	42,005	49,308	54,962	61,017
<30	**Ottawa-Civic**	432,734	475,463	505,869	536,427	30,050	35,468	39,563	43,890
<60	**Ottawa-Civic**	1,170,033	1,285,581	1,367,716	1,450,149	70,030	82,545	92,063	102,139
<90	**Ottawa-Civic**	817,090	897,931	954,813	1,011,547	43,163	50,545	56,324	62,533

An analysis of the population within the previously identified drive times can support a preliminary indication of the types of services by physician complement. Specifically, guidelines from the Royal College of Physicians and Surgeons of Canada on a physician to population ratio estimate the number of physicians required for that population.

Exhibit 5-13
Physicians by discipline required by population

Specialty	MD to Pop Ratio	30 min Drive 839,177	60 min Drive 1,052,899
Anesthesia	11,500	73	92
Cardiology	32,100	26	33
Cardiovascular/Thoracic Surgery	158,400	5	7
Clinical Immunology/Allergy	140,100	6	8
Community Medicine	53,450	16	20
Dermatology	62,650	13	17
Diagnostic Radiology	16,000	52	66
Emergency Medicine	50,400	17	21
Endocrinology/Metaboloism	76,600	11	14
Family Practice	2,500	336	421
Gastroenterology	62,800	13	17
General Internal	21,650	39	49
General Surgery	13,850	61	76
Geriatric Medicine	221,750	4	5
Hematology	95,850	9	11
Infectious Diseases	191,750	4	5
Medical Genetics	425,000	2	2
Medical Oncology	114,350	7	9
Nephrology	112,350	7	9
Neurology	59,300	14	18
Neurosurgery	129,450	6	8
Nucear Medicine	127,500	7	8
Obstetrics/Gynecology	19,050	44	55
Ophthalmology	29,650	28	36
Orthopaedic Surgery	27,500	31	38
Otolaryngology	45,700	18	23
Paediatrics - General	26,950	31	39
Paediatrics - Subspecialties	42,950	20	25
Pathology - Clinical	79,450	11	13
Pathology - Tissue	25,400	33	41
Physical Medicine/Rehabilitation	85,550	10	12
Plastic Surgery	85,550	10	12
Psychiatry	8,400	100	125
Radiation Oncology	131,450	6	8
Respiratory Medicine	81,450	10	13
Rheumatology	94,100	9	11
Urology	51,950	16	20

Sources: Canadian Royal College of Physicians and Surgeons - Specialty Review, 1989, Dept. of Health-Nova Scotia, 2003 a

Further analysis ensuring a critical mass exists (minimum of 8 MD's per site) to create a viable call an service within the discipline will assist in identifying where a critical mass is not evident.

Exhibit 5-14
On a site specific basis, the model has been developed

Viable Physician Complement 8

Specialty	MD to Pop Ratio	30 min Drive	60 min Drive	90 mn Drive
Anesthesia	11,500	9	11	12
Cardiology	32,100	3	4	4
Cardiovascular/Thoracic Surgery	158,400	0	0	0
Clinical Immunology/Allergy	140,100	0	0	1
Community Medicine	53,450	1	2	2
Dermatology	62,650	1	2	2
Diagnostic Radiology	16,000	6	8	9
Emergency Medicine	50,400	2	2	2
Endocrinology/Metaboloism	76,600	1	1	1
Family Practice	2,500	41	52	59
Gastroenterology	62,800	1	2	2
General Internal	21,650	4	6	6
General Surgery	13,850	7	9	10
Geriatric Medicine	221,750	0	0	0
Hematology	95,850	1	1	1
Infectious Diseases	191,750	0	0	0
Medical Genetics	425,000	0	0	0
Medical Oncology	114,350	0	1	1
Nephrology	112,350	0	1	1
Neurology	59,300	1	2	2
Neurosurgery	129,450	0	1	1
Nucear Medicine	127,500	0	1	1
Obstetrics/Gynecology	19,050	5	6	7
Ophthalmology	29,650	3	4	4
Orthopaedic Surgery	27,500	3	4	5
Otolaryngology	45,700	2	2	3
Paediatrics - General	26,950	3	4	5
Paediatrics - Subspecialties	42,950	2	3	3
Pathology - Clinical	79,450	1	1	1
Pathology - Tissue	25,400	4	5	5
Physical Medicine/Rehabilitation	85,550	1	1	1
Plastic Surgery	85,550	1	1	1
Psychiatry	8,400	12	15	17
Radiation Oncology	131,450	0	1	1
Respiratory Medicine	81,450	1	1	1
Rheumatology	94,100	1	1	1

Observations:

1. Some disciplines (highlighted above) are not viable at QCH with the current population estimates. In these cases the hospital should explore partnerships with other facilities to create a critical mass.
2. Specific ervices may be rationalized within the Champlain LHIN, which will affect the discipline scope.

