



Hospital Annual Planning Submission (HAPS)
Guidelines **2008-2010**

Copies of this report can be obtained from your
Local Health Integration Network office

Or online at **www.lhins.on.ca**

For contact details see Appendix C.

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1 Introduction

The introduction of 14 Local Health Integration Networks (“LHINs”) is a key component of the provincial government’s plan to improve the delivery of health care. On April 1, 2007, LHINs assumed full responsibility for planning, funding and integrating health services in their geographic areas pursuant to the terms of the *Local Health System Integration Act, 2006* (“LHSIA”). As a result of this devolution of authority from the Minister of Health and Long-Term Care (the “Minister”) the LHINs assumed the Minister’s rights and obligations under substantially all of the current funding and accountability agreements with health service providers (“HSPs”). The agreements assigned to the LHINs include the Hospital Accountability Agreements (“HAAs”).

In addition to assuming responsibility for the assigned agreements, the LHSIA requires the LHIN to negotiate Service Accountability Agreements (SAAs) between HSPs and the LHINs. The accountability agreements in place between the Minister and the LHINs require the LHINs to negotiate SAAs with hospitals to commence on April 1st, 2008. As a result, hospitals will now submit their Hospital Annual Planning Submission (“HAPS”) to the LHINs for approval. This year the HAPS, and the resulting hospital – SAA (“H-SAA”), will cover a two-year period.

The purpose of these guidelines is to assist hospitals in completing the 2008 – 2010 HAPS. Central themes of the HAPS are service planning, measurement and evaluation of health services, and organizational performance. The HAPS together with the H-SAA form the basis of a multi-year funding and planning framework. This framework supports the province’s efforts to enhance stability and accountability of the health system by providing a more sustainable financial footing and facilitating alignment of the provision of health services.

1.1 LHSIA, 2006

The LHSIA provides the underpinnings for the new accountability relationship between LHINs and hospitals. The purpose of the LHSIA is to provide for an integrated health system that will improve the health of Ontarians through (i) better access to high quality health services; (ii) coordinated health care in local health systems and across the province; and (iii) effective and efficient management of the health system at the local level.

LHIN Funding and the Accountability Agreement with the Ministry of Health and Long-Term Care (MOHLTC): The LHINs’ relationship to the province is set out in the LHSIA and in a Memorandum of Understanding between each LHIN and the MOHLTC. Funding for the LHINs is provided by the MOHLTC on terms set out in an agreement between the Minister of the MOHLTC and the LHINs, and referred to in the LHSIA as the accountability agreement. The MOHLTC-LHIN Accountability Agreement sets out:

- (a) performance goals and objectives for the LHIN and the local health system;
- (b) performance standards, targets and measures for the LHIN and the local health system;
- (c) requirements for the LHIN to report on its performance and that of the local health system;
- (d) a requirement that the LHIN provide a plan for spending the funding that the LHIN receives from the MOHLTC; and
- (e) a progressive performance management process.

Health Service Provider (HSP) Funding and Service Accountability Agreements (SAAs):

The LHSIA also provides that a LHIN may provide funding to an HSP in respect of the services that the HSP provides in, or for, the geographic area of the LHIN. Funding must be provided on terms and conditions that (a) the LHIN considers appropriate; and that (b) are in accordance with (i) the funding that the LHIN receives from the MOHLTC; (ii) the LHIN's accountability agreement with the MOHLTC, and any other requirements that may be set out in regulations under the LHSIA.

SAAs are subject to the terms of the *Commitment to the Future of Medicare Act, 2004* and must establish one or more of:

- (a) performance goals and objectives, roles and responsibilities, service quality, accessibility of services, related health human resources, performance management framework, shared and collective responsibilities for health system outcomes, consumer and population health status, value for money, consistency, and other prescribed matters;
- (b) a plan and a timeframe for meeting anything mentioned in clause (a);
- (c) requirements for reporting and the provision of information, excluding personal information;
- (d) any other matter prescribed by regulation; and
- (e) the standards and measures to be used with respect to anything mentioned in clauses (a) to (d).

These HAPS guidelines are intended to facilitate the completion of the HAPS and highlight the connection between the MOHLTC-LHIN Accountability Agreement, the HAPS and the SAAs that will be executed with hospitals. It is important to recognize and appreciate this connection. By aligning the performance objectives of health service providers, including hospitals, with the performance objectives for the local health system, the provincial goal of a transformed, integrated and sustainable health system can be realized.

1.2 How these guidelines were developed

The 14 LHINs established a working group to develop and launch the 2008 – 2010 HAPS process. The LHINs approached this development phase as an opportunity to build on the foundation of accountability already established, while working toward changes that would align hospital structures and priorities with those of other HSPs to meet integration and service requirements identified by each LHIN. The LHINs, MOHLTC and the Joint Policy and Planning Committee (the “JPPC”) worked together in order to align the HAPS with the areas of responsibility for the health sector that remain with the MOHLTC and with prior indicator development work of the JPPC.

A LHIN-MOHLTC Steering Committee was established to oversee, review and approve (as required) components of the 2008 - 2010 HAPS process. The LHINs will assume primary responsibility for coordinating the launch, completing negotiations with hospitals, and obtaining signed H-SAAs. The LHINs will work with the JPPC, the MOHLTC and the Ontario Hospital Association (“OHA”) to ensure a well-coordinated and effective process.

2 Key Planning Considerations for the HAPS and H-SAA Process

2.1 Changes to the Process and Tools

As a result of the collaborative developmental work completed to date, the following changes have been made to the HAPS completion process and submission requirements:

- The HAPS and H-SAA will each cover a two year period: 2008/09 and 2009/10;
- The HAPS and the H-SAA may be refreshed and updated mid-term in alignment with changes to the MOHLTC-LHIN Accountability Agreement;
- A mandatory web-enabled Narrative component has been introduced;
- With the addition of the Narrative, the Financial Optimization Strategies forms have been removed;
- Pre-proposal submission processes for operational changes have been introduced. A web-enabled Health System Improvement Pre-proposal (“H-SIP”) will be available for operational changes that involve a new service or service enhancements that may or may not require additional funding. A further pre-proposal process for operational changes that result in clinical service reductions, terminations or transfers is under development. Both processes are outlined in Section 4 of these guidelines;
- Examples of previously implemented hospital strategies aligned to each step of the prioritization framework can now be found as a resource document posted on the Web Enabled Reporting System (WERS, www.mohltchb.com).

2.2 Principles Guiding the Process

The requirements of the multi-year funding, planning and accountability framework will continue to evolve and change to reflect the changing nature of the health care system within which hospitals and LHINs are now operating. Steps have been taken, and will continue over the coming years, to align the HAPS and H-SAA process more closely with the local LHIN integration priorities and provincial strategic directions.

It should be noted that each hospital is responsible for any internal and external communications plan required to explain the hospital’s HAPS. These communication plans must present information in a spirit of cooperation with its partners, including the LHIN.

Hospitals should consider the following principles when preparing their submission and engaging their local and regional partners.

1. Accountability

- The HAPS is owned and managed by the hospital.
- The HAPS will inform the negotiation of the H-SAA between the LHIN and the hospital.
- The LHINs will provide guidance, approve and monitor the performance obligations of the H-SAA.
- Hospitals will be accountable to the LHINs for the achievement of the hospital's performance obligations in the H-SAA.