D. Socio-demographic Indicators

Based upon the information from the most recent census and the Canadian Community Health Survey (2001), the following are the key socio-demographic indicators for the service areas:

Exhibit 5-15
Key Sociodemographic Indicators

Descriptor	Ontario	Ottawa	Lanark	Renfrew
Median household income	$53,626	$62,130	$49,701	$43,608
Unemployment rate	6.1%	5.8%	5.1%	6.8%
Labour force participation rate	67.3%	70%	65.1%	62.3%
Non-retirement population without completed post secondary education**	27.2%	24.6%	28.1%	29.3%
Lone parent families	15.2%	15.9%	13.7%	12.1%
Aboriginal population	1.67%	1.13%	1.25%	3.44%

*Source: Statistics Canada - Census 2001, Community Profiles

Exhibit 5-16
Health Status Indicators

Descriptor	Ontario Mean	Champlain
Life expectancy		
Males	77.9	77.5
Females	82.1	82.2
Self reported obesity (BMI>30)	15.1%	14%
Self perception of health status (Rating Very Good/Excellent)	57.4%	59.9%
Population with activity limitation	28.4%	24.6%
Daily smokers	16%	15.2%
Smoking during pregnancy	15.8	9.2-16.3**
Low birth weight babies	5.6%	5.4%
Infant mortality rate per 1000	5.4%	6.1%
Fertility rate	1.5	1.43
Physically inactivity	47.1%	43.9%
Self reported life stress	26.3%	24.4%

*CCHS – Canadian Community Health Survey – Stats Can 2001. **Estimated due to under-reporting.

Exhibit 5-17
Use of Preventative Care

Descriptor	Ontario Mean	Champlain
Had Mammogram in past year	70.6%	70.6%
Had Pap Test in past year	69.2%	75.5%
Flu shot within the past year	34.2%	37.7%
Contact with Medical Doctor within the past year	81.4%	83.1%
Prostate Exam (PSA Test) Men >40 yrs	52.4%	51.2%

*CCHS, 2001/2003

The following are the major causes of death in the areas serviced by QCH:

Exhibit 5-18
Mortality

Descriptor	Ontario Rate	Champlain
Circulatory system deaths per100,000	209.1	210.0
Neoplasm deaths per 100,000	181.4	183.6
Respiratory system deaths per 100,000	45.4	45.5
Nervous system deaths per 100,000	24.8	26.1
Perinatal condition deaths per 100,000	4.2	5.3
All causes	602.6	595.2

*Based on Age/Sex standardized rates, 2003/04 (CIHI, Morbidity Database)

Exhibit 5-19
Leading conditions causing death in the Champlain Region:

Condition	Ontario Mortality Rate	Champlain Mortality Rate
Ischemic Heart Disease	118.3	120.1
Cerebrovascular Disease (e.g. Stroke, TIA, etc)	43.6	46.4
Other circulatory diseases	43.0	40.2
Respiratory diseases	28.5	30.1
Pneumonia	12.9	11.8

*Source – Statistics Canada Mortality Data

E. Alignment with LHIN Priorities

Planning for the hospital's future requires careful consideration of its role within the context of the region. This will ensure that the hospital remains relevant within a regional context and allow QCH to continue to grow its role as an important leader in the delivery of efficient, high quality service for residents of Ottawa and the Champlain LHIN. In this context, this plan highlights elements of the current LHIN priorities that are integrated into the hospital's Strategic Plan.

1. Access

Access to the health system is generally measured as the degree of service offered in a region – measured by adjusted utilization rates for key services and by wait time information according to the MoHLTC's priority services.

Exhibit 5-20
Utilization & Health System Characteristics (CPHI Indicators)

Descriptor	Ontario	Champlain
Hip Replacement rate	67.2	64.6
Knee Replacement rate	90.2	81.3
Hysterectomy rate (lower values are more favourable)	351	386
CABG rate (Coronary Arterial Bypass Graft)	93.3	81.7
Overall inflow/outflow rate*	N/A	1.1

*Inflow/outflow measures the relative proportion of cases in the region being treated outside the region for selected conditions – values greater than one indicate an 'inflow' from patients outside the region, for the above conditions).