2. Funding and Allocation

- Hospitals must be in a balanced operating position for each year of the H-SAA.
- Hospital funding can only be used in accordance with the terms on which it is provided as set out in the H-SAA.

3. Integration and Service Coordination

- Hospital planning must reflect a hospital's on-going responsibility to review all aspects of the hospital's operations to find efficiencies in non-clinical and clinical areas with the direction of its planning submission.

4. Local Health System Planning

- Hospital planning must be in alignment with the LHIN Integrated Health Service Plan ("IHSP"), the government's health care priorities, and reflect best practices, evidence-informed decisions, and the pursuit of efficiency opportunities within the hospital and in collaboration with community partners and other HSPs.
- Hospital planning must now integrate a hospital's obligations under s. 16(6) and s. 24 of the LHSIA.

Engagement by health service providers

s. 16(6) Each health service provider shall engage the community of diverse persons and entities in the area where it provides health services when developing plans and setting priorities for the delivery of health services.

Identifying integration opportunities

s. 24 Each LHIN and each HSP shall separately and in conjunction with each other identify opportunities to integrate the services of the local health system to provide appropriate, co-ordinated, effective and efficient services.

5. Local Community Engagement

- Hospital planning must clearly contemplate ongoing consultation and engagement by the hospital with local health service providers and other stakeholders with a view towards closer cooperation and partnership between providers.

2.3 Multi-Year Funding

Since the government moved to multi-year funding commitments and accountability agreements, hospitals have been provided the stability and capacity to plan their operations effectively and within fiscal parameters. Hospitals have been provided with information on their 2007/08 funding allocation, along with financial planning estimates for 2008/09 and 2009/10 hospital operations. Hospitals must use this information in developing their forecasts on service volume and indicator performance.

2.4 The 2008 – 2010 Monitoring Process

The LHINs will be reviewing the hospital performance indicator results outlined in the 2008 -2010 H-SAA through the HAPS and MIS Trial Balance Submissions on a quarterly basis.

The WERS will generate, for LHIN and hospital use, reports that will identify variances from the H-SAA performance objectives. Hospitals will be required to monitor their performance against variances. Hospitals may be required to meet with their LHIN to review any variances, and at the discretion of the LHIN, will be required to propose an improvement plan.

During 2008/09 a refresh process will be used to confirm the funding allocation and performance targets for 2009/10. The refresh process may include a request from a LHIN to a hospital to update its planning submission to take into account a change in circumstances or requirements, or perhaps to address variances, or the availability of new data.

2.5 Data Quality

The reporting of valid and reliable health care clinical and financial/statistical data is essential. This is reflected in s. 2.7 below and the H-SAA. The ability of hospitals to negotiate and meet their performance objectives is directly proportional to how well the historical data reflects actual hospital performance. Improvements in the quality of health care data reported from hospitals will improve the ability of hospitals, LHINs and the province to set and meet performance targets.

2.6 Timelines

Hospitals will have seventeen (17) weeks to complete the forms in the WERS, which can be found at www.mohltchb.com. An instructional WERS guide and WERS Web forms are expected to be available to hospitals on the WERS web site by the end of June 2007. Board-approved HAPS must be submitted to the LHINs no later than **October 31, 2007**.

2.7 Financial Penalty

Pursuant to the terms of the H-SAA, a hospital may be subject to a financial penalty if:

- Its Board-approved HAPS is received by the LHIN after October 31st, 2007; or
- The HAPS is incomplete; or
- The quarterly performance reports are not provided on a timely basis; or
- Financial and/or clinical data requirements are late, incomplete or inaccurate.

The penalty for submitting a HAPS within the first seven (7) days after October 31st, 2007, will be the greater of (i) a reduction of 0.03 percent (0.03%) of the hospital's base funding allocation, or (ii) two thousand dollars (\$2,000). For every full or partial week of non-compliance thereafter, the rate will be one half of the initial reduction. In addition, an equivalent penalty will apply to HAPS submissions that are incomplete, as well as late, incomplete or inaccurate financial or clinical data submissions.

2.8 Overview of the 2008-2010 Hospital Planning and Accountability Cycle



3 HAPS Components

3.1 Narrative

The HAPS includes a *mandatory* narrative component (the “Narrative”). This year, the format of the Narrative has been changed to provide greater clarity, and to improve the ease of use for those reviewing it.

The Narrative provides the opportunity to provide context and insight into the clinical and local environments in which the hospital functions. In prior years, the Narrative was a free-form document with suggested content provided through the guidelines. This year, the Narrative has been web-enabled. The “notes” feature included in the web format is intended to supplement the content of the Narrative.

Please note that the Narrative (Sections 1 to 4) may not exceed four (4) pages. Additional pages for Section 5 may be included as required. Hospitals may present additional content as part of the dialogue and discussions with the LHIN.

The following sections form the Narrative:

1. Overview

This section should include a snapshot of the hospital’s position, including financial outlook, assets, service provision summary, major activities underway or planned, and goals for the years being submitted.

2. Advancement of the IHSP

This section should explain how the hospital’s strategic and operating plans contribute to the LHIN IHSP and improve coordination of care in the local health system. Identification of barriers to and opportunities for effective service provision should also be highlighted. In addition, this section should address how the hospital will fulfil its obligations under sections 16(6) and 24 of the LHSIA.

Engagement by HSPs

16(6) Each HSP shall engage the community of diverse persons and entities in the area where it provides health services when developing plans and setting priorities for the delivery of health services.

Identifying integration opportunities

24 Each LHIN and each HSP shall separately and in conjunction with each other identify opportunities to integrate the services of the local health system to provide appropriate, co-ordinated, effective and efficient services.

3. Situation Analysis

A hospital should provide

- (i) a summary of significant budgetary and operational issues for the planning periods;
- (ii) business assumptions and rationale regarding accruals, volumes, overall expenses and revenues;
- (iii) an explanation of how it anticipates using the funding provided by the LHIN and other third parties; and
- (iv) an outline of any systemic challenges and opportunities that have not already been addressed in an H-SIP (see Section 4.1) or Clinical Service Change Pre-proposal (Section 4.2). An example would be a lack of physician human resources resulting in clinical service pressures.

The hospital may wish to detail any other significant factors which may impact operations (i.e. contract negotiations, arbitrations, health human resource shortages, service conflicts, other risk management issues).

4. Evaluation of Prior Year Performance

In this section, a hospital must provide a critical and objective evaluation of its performance in the past year. The evaluation should highlight the attainment of objectives identified in previous submissions, challenges encountered in working towards agreed-to goals, and other strategies undertaken to address challenges faced by the hospital.

5. Changes to Operations Summary

In this section of the Narrative, hospitals must highlight changes to operations that will be undertaken in the upcoming planning period. Changes to operations that require pre-approval from the LHINs cannot be included in the Narrative unless the change has been approved. Further information is provided in Section 4 below.

3.2 Operating Assumptions

Expense Assumptions:

The assumption form should report the estimates used in the development of the budget. Management is expected to make reasonable, prudent and responsible assumptions with respect to all operating expense estimates and clearly communicate those assumptions.

Revenue Assumptions:

Hospitals have planning (funding) targets for 2008/09 and 2009/10. In completing the assumption form the planning (funding) targets should be used to forecast levels of activity. Explanations should be provided if activity levels are beyond the funding targets. Revenue from sources other than the LHIN should be anticipated and disclosed.

3.3 Cancer Care Ontario Funding

Any service agreement signed between the hospital and Cancer Care Ontario (“CCO”) operate outside of the H-SAA. The hospital is responsible for ensuring that all performance indicators under both the H-SAA and any service agreement with CCO are attained, while respecting the accountabilities detailed in the H-SAA and the service agreement with CCO. As detailed in the CCO service agreements, all related funds are protected and targeted for delivery of the services funded by the agreements. Funding from the Cancer Program Integration Agreement continues to remain protected and dedicated for the Integrated Cancer Programs.

Funds received from any CCO agreement are not to be used to address hospital operating pressures.

3.4 MOHLTC Policies for Protected Services

The majority of hospital base funding is allocated subject to an individual hospital board’s direction. This allows hospitals to be flexible and respond to the health care needs of their referral population. In addition, there are funding allocations that are purpose-specific, conditional and recoverable should volumes or other funding conditions not be met. Providing sufficient funding flexibility to meet emerging needs without imposing a degree of control that impedes ongoing service innovation, or that distorts local and provincial planning processes, is a balancing act. As a principle, the protection of services will be done carefully and sparingly. For those services that are protected, the need for protected status will be reviewed as necessary.

The 2008 - 2010 HAPS continues with the direction that started in 2003 to normalize special status services for many of the traditional priority programs. It moves away from the concept of ‘priority services’ and ‘specialized hospital services’ included in the 2006/07 and 2007/08 HAPS. Instead, new concepts of Provincial Strategies/Projects and Provincial Resources are incorporated to reflect the LHIN’s obligations under the MOHLTC-LHIN Accountability Agreement.

3.4.1 Provincial Strategies

Provincial Strategies are emerging services still in the pilot or developmental phases, that have been approved by the MOHLTC for dedicated funding (one-time or base) to complete implementation planning, assess the merits of a delivery approach or service, or inform final policy. Services that are designated as part of a Provincial Strategy are planned, managed, funded and reconciled by the LHIN in consultation with the MOHLTC. The designation period for all Provincial Strategies is **time-limited**. Once the designation period expires and a decision is made to continue the service, these Provincial Strategies would be rolled into the base budget of the hospital as ongoing services. Conditions of funding such as certain volumes or other standards may also be confirmed.

Current “Provincial Strategies” are endovascular aortic aneurysm repair, electrophysiology studies EPS / ablation, percutaneous coronary intervention (PCI) (angioplasty), implantable cardiac defibrillators (ICD), daily nocturnal home hemodialysis, provincial peritoneal dialysis initiative, newborn screening program, living organ donation and organ transplantation services.

This list of Provincial Strategies is subject to change. The LHINs will inform hospitals of any changes made to this list by the MOHLTC as the information becomes available.

3.4.2 Provincial Resources

“Provincial Resources” are selected, stable, low volume, specialized services that depend upon expensive physical infrastructure and highly skilled clinical resources. Hospitals receiving funding for Provincial Resources must maintain the volume or activity and scope of service delivery at the levels set out in the hospital’s 2007/08 HAA. Provincial Resources have no automatic entitlement to new incremental funding. Should a hospital propose to discontinue or reduce Provincial Resources, the hospital must submit a plan for approval to its LHIN and, if approved, enable the recovery by the LHIN of all associated base funding.

Current “Provincial Resources” are bone marrow transplants, adult interventional cardiology for congenital heart defects, cardiac laser lead removals, pulmonary thromboendarterectomy services, and thoracoabdominal aortic aneurysm repair.

3.4.3 Services Transferred in Previous Years

Permanent cardiac pacemakers is the last of the specialized hospital services identified in the 2007/08 HAPS. To fulfil the commitment made in 2007/08, permanent pacemaker services will be protected until April 1st, 2011. These services have no automatic entitlement

to new incremental volume funding and existing base service volumes will continue until April 1st, 2011. These services will be monitored and reconciled by the LHINs. Should the LHINs agree that protected status for permanent pacemaker services is no longer required, a final base reconciliation will be completed and hospitals will continue to report activity on these services to LHINs in a manner prescribed by LHINs.

3.4.4 Performance Obligations Applying to all Prior Protected Services

Although all other specialized hospital services and former priority services (e.g. cardiac surgery, cardiac catheterization and chronic kidney disease services) from the 2007/08 HAPS are no longer protected services, the following conditions on the planning and management of these services continue to apply:

- (i) Any planned program changes must be discussed with, and approved in advance by the LHINs. When proposing a change to these services, a hospital must demonstrate that the needs of patients are addressed and established service levels are maintained;
- (ii) Hospitals shall maintain the established regional or provincial service catchment area to ensure continued access where local provision of these services is not otherwise available;
- (iii) Hospitals shall maintain the service delivery model and designated coordination functions where they have been identified;
- (iv) LHINs will monitor and reconcile these services;
- (v) The hospital shall plan for these services as part of its global budget and provide the volumes as detailed in the relevant schedule of the 2008 - 2010 H-SAA. Where no service volumes are prescribed, the hospital shall not make service changes that adversely affect the delivery of these services to their established referral population.

3.5 Other MOHLTC Policies

3.5.1 Mental Health Programs

There are three (3) types of mental health funding in hospitals that are protected:

- In-patient and outpatient mental health programs;
- Programs operated and/or sponsored by hospitals as special vote programs;

- Programs funded since 04/05 under the Mental Health Accord or the service enhancements to keep people with mental illness out of the criminal justice system (e.g. Intensive Case Management, Crisis Teams/Mobile Crisis Teams, ACT Teams funded since 04/05).

Hospitals that are designated under the Mental Health Act (Schedule 1-5) are required to provide the level of service specified by their schedule. The hospital is required to discuss any material changes to service delivery or service levels with the LHIN.

Hospitals that have supplemented mental health programs from their global budgets may reduce programs and expenses to the level of protected funding. It is expected that all efficiencies will be implemented to prevent or minimize reduction to current service levels.

Hospitals that have been the recipients of former Provincial Psychiatric Hospitals, but have not yet undergone the budget “right sizing” process referenced in the transfer agreement, will continue to work directly with the MOHLTC to conduct this process.

The MOHLTC will determine and advise the LHIN of the number and type of forensic mental health beds and associated services, as well as the designated hospitals that provide the forensic mental health service where applicable.

Hospitals designated under the Criminal Code of Canada to provide forensic mental health services are required to discuss any changes to the service delivery or service levels with the LHIN.

3.5.2 Reclassification of Beds

LHIN approval is required for the reclassification of beds. This type of approval will be considered through a process outside the HAPS and H-SAA. For further information, please see the example in Step 5, specifically 5.11 and 5.12 of the prioritization framework resource document available on the WERS.

3.5.3 Post Construction Operating Plans (PCOP)

PCOP funding is provided for service expansion and other operating costs occurring in conjunction with the completion of an approved constructed capital project. A hospital must use PCOP funding in accordance with its approved post-construction operating plan. PCOP funding cannot be used to balance a hospital’s budget. PCOP funds not used for service expansion and other operating costs will be recovered.