Exhibit 5-21
Wait Time Performance

Descriptor	Ontario Wait Time (90th Percentile)	Champlain Wait Days (90th Percentile)
Hip Replacement	202	331
Knee Replacement	243	343
MRI Scan	109	249
CT Scan	48	62
Cancer Surgery – (Breast)	38	51
Angiography	25	29
Angioplasty	14	13
Bypass Surgery	49	78
Cateract Surgeries	125	198

Sourc: MoHLTC - February - April 2008

2. e-Health

e-Health is a broad term used to describe the application of information and communications technologies in the health sector. In a broader sense, the term characterizes not only the development and use of technology, but also a new state of mind and a commitment for networked, global thinking, to improve health care locally, regionally and beyond, by using and sharing information.

The development and implementation of effective, interoperable Electronic Health Record solutions in Canada is an immediate priority of the Federal Government's Canada Health Infoway Inc. This goal is shared by provincial governments including Ontario, whose eHealth Vision is excerpted below:

> *"e-Health is much more than an overlay of technology on the current health care system. The Ontario Hospital e-Health Council defines e-Health more broadly to encompass significant change towards a new model of care:*
> *"e-Health is a consumer or patient-centered model of health care where stakeholders collaborate utilizing Information and Communications Technology (ICTs) including Internet technologies to manage health, arrange, deliver, and account for care, and manage the health care system."*

QCH is committed to the development of an Electronic Patient Record, and significant progress has been made toward this goal. Currently, the QCH electronic patient record contains information for patient demographics, visit history, laboratory and radiology results, pharmacy information including medication history and links to PACS images.

An active Telemedicine program provides remote consultations to rural patients.

QCH leads and/or participates in regional e-Health projects including:

- Regional EMPI (Electronic Master Patient Index)
- Regional Lab Information System
- Regional Clinical Repository
- Regional Supply Chain Information System
- Regional Human Resources/Payroll System
- Regional Credentialing

Progress on the above ranges from fully implemented (EMPI), to designed and costed (Clinical repository).

QCH has developed a 5 Year e-Health Strategic Plan, and will continue to invest in systems that improve quality and efficiency internally, and will continue progress toward the Electronic Patient Record.

QCH will also continue to be a regional leader in the development of a regional Electronic Health Record.

3. Primary Care

Primary care is the 'front-line' of the health system where most people will ideally first seek contact for assistance with their problems. Primary care is considered ideal and comprehensive when the primary care provider enters into a sustained partnership with the patient to take responsibility for the overall co-ordination for the patient's health issues, with a community based focus on prevention and health promotion.

Exhibit 5-22

Descriptor	Ontario	Champlain
Proportion of women receiving prenatal care	88%	89%
Proportion of children without a regular Primary Care Provider (RPCP)	25%	26%
Ratio of the percent of the population with ED visits – low to high income	1.32	>1.60
Family & GP physicians per 100,000**	TBD	TBD
High Blood Pressure	15.2%	14.3%
Asthma	8%	9.7%
Diabetes	4.8%	5.1%

*ICES Practice Atlas, Primary Care – 2006, **CIHI, 2004

The face of primary care will be completely different than it is now. There will be an amalgamation of all health care services and co-ordination of health care delivery to individual patients with one central patient chart (EMR) and one central health care manager (The Family Physician or Primary Care Health Team.)

In 2021 primary care will be re-organized such that all family doctors will be in groups of at least 3 or more family doctors or primary care providers. They will be supported by a complete EMR. All hospitals, pharmacies, labs and radiology departments will interface with the EMR.

The group of Primary Care Providers will have 24/7 on call with extended clinic hours and telephone advice. In addition, the primary care groups will have a team of allied health professionals to provide preventative health care strategies and chronic disease management, which will be critical to reduce care demands on the hospital. The group may include nurse

practitioners, pharmacists, counselors, nutritionists, physiotherapists, clinical nurse specialists and whatever else may be required for that particular community. This will not be hospital based but community based.

A. Challenges

- Not all patients have family doctors
- There is an increase in residency positions but there will be a lag time so the plan would be for all patients to have a family doctor by 2021
- Not all family doctors are prepared for the change particularly IT implementation. Those doctors will eventually leave the system-retire
- Communication between family doctors and the hospital is fragmented both ways
- Family doctors are hard to get a hold of/specialists give up and don't try
- The hospital will be/is dealing with a group of professionals that have no involvement or contact with the hospital (90% of family doctors do not go to the hospital yet they care for people that go to the hospital)
- Hospital caregivers are not trusting that primary caregivers will follow-up on the needs of the patients.
- There will be /is a need to connect to all family doctors not just the ones affiliated with the hospital because primary care has /is moving out of the hospital.
- Funding for IT and Primary care Re-organization
- QCH is a specialist-dominated hospital and the need to team up with the family doctor has not been a priority.
- The QCH Vision is a major undertaking and "may" be in place by 2021

B. Strengths

4. The province has already embarked on the re-organization for Family Health Teams, Family Health Groups, Family Health Networks, etc.
5. The province is providing IT funding to some of these groups
6. Preventative care bonuses are in place to compensate for providing preventative medicine, and chronic disease management
7. There is a blending of walk –in clinics and Family Medicine that we are seeing now in the community.
8. One family doctor will be able to provide care to more patients with more support from the allied health professionals.