3.5.4 French Language Services

Pursuant to the *French Language Services Act*, hospitals must provide services in French if:

- they are designated under the Act;
- they have been directed by the former Health Services Restructuring Commission (“HSRC”).

For these hospitals, patient-centered care includes providing equitable access to quality professional services in French on a permanent basis. Designated and identified hospitals must complete the integrated French Language Services Report in WERS.

3.5.5 Preschool Speech and Language Services

These services are funded through the Ministry of Children and Youth Services. Any reductions in these services must be negotiated and approved under the terms of agreements with the Ministry of Children and Youth Services.

4 Changes Needing LHIN Pre-Approval

4.1 Proposing Operational Changes

As noted in Part 3 above, certain types of operational changes will require pre-approval from the LHIN before the proposed change can be incorporated into the hospital's HAPS. These would include any changes affecting funding or volumes, the reduction, elimination or transfer of clinical service, and integration activities.

4.2 Health System Improvement Pre-proposal (H-SIP)

The Health System Improvement Pre-proposal ("H-SIP") process has been developed and implemented by LHINs to (i) reduce the costs incurred by HSPs when proposing improvements to the local health system and (ii) improve the efficiency and effectiveness of the LHIN's ability to respond to these proposals.

This process contemplates the initial submission of a brief pre-proposal, known as an H-SIP, to enable a LHIN to make a preliminary assessment of any request or activity contemplated by an HSP that requires the LHIN's approval (e.g., new service or service enhancement). All H-SIPs will be evaluated against LHIN priorities as outlined in the LHIN's IHSP, local health system needs and financial feasibility. Following the LHIN's review and evaluation of the H-SIP, an HSP may be invited to submit a detailed proposal and a business plan for further analysis by the LHIN. Guidelines for the development of a detailed proposal and business case will be provided by the individual LHIN.

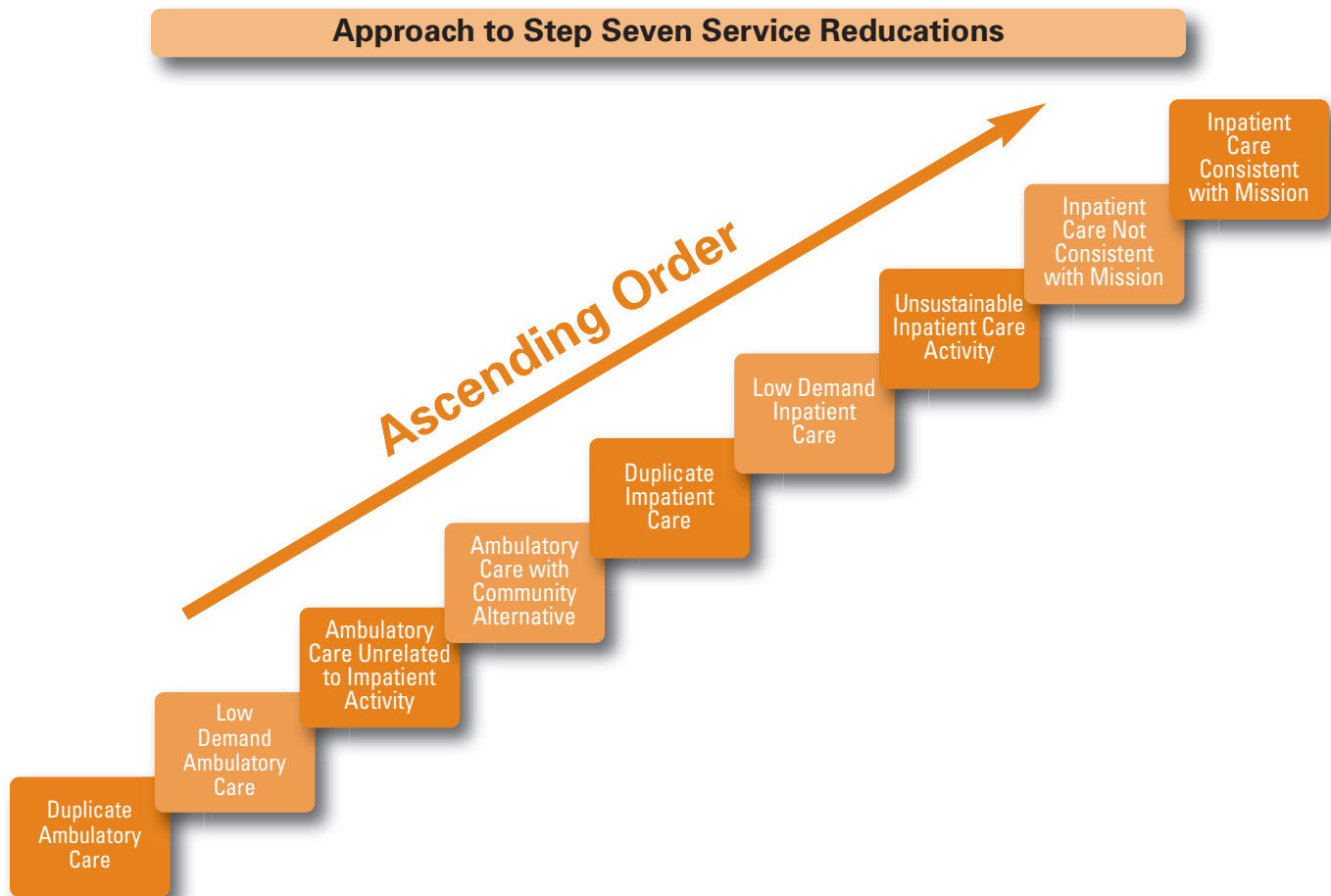
The submission of an H-SIP is not formal notice of a proposed integration to the LHIN as contemplated by s. 27 of the LHSIA. HSPs wishing to provide notice to the LHIN of a proposed integration under s. 27 of the LHSIA, should contact the LHIN for more information.

Hospitals that wish to reduce or eliminate clinical services, or transfer them to the community must follow the steps set out in Section 4.3 of these guidelines.

4.3 Clinical Service Change Pre-proposal

Access to hospital services is an important priority for the government, LHINs and hospitals. As a result, any proposed reduction, transfer or elimination of clinical services should be consistent with the overall goal of an integrated health system that provides access to high quality health services and coordinated health care in an effective and efficient manner. A transfer of services to the community must ensure that current levels of service (both quality and quantity) are maintained.

Hospitals considering a change to a clinical service(s) must use the approach outlined in the following graphic:



A hospital must have the LHIN's prior approval before including a proposed change in clinical service in its HAPS. Recognizing that different types of service reductions may require additional information, the following basic information would be expected in all proposals to reduce, eliminate or transfer clinical services.

1. A hospital must be able to demonstrate:

- how the base funding allocation for the hospital could be adjusted to reflect service volume reductions or program transfer, and the resulting financial impact, if any, on the hospital;
- that the service(s) are not included in the listing of protected services or provincial resources/strategies;
- the permanency of the service(s) (e.g. long-standing vs. pilot or time-limited which is now or soon to be concluded);
- the impact on performance obligations in the H-SAA;

- the human resource impact, including:
 - potential net FTE reduction once vacancies, retirements etc. have been considered;
 - potential impact of redeployment to other areas within the hospital;
 - reference to nursing and the impact on the percentage of full time nurses employed;
 - a mitigation strategy for patient access to service(s) that includes:
 - quality of care ramifications of the proposed change;
 - impacts on the community and steps being taken to address this issue;
 - confirmation of how individuals will access service post the change;
 - confirmation from the community provider that the capacity exists to accommodate the service delivery change;
 - impacts of the reduction on direction of the LHIN IHSP;
 - the extent of consultation that has been undertaken to date regarding the initiative, impacts and mitigation strategies;
 - a communications plan to communicate to both internal and external audiences.
2. The hospital must also demonstrate to the LHIN that any proposed reduction in service has been approved by the hospital's Board of Directors. Prior to approving the proposed reduction, the Board must determine and confirm the following:
- all other opportunities to reduce expenses have been exhausted;
 - the proposed service does not fit with the strategic direction/plan identifying the core or cornerstone services that the hospital will deliver to the community;
 - planning has been undertaken with neighbouring hospitals confirming the duplication of service;
 - potential community providers have been identified and discussions initiated with these providers on community capacity to deliver service.

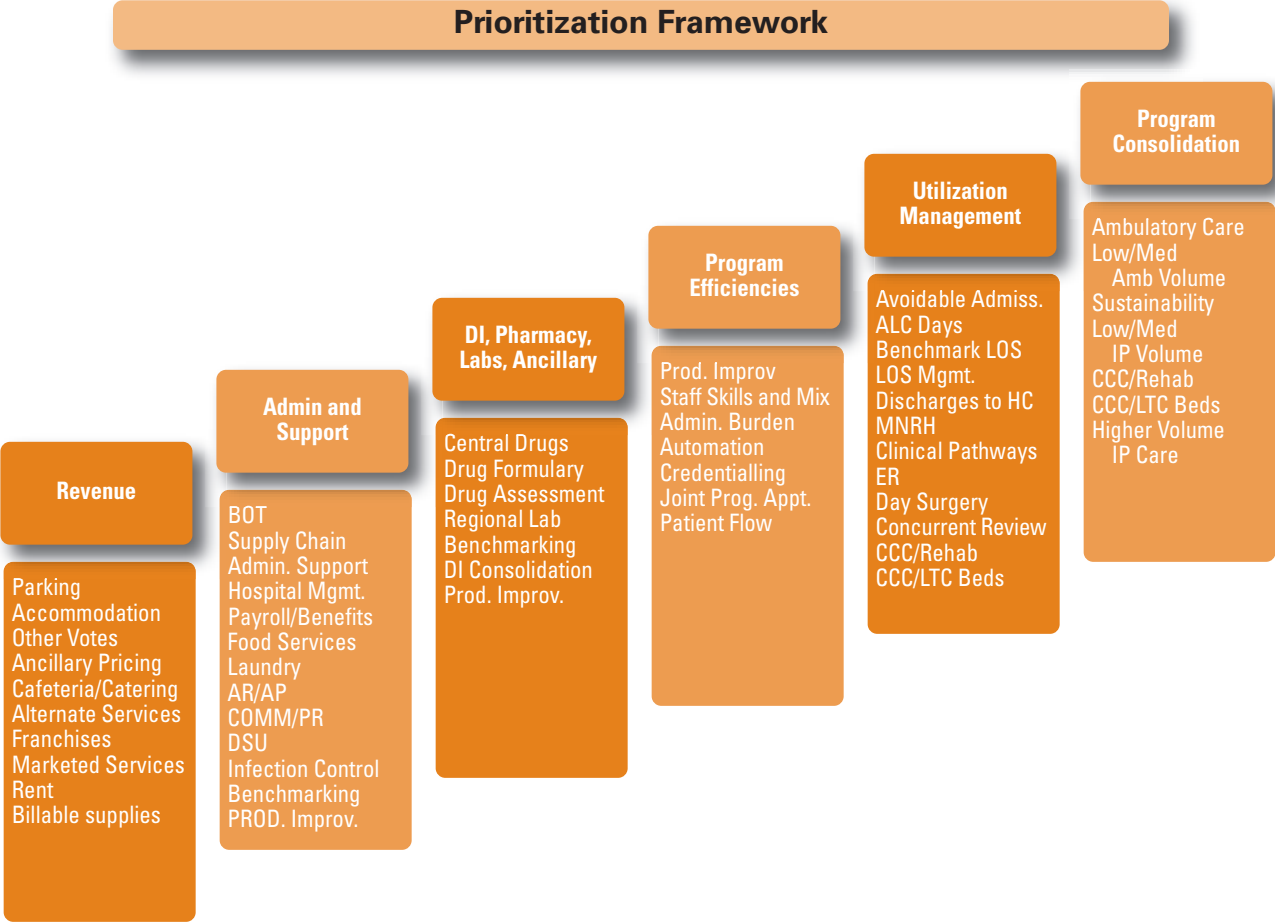
5 Guidelines for Balanced Operating Plans

5.1 Basic Requirement: A Balanced Operating Position

Hospitals are required to submit H-SAAs demonstrating a balanced budget (Total Margin of 0% or better). The H-SAA will require a hospital to maintain a balanced budget.

5.2 Prioritization Framework

The Prioritization Framework provides a stepped methodology to making decisions to allow a hospital to achieve and/or maintain a balanced operating position. The Prioritization Framework is similar to the Framework in the 2007/08 HAPS guidelines and was originally vetted through consultation with several hospital sector leaders prior to its completion. It is meant to assist hospitals to consider opportunities for greater efficiency of operations and to align changes in clinical services offered by the hospital with more strategic considerations. The framework should be consulted when identifying strategies in the Narrative.



Hospitals are expected to clearly outline the decision-making tool utilized in order to identify and categorize savings and revenues within the Prioritization Framework. The goal is to clearly portray the relationship between the savings and revenue options presented by the hospitals in the HAPS in comparison to the Prioritization Framework.

Examples of previously implemented hospital strategies aligned to each step of the Prioritization Framework can now be found as a resource document posted on the WERS. The examples provided are not an exhaustive list and hospitals are also encouraged to consult with other peer hospitals to benefit from the learning experienced during previous HAPS processes.