9. The hospital will serve increasingly as a resource for education to support the Primary Care Teams
10. The Hospital can off load some of the follow-up care that they are assuming responsibility for i.e. chronic care management, preventative care strategies.
11. Better patient care due to fewer issues with medication errors, polypharmacy, etc. with all patient care providers in and out of the hospital.

C. Opportunities

1. Emergency Department- needs to tap into the rostered (family health groups) patients and redirect to their extended hour clinics that are operating.
2. With EMR in family doctors' offices, linked to the hospital, there will be a more effective and efficient patient encounter. (e.g. Radiology and Lab –with EMR less duplication of services and tests).
3. The West Carleton Medical Clinic is a Family Health Team and is at the forefront of developing the new face of primary care. The group has made an open offer to pilot a project with the hospital to move things forward particularly in the area of EMR. Their clinic is paperless and has a full EMR.
4. This model looks at how can we have a better model of integrated health care.

4. Frail Elderly

When undertaking a healthcare forecasting exercise, planning evidence suggests the largest predictors of service are age and gender. As noted earlier, (Exhibit 5-1), the ratio of growth of the elderly in the LHIN is significantly higher that the provincial average. The following Exhibit illustrates a number of potential health service impacts. QCH will need to continue to be pro-active in the care of this segment through initiatives such as the seniors' friendly hospital and the geriatric programs.

Exhibit 5-23

Descriptor	Ontario	Champlain
Proportion of elderly aged 75+ receiving Flu Vaccine within previous 2 years	Men – 69% Women – 74%	Men – 67% Women – 73%
Number of physician visits per person, age 65+	15.2	15
Percent of the population with an activity limitation	31.7%	33.6%
Disability free life expectancy >65 yrs	Men – 10.5 years Women – 11.9 years	Men – 10.5 years Women – 11.8 years

*Statistics Canada/ ICES Practice Atlas – Primary Care, 2006

5. Addictions and Mental Health

The redesign of health services related to addictions and mental health commenced with the HSRC directions and the refocusing of roles of organizations such as the Royal Ottawa Healthcare Group. QCH's role is inter-dependent upon these roles, as more specialized facilities impact both inpatient and outpatient programs offered. The following exhibit illustrates higher need for addiction and mental health services in Champlain versus the provincial norm.

Exhibit 5-24

Descriptor	Ontario	Champlain
Percent of the population reporting contact with ambulatory mental health services	7%	10%
Proportion of people reporting suffering from major depression	5%	5%
Proportion of the adult population who are heavy drinkers of alcohol	21.2%	21.3%
Suicide rate		
Mental & behaviour disorders per 100,000 population (hospitalization rate)	502.7	515.5

6. Chronic Diseases and Prevention

Chronic diseases "…have a prolonged course, do not resolve spontaneously and for which a complete cure is rarely achieved." (CDC and Health Canada). There is an increasing prevalence of chronic illness in the Champlain LHIN and a significant increase of individuals with more than one chronic condition. This will continue to impact the care requirements of our patients and as this document has indicated, we will direct our attention to developing interdisciplinary approaches to care that will improve health outcomes for our patients and improve their quality of life. Developing strong linkages to community resources to support the patient in the community will be an area of continued focus.

Exhibit 5-25

Indicator	Ontario	Champlain
Hypertension	14.7%	14.0%
Diabetes	4.6	6.0%
Overweight	33.3%	36.6%
Obesity	14.8%	14.3%
Smoking rate (all types of smoking)	22.1%	21.2%
Physical inactivity	47.3%	43.9%
Consume <5 servings of fruit/vegetables	55.3%	54.8%
Hospitalizations due to accidental injury (per 100,000 population)	517	472

VI. STRATEGIC DIRECTION

The overall purpose for strategic themes is to: a) clarify strategic priorities over a five-year timeline, and b) ensure that an organization is working continuously on achieving short, medium, and long-term outcomes. Strategic themes offer ease of communicating clear strategic priorities about what we need to achieve for our stakeholders in the short-term, mid-term, long-term, and on a continuous basis with QCH community and the regional and provincial governments.