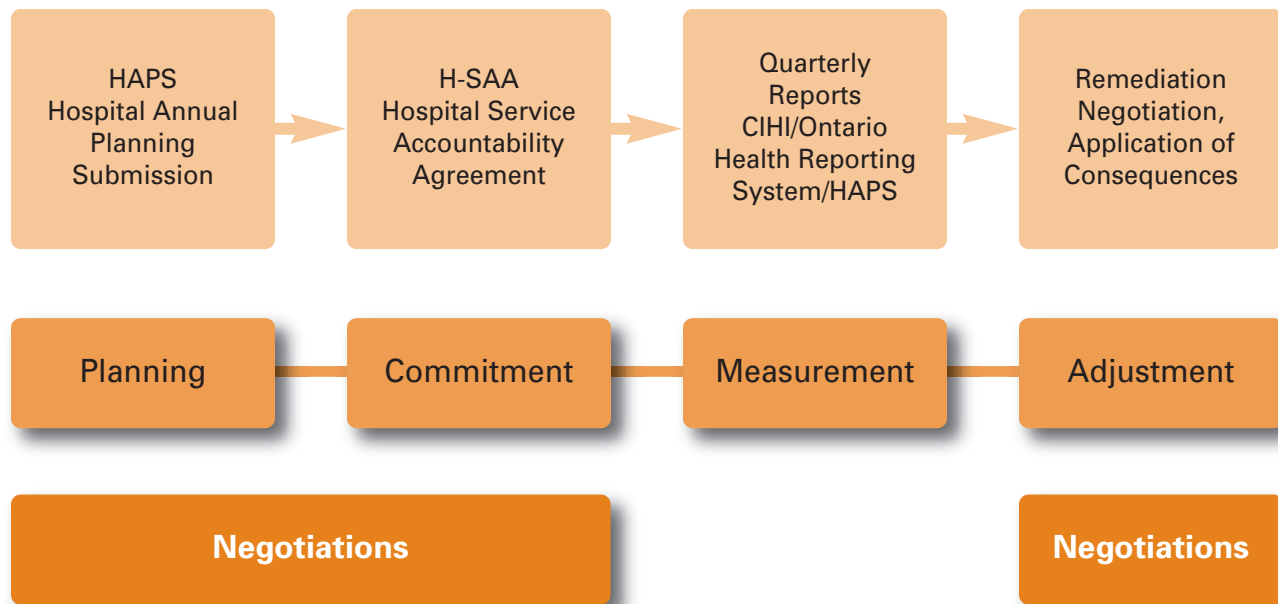
5.3 Exceptions

The LHIN may consider exceptions on a case-by-case basis as follows:

- a) If the hospital has the capacity to fund a negative margin, it can request a different target. The LHIN may consider the request based upon overall financial health of the hospital (as measured by its Current Ratio), the hospital's commitment to use its working capital to fund its deficit, and the hospital's plan to achieve a balanced budget position within an agreed upon timeframe; or
- b) The LHIN may consider accepting a proposed deficit where the LHIN has determined that achievement of a balanced budget position is not feasible. In such cases the LHIN may agree to a reasonable deficit in the first fiscal year of the H-SAA as long as a balanced budget will be achieved within a timeframe acceptable to the LHIN;
- c) In the event the LHIN agrees to allow an exception to the basic requirement of a balanced budget, the monitoring requirements will be established by the LHIN on a case by case basis.

6 HAPS Link to the H-SAA

6.1 Overview of the HAPS / H-SAA Cycle



Both the HAPS and the H-SAA promote enhanced accountability through multi-year planning and funding projections.

The HAPS focuses on service planning and the measurement and evaluation of hospital services and organizational performance. Data submitted by hospitals is used to calculate targets, corridors and performance standards related to:

- financial performance;
- organizational health;
- patient access and outcomes;
- system coordination and integration;
- protected services;
- post construction operating plans.

The H-SAA focuses on accountability as an integral part of the ongoing effort to improve health sector performance and provide high-quality, patient-centered care. LHINs are committed to achieving a balanced, innovative and realistic H-SAA; one that relies on negotiation and collaboration to the greatest extent possible, while meeting the requirements of the LHSIA and *the Commitment to the Future of Medicare Act, 2004*. Once negotiated, the LHINs and hospitals each have a role in ensuring that provisions are successfully implemented and targets achieved.

Refinements to the accountability documents, indicators and planning and negotiation processes were developed by the LHIN based on input from the LHINs, the MOHLTC, and the JPPC.

6.2 Developing the Initial H-SAA Template

The mandate of the JPPC is to recommend and facilitate the implementation of hospital reform in Ontario. Prior to the implementation of the LHSIA, the JPPC developed the terms of the template accountability agreements executed between the MOHLTC and hospitals. The JPPC's experience and expertise in this area has greatly facilitated the development of the H-SAA template to be used for the 2008 -2010 fiscal years.

Although substantially unchanged from previous years, the H-SAA template recognizes and acknowledges the changes implemented by the LHSIA; specifically that

- (a) The LHINs are now responsible and accountable for the planning, funding and integration of the local health system, including hospitals;
- (b) The funding of hospitals, and the terms on which that funding is provided, is now subject to both the LHIN's obligations under the LHSIA, and the parameters and limits established in the accountability agreements executed between the LHINs and the MOHLTC; and
- (c) the important leadership role that will be played by hospitals in enabling the Province of Ontario to achieve the integrated health system envisaged by the LHSIA in order to provide better access by Ontarians to sustainable high quality health services.

The H-SAA also reflects the importance that both the LHINs and the JPPC place on the need for collaboration, clear lines of communication and responsibility, the development of achievable performance obligations, and the obligation of both parties to an H-SAA to work diligently to identify and resolve issues in a proactive and timely manner.

The LHINs and the JPPC intend that the 2008 - 2010 H-SAA template will enable the parties to conclude their negotiations and conduct their on-going relationship in an effective and efficient manner.

6.3 MOHLTC, LHIN and Hospital Roles

MOHLTC:

- Sets strategic policy direction for the health care system that is patient-centred, enhances accessibility, promotes and enhances system integration and is accountable to the public;
- Establishes the legislative framework that enables implementation of the strategic directions;
- Enables the LHIN to fulfil the LHIN's responsibilities under the LHSIA.

LHIN:

- Provides system planning and integration direction as outlined in the IHSP;
- Negotiates an accountability agreement with the MOHLTC;
- Negotiates an H-SAA with the hospital;
- Provides funding in accordance with the terms of the LHSIA and the MOHLTC-LHIN Accountability Agreement and pursuant to the terms of an H-SAA;
- Monitors hospital performance against set targets;
- Provides necessary logistical support to enable planning, execution, monitoring and remediation of any variations.

Hospital:

- Negotiates an H-SAA with the LHIN;
- Delivers accessible, appropriate services funded pursuant to the terms of an H-SAA that:
 - Maximizes service levels and outcomes aligned with the MOHLTC-LHIN Accountability Agreement and the LHIN IHSP;
 - Meets planned and agreed upon performance targets, including achieving a balanced budget;
 - Establishes agreed upon mechanisms for consequences for falling short of agreed upon performance targets.

6.4 Development of Performance Indicators

A list of indicators approved for use as performance indicators for this year's HAPS and H-SAA is set out below. This list was compiled from recommendations made by the JPPC's HAA Indicators and Volumes Subcommittee and indicators from the LHINs' Accountability Agreement with the MOHLTC that require hospital participation.

Domains & Indicators	Activity Type	2005-2007	2007-2008	2008-2010
FINANCIAL HEALTH				
Current Ratio (Consolidated)	All	Performance	Performance	Performance
Total Margin (Consolidated)		Performance	Performance	Performance
ORGANIZATIONAL HEALTH				
% Full-Time Nurses	All	Performance	Performance	Performance
PATIENT ACCESS & OUTCOMES (including Service Volumes)				
Total (Inpatient & Day Surgery) Weighted Cases	Various	Performance	Performance	Performance
Mental Health Inpatient Days		Performance	Performance	Performance
Eldcap		Performance	Performance	Performance
Rehabilitation Inpatient Days		Performance	Performance	Performance
CCC RUG-weighted Patient Days		Performance	Performance	Performance
Ambulatory Care Visits (Outpatient-ED)		Performance	Performance	Performance
ED Visits		Performance	Performance	Performance
Protected Services		Performance	Performance	Performance
Readmission to Own Facility for Specified CMGs		Performance	Performance	Performance
% Chronic Patients with New Stage 2 or Greater Skin Ulcers	Chronic Care	Developmental	Performance	Performance (Explanatory)

In their accountability agreements with the MOHLTC, the LHINs are accountable for systemic performance indicators – indicators that for the most part will require a concerted effort on the part of all HSPs providing services in or to the LHIN. Hospitals will have a significant role to play in enabling the network of HSPs within to achieve these collective goals. In particular the H-SAA will require hospitals to demonstrate their contributions to the achievement of systemic targets in the following areas:

- (i) Ontario Wait Time Strategy indicators;
- (ii) Percentage of ALC days;
- (iii) Rate of ED visits that could be managed elsewhere;
- (iv) Hospitalization rate for ambulatory care for sensitive conditions.

Recognizing that hospitals across the province are already working with their respective LHINs in these and other areas, the form an individual hospital's contributions will take to enable a LHIN to achieve its systemic targets, and how these contributions will be measured, will be left to the LHIN and the hospital to determine.

Hospitals will not be expected to achieve systemic targets that are beyond their control. However, depending on the needs of the local health system, hospitals may be asked to assist with the achievement of systemic wait time targets by meeting the types of conditions already required of all hospitals currently receiving wait time volume allocations. They may be asked to participate in cross-LHIN collaboratives and initiatives with other HSPs that are designed to identify, recommend and implement ways in which other systemic performance indicators may be addressed. There are many ways in which hospitals will be able to demonstrate their individual and collective contributions to the achievement of the LHIN's systemic goals and the H-SAA will reflect those that the hospital and the LHIN agree are most appropriate for their local health system.

6.5 Additional Indicators

With the addition of the performance indicators identified in 6.4 above, the list of indicators referenced in prior years' HAPS guidelines has grown to include performance, monitoring and developmental indicators. Some of these indicators are used internally within hospitals, some of these indicators are included in external reports, some of these indicators are being piloted and others are essential to demonstrating performance, accountability and progress towards meeting the province's health care goals. Recognizing that the development, monitoring and achievement of these indicators is an expensive process for both hospitals and the LHINs, the JPPC and the LHINs have agreed to establish a committee to review the indicators over the coming year. The committee will be tasked with examining the efficiency and effectiveness of the indicators as well as their alignment with the needs of the hospital, the LHIN and the MOHLTC. Pending the report of this committee and any recommendations that may be incorporated into the guidelines for subsequent planning processes, hospitals are encouraged to continue their collection of data for, and their use of, the larger list of indicators. A complete list of performance, monitoring and developmental indicators is set out in Appendix B.

6.6 Corridors

Negotiated performance targets have standard corridors of performance. These are numerical ranges that account for normal variation in service needs, measurement error and other factors. When a hospital's performance falls outside of the corridor, the LHIN and the hospital will use the mechanisms of the H-SAA to review and resolve the issues.

As part of the H-SAA negotiation process, the LHIN and the hospital will agree on what constitutes an appropriate target. Various factors will be considered in agreeing upon a target, including the goals set out in the accountability agreement between the MOHLTC and the LHIN, a hospital's past performance, and its capacity to effectively manage future risk. Hospitals will be expected to independently manage any minimal variances. Variances that fall significantly outside an agreed-to corridor will require consultation with the LHIN to develop an appropriate mitigation strategy.

7 Appendix A: Glossary

Terms used throughout these guidelines are defined below. Terms that appear in a single section or part are defined there for ease of reference.

Accountability Agreement or MOHLTC-LHIN Accountability Agreement, means the accountability agreement that must be signed between the LHINs and the Minister pursuant to the terms of the LHSIA. Further information can be found at s.18 of the LHSIA.

CFMA means the *Commitment to the Future of Medicare Act*. The CMFA contains provisions applicable to SAAs. Further information can be found in Part III of the CFMA.

HAPS means Hospital Annual Planning Submission. The HAPS is the planning tool used by hospitals to inform the negotiation of the HAA, now the H-SAA. Previously submitted to the MOHLTC, it is now submitted to the LHINs beginning with the 2008-2010 planning period.

HAA means Hospital Accountability Agreement. The 2007-2008 HAA has been assigned by the Minister to the LHINs. For 2008-2010 the HAA will be replaced by the H-SAA.

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

H-SIP means a Health System Improvement Pre-proposal, a document submitted by HSPs to the LHIN to determine whether a formal proposal should be submitted.

HSP means health service provider as that term is defined in the LHSIA, and includes hospitals.

IHSP means the Integrated Health Service Plan developed and published by each LHIN pursuant to s. 15 of the LHSIA. A copy of a LHIN's IHSP is available through the LHIN's office or on its web site.

Integration has the same meaning as is set out in part I of the LHSIA, specifically: "integrate" includes (a) to co-ordinate services and interactions between different persons and entities; (b) to partner with another person or entity in providing services or in operating; (c) to transfer, merge or amalgamate services, operations, persons or entities; (d) to start or cease providing services; (e) to cease to operate or to dissolve or wind up the operations of a person or entity; and "integration" has a similar meaning; Further information on integration can be found in Part V of the LHSIA.

JPPC means the Joint Policy and Planning Committee, a partnership between the MOHLTC and the Ontario Hospital Association.

LHIN means Local Health Integration Network. The LHINs are 14 networks established by the LHSIA across the province. Specific information about their geographic parameters and contact information can be found at www.lhins.on.ca.

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

Minister means the Minister of Health and Long-Term Care.

MOHLTC means the Ministry of Health and Long-Term Care.

SAA means a Service Accountability Agreement as that term is defined in the LHSIA. SAAs are executed between LHINs and HSPs and include the H-SAAs.

WERS means Web Enabled Reporting System. It can be found at www.mohltchb.com.

8 Appendix B: Complete Listing of Domains and Indicators

Domains & Indicators	Activity Type	2005-2007	2007-2008	2008-2010
FINANCIAL HEALTH				
Current Ratio (Consolidated)	All	Performance	Performance	Performance
Total Margin (Consolidated)		Performance	Performance	Performance
Operational Efficiency			Monitoring	Monitoring
Total Margin (Hospital Sector Only)			Explanatory	Explanatory
Capital Health: Facilities Condition Index				Developmental
Capital Health: IT & Medical Equipment				Developmental
Other Measures of Op Efficiency		HAPS	HAPS	Developmental
ORGANIZATIONAL HEALTH				
% Full-Time Nurses	All	Performance	Performance	Performance
Paid Sick Time			Monitoring	Monitoring
Paid Overtime			Developmental	Monitoring
NEER Index		Monitoring	Developmental	Retired
Workplace Safety: Injury Frequency				Monitoring
Workplace Safety: Injury Severity				Explanatory
Turnover Rate				Developmental
Vacancy Rate				Developmental
Training & Professional Development				Developmental
Staff Satisfaction				Developmental