The following four strategic directions have been identified as over-arching themes. Specific goals and objectives will be defined for the period ending 2021. Each strategic direction has five-year goals and longer-term goals to 2021.

A. Theme 1: Operational and Clinical Excellence

We can use this theme to improve care and service quality and safety processes. Every patient will experience exemplary care/service in an environment of safety and best practice.

Five Year Goals

Patient Safety
- Fully compliant with all 'Safer Healthcare Now' initiatives
- Fully compliant with all CCHSA patient safety standards

Operational and Clinical Excellence
- Clinical and operational performance is consistently rated good to excellent as confirmed through Accreditation and other benchmarking surveys (e.g. OHA Report Card)
- Fully compliant with MOHLTC performance expectations (i.e. Hospital Accountability Agreement -Wait Times, readmission rates, ER time to admit, balanced budget etc.) and governance policies
- Increased educational training opportunities and relationships (e.g. University of Ottawa, Algonquin College)

Workforce Planning & Management
- Recognized as a preferred workplace within the province
- Required human resources are in place to enable us to fulfill our mission
- Utilization of human resources is optimized (i.e. full use of scope of practice; top quartile performance for sick time)

2021 Goals

- Recognized for providing an expanded and reconfigured range of clinical programs characterized by clinical excellence, patient satisfaction and meeting the evolving needs of our community.
- New and creative Recruitment and Retention Strategies will be utilized to ensure that our Human Resources needs are anticipated and met in a labour market where the demand will exceed the supply.

- Recognized as a learning organization successful in engaging and developing talent.

B. Theme 2: Patient/Family Centered Care & Service

Use this theme to describe our interactions with patients and their families to improve clinical outcomes and patient/family satisfaction.

Five Year Goals

- All patient satisfaction scores will be at or above the Mean on the OHA Patient Satisfaction Survey
- Staff, physicians, students and volunteers will have increased and demonstrated knowledge of cultural and environmental needs of their clients and colleagues.

2021 Goals

- .All patient satisfaction scores will be at or above the 25th percentile on the OHA Patient Satisfaction Survey.
- QCH's environment and clinical programs will be responsive to its demographic and ethnic diversity.

C. Theme 3: Integrated Care and Service

Use this theme to describe innovating our programs and support services to achieve an effective and efficient continuum of care and service both internally and externally.

Five Year Goals

- A minimum of four clinical programs and two service programs achieve regional integration (e.g. cancer; dialysis; mental health; orthopedics; Lab; DI) as recognized by the Champlain LHIN.
- Chronic disease management (e.g. COPD) is enhanced across the continuum of care through increased coordination and effective use of innovative technology with community partners.

- Care for the frail elderly is enhanced across the continuum of care resulting in the achievement of benchmark levels of ALC patient days.
- Clinical program configuration supports the achievement of optimal service delivery

2021 Goals

- Care and service capacity is optimized through alternate models of care and/or settings (e.g. freestanding ambulatory care facilities).
- A sustainable and appropriate clinical profile is maintained in the context of local and regional service needs and strategies.
- Promote and partner to achieve appropriate capacity in the community to efficiently and effectively care for individuals with complex chronic conditions.
- Partner with other stakeholders to deploy innovative technologies to enhance patient self-care management in the community to reduce or delay hospitalization

D. Theme 4: Responsiveness to Care & Service Needs Through Alignment With System Priorities

Use this theme to describe how we will enhance responsiveness to our community's healthcare needs by increasing collaboration with community, regional and government stakeholders.

Five Year Goals

- Facilitate the development and implementation of LHIN priorities to address local and regional health care needs
    - Access (Wait Times {efficiency, system-wide approach}, ALC, Coordination of Transportation, Human Resources Planning, Services Closer to Home, Diversity and Special Needs)
    - Primary Health Services for Healthy Communities
    - Chronic Disease Prevention and Management
    - Addictions and Mental Health
    - Seniors with Complex and Chronic Conditions
    - e-Health
- All drugs, diagnostic and lab tests are ordered electronically contributing to a basic electronic health record (e.g. minimum data set; DI & Lab results.
- Clinicians refer and schedule patients electronically on site and remotely.
- Community funding share required for capital redevelopment has been secured by the QCH Foundation.

- A comprehensive community engagement program will increase understanding and manage the community's expectations with the reality of limited healthcare resources

2021 Goals

- All QCH patients will have a comprehensive electronic health record that follows the patient through the system
- Priority acute care needs of the catchment population are met in a timely and effective manner