Domains & Indicators	Activity Type	2005-2007	2007-2008	2008-2010
SYSTEM INTEGRATION				
ALC Profile (Expected)	Acute			Developmental
ALC Index (Reported/Expected)				Developmental
Propensity to Identify ALC (Data Quality)				Developmental
Conservable Days		HAPS	HAPS	Retired
Proportion of patients in high-risk of readmission groups receiving first home care visit w/in 3 days			Developmental	Developmental
Time to first home-care visit			Developmental	Developmental
Frequency of nursing home care visits in post-acute period			Developmental	Developmental
Proportion of DAD-coded referrals who receive first home care visit			Developmental	Developmental
PATIENT ACCESS & OUTCOMES (including Service Volumes)				
Total (Inpatient & Day Surgery) Weighted Cases	Various			Performance
Mental Health Inpatient Days				Performance
Eldcap				Performance
Rehabilitation Inpatient Days				Performance
CCC RUG-weighted Patient Days				Performance
Ambulatory Care Visits				Performance
ED Visits				Performance
Other Volumes (Wait Times, PCOP, Protected Services, Critical Care)				Performance
Readmission to Own Facility for Specified CMGs	Acute	Performance	Performance	Performance
Readmission to <i>Any Facility</i> for Specified CMGs		Monitoring	Monitoring	Monitoring
Readmission to Own Facility for Congestive Heart Failure only		Monitoring	Monitoring	Monitoring
Relative Total Length of Stay for Specified CMGs		Performance	Explanatory	Retired
ED LOS for CTAS Level 1-2 Patients	Acute w/ ED	N/A	Monitoring	Monitoring

Domains & Indicators	Activity Type	2005-2007	2007-2008	2008-2010	
PATIENT ACCESS & OUTCOMES (including Service Volumes) continued					
ED LOS for CTAS Level 3 Patients	Acute w/ ED	N/A	Monitoring	Monitoring	
ED LOS for CTAS Level 4-5 Patients			Monitoring	Monitoring	
ED Time to Admission			Developmental	Developmental	
% Chronic Patients with New Stage 2 or Greater Skin Ulcers	Chronic Care		Performance	Performance	
CCC Quality of Care Index				Developmental	
% Chronic Patients with Indwelling Catheters		Developmental	Monitoring	Monitoring	
% Chronic Patients with Worsened Bladder Continence				Monitoring	
% Chronic Patients in Physical Restraints Daily				Monitoring	
% Long-Stay Chronic Patients with Pain				Monitoring	
% Chronic Patients with Rehab Potential with Improved ADL				Monitoring	
% Chronic Patients with Decline in Mobility				Monitoring	
% Chronic Patients with Decline in Communication				Monitoring	
% Chronic Patients with Increased Depression/Anxiety				Monitoring	
% Patients w/ falls within 30 days of prior assessment				Monitoring	
% Chronic Patients with Pressure Sores				Monitoring	
% Chronic Patients on Anti-Psychotic meds w/out psychosis				Monitoring	
% Short-Stay Patients with Pain				Monitoring	
Change in FIM Scores (Stroke Patients only) without LOS Adjustment		Rehab		Monitoring	Monitoring
Change in FIM Scores (Stroke Patients only) with LOS Adjustment					Explanatory
Rehab LOS (Stroke Patients only)			Monitoring	Monitoring	
Rehab LOS Efficiency (Stroke Patients only)			Explanatory	Explanatory	

Domains & Indicators	Activity Type	2005-2007	2007/08	2008-2010
PATIENT ACCESS & OUTCOMES (including Service Volumes) continued				
Stroke Care Quality Index	Designated Stroke Centres			Developmental
CT/MRI (within 24 hours)			Developmental	Monitoring
Atrial Fibrillation/Anticoagulation			Developmental	Monitoring
Discharge ASA			Developmental	Monitoring
Hospital Standardized Mortality Ratio	Various			Developmental
Other Outcome Measures (patient safety, adverse events)				Developmental
Mental Health Indicators				Developmental
PATIENT EXPERIENCE				
New Domain, Indicators TBD				

<p>Performance Indicator</p> <ul style="list-style-type: none"> <input type="checkbox"/> May trigger consequences under the H-SAA. <input type="checkbox"/> Indicator meets Primary and Secondary Criteria. <i>Primary Criteria are:</i> Construct validity, evidence basis, within hospital control and responsiveness to change. <i>Secondary Criteria are:</i> Availability and timeliness of data, data quality and reliability, acceptability/familiarity by the field. 	<p>Monitoring Indicator</p> <ul style="list-style-type: none"> <input type="checkbox"/> Indicator meets Primary Criteria and can be reported (with possible material time lag) but indicator fails to meet at least one of the Secondary Criteria. <input type="checkbox"/> Indicator may currently support negotiation, problem-solving, planning with appropriate caveats. <input type="checkbox"/> Indicator may "graduate" to become performance indicator when all Secondary Criteria are met.
<p>Developmental Indicator</p> <ul style="list-style-type: none"> <input type="checkbox"/> Indicator meets Primary Criteria but indicator cannot currently be reported in the H-SAA data and reporting environment. <input type="checkbox"/> Indicator may "graduate" to become monitoring/performance indicator when all Secondary Criteria are met. 	<p>Explanatory Indicators</p> <ul style="list-style-type: none"> <input type="checkbox"/> Indicators provide operational information but fail to meet at least one of the Primary Criteria. <input type="checkbox"/> Indicator may support negotiation, problem-solving, planning with appropriate caveats.

9 Appendix C: LHIN Contact Information

LHIN Name (English)	Address				Office Main # Fax #
Central	140 Allstate Parkway	Suite 210	Markham	L3R 5Y8	Tel: 905-948-1872 1-866-392-5446 Fax: 905-948-8011
Central East	Harwood Plaza 314 Harwood Ave South	Suite 204A	Ajax	L1S 2J1	Tel: 905-427-5497 1-866-804-5446 Fax: 905-427-9659
Central West	8 Nelson St. West	Suite 300	Brampton	L6X 4J2	Tel: 905-455-1281 1-866-370-5446 Fax: 905-455-0427
Champlain	1900 City Park Drive	Suite 204	Ottawa	K1J 1A3	Tel: 613-747-6784 1-866-902-5446 Fax: 613-747-6519
Erie St. Clair	180 Riverview Drive.	N/A	Chatham	N7M 5Z8	Tel: 519-351-5677 1-866-231-5446 Fax: 519-351-9672
Hamilton Niagara Haldimand Brant	270 Main Street East.	Units 1-6	Grimsby	L3M 1P8	Tel: 905-945-4930 1-866-363-5446 Fax: 905-945-1992
Mississauga Halton	700 Dorval Drive	Suite 500	Oakville	L6K 3V3	Tel: 905-337-7131 1-866-371-5446 Fax: 905-337-8330
North Simcoe Muskoka	210 Memorial Avenue	Suite 127-130	Orillia	L3V 7V1	Tel: 705-326-7750 1-866-903-5446 Fax: 705-326-1392
North East	555 Oak St. East	3rd Floor	North Bay	P1B 8E3	Tel: 705-840-2872 1-866-906-5446 Fax: 705-840-0142
North West	975 Alloy Drive	Suite 201	Thunder Bay	P7B 5Z8	Tel: 807-684-9425 1-866-907-5446 Fax: 807-684-9533
South East	48 Dundas St. West	Unit 2	Belleville	K8P 1A3	Tel: 613-967-0196 1-866-831-5446 Fax: 613-967-1341
South West	201 Queens Avenue	Suite 700	London	N6A 1J1	Tel: 519-672-0445 1-866-294-5446 Fax: 519-672-6562
Toronto Central	425 Bloor St. East	Suite 201	Toronto	M4W 3R4	Tel: 416-921-7453 1-866-383-5446 Fax: 416-921-0117
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