Agenda

1. Background

2. Information Management Strategy v1.0

3. EMR Project Lessons Learned
   – EMR journey
   – Governance structure
   – Staff perspective
   – Lessons learned

4. IM Strategy v2.0

5. Questions & Answers (maybe) ...

6. Appendix – More related stuff
Who is AOHC?

AOHC Vision:
• The best possible health and wellbeing for everyone living in Ontario

AOHC Mission:
• We champion transformative change to improve the health and wellbeing of people and communities facing barriers to health
AOHC represents 109 community-governed primary care organizations

AOHC membership is unified and organized

- 75 or 100% of Community Health Centres (CHCs)
- 10 or 100% of Aboriginal Health Access Centres (AHACs)
- 11 or 44% of Community Family Health Teams (CFHTs)
- 13 or 52% of Nurse Practitioner-Led Clinics (NPLCs)
AOHC 2015-2020 Strategic Directions

1. Champion health equity and population needs based planning, and challenge systemic inequities to achieve improved health outcomes.

2. Advance people centered, high quality primary health care as the foundation of the universal and publicly funded health system to increase access to appropriate services especially for populations facing barriers.

3. Demonstrate the value and impact of the Model of Health and Wellbeing on the improved health outcomes and experience of people and communities.

4. Advocate for appropriate policies, processes and resources to ensure members are equipped to operate healthy organizations and realize their potential as effective catalysts in system transformation.
Part II

INFORMATION MANAGEMENT STRATEGY V1.0
One Overarching Principle

“CHCs as Information Management Owners, acting as a unified sector”
Information Management Strategy v1.0

The Information Management Strategy is designed to support optimal client service and care provided by AOHC member organizations through the strategic management of information and information systems.

**Strategic Objectives**
- Improving client health through high-quality care
- Improving the health of communities
- Alignment to the broader provincial healthcare sector
- Accountability and sustainability

**Effective and efficient information management tools and processes**

1. “Get Electronic”
2. “Share your Data”
3. “Promote Collaboration”
4. “Improve Health”

**Work Streams**
- eHealth Alignment (Electronic Health Record, Drug Profile Viewer, OLIS, HRM, cGTA, etc.)
- Non-Operational Reporting and Analytics
- Community Initiatives Online
- Ontario Healthcare Reporting Standards/Management Information System
- Legacy Systems Management
# Q3 15/16 MSAA Dashboard

**MSAA Dashboard**

| LHIN: South East | Fiscal Year: 2015/2016 | Fiscal Quarter: Q3 |

<table>
<thead>
<tr>
<th>MSAA Indicators</th>
<th>Per. %</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Delta</th>
<th>Prov. Per. %</th>
<th>Provincial Numerator</th>
<th>Provincial Denominator</th>
<th>Prov. Delta</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A. Influenza Vaccination Rate</td>
<td>25.32%</td>
<td>4,994</td>
<td>19,720</td>
<td>14,726</td>
<td>20.69%</td>
<td>44,323</td>
<td>214,253</td>
<td>169,930</td>
<td>4.64%</td>
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<tr>
<td>1B. Influenza Vaccination Rate for High Risk Clients</td>
<td>51.89%</td>
<td>1,527</td>
<td>2,943</td>
<td>1,416</td>
<td>44.16%</td>
<td>10,481</td>
<td>23,735</td>
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<tr>
<td>2. Breast Cancer Screening Rate</td>
<td>76.38%</td>
<td>2,729</td>
<td>3,573</td>
<td>844</td>
<td>63.77%</td>
<td>19,976</td>
<td>31,324</td>
<td>11,348</td>
<td>12.61%</td>
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<td>3. Cervical Cancer Screening Rate (PAP)</td>
<td>78.85%</td>
<td>5,617</td>
<td>7,124</td>
<td>1,507</td>
<td>67.41%</td>
<td>56,005</td>
<td>83,086</td>
<td>27,081</td>
<td>11.44%</td>
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<td>4. Inter-Professional Diabetes Care Rate</td>
<td>93.79%</td>
<td>1,902</td>
<td>2,028</td>
<td>126</td>
<td>88.81%</td>
<td>18,549</td>
<td>20,885</td>
<td>2,336</td>
<td>4.97%</td>
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<tr>
<td>5. Colorectal Cancer Screening Rate</td>
<td>72.19%</td>
<td>5,553</td>
<td>7,692</td>
<td>2,139</td>
<td>64.33%</td>
<td>42,076</td>
<td>65,411</td>
<td>23,335</td>
<td>7.87%</td>
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<tr>
<td>6A. Periodic Health Examination Rate</td>
<td>44.13%</td>
<td>7,131</td>
<td>16,158</td>
<td>9,027</td>
<td>53.86%</td>
<td>91,295</td>
<td>169,490</td>
<td>78,195</td>
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<tr>
<td>6B. Periodic Health Examination Rate for Diabetics Only</td>
<td>47.84%</td>
<td>964</td>
<td>2,015</td>
<td>1,051</td>
<td>59.74%</td>
<td>12,403</td>
<td>20,760</td>
<td>8,357</td>
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<td>6C. Periodic Health Examination Rate for Mental Health</td>
<td>45.86%</td>
<td>249</td>
<td>543</td>
<td>294</td>
<td>54.73%</td>
<td>4,208</td>
<td>7,689</td>
<td>3,461</td>
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<table>
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<th>Explanatory Indicators</th>
<th>Per. %</th>
<th>Numerator</th>
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<th>Prov. Per. %</th>
<th>Provincial Numerator</th>
<th>Provincial Denominator</th>
<th>Prov. Delta</th>
<th>Difference</th>
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<tbody>
<tr>
<td>1. Panel Size Count</td>
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<td>21,885</td>
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<td></td>
<td></td>
<td>265,141</td>
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<tr>
<td>2. Registered Client</td>
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<td>3. Interpretation</td>
<td>0.11%</td>
<td>24</td>
<td>21,885</td>
<td>21,861</td>
<td>4.03%</td>
<td>10,686</td>
<td>265,141</td>
<td>254,455</td>
<td>-3.92%</td>
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</table>

Association of Ontario Health Centres
MSAA Indicator Trending Report – SE LHIN CHCs
Inter-Professional Teams – Working to Full Scope
IMS Portfolio Guiding Principles

• CIO Values – (see Appendix)
• Person-centric/Customer Service Orientation
• Maximize Benefits
• Minimize Costs
• Robust Evidence-based Evaluation
• Openness & Transparency
• Partnerships
  – Shared risk/rewards
  – Mutual respect for needs
  – Economies of scale
  – Alignment of needs
IMS Program Benefit Evaluation

• August 2014, sector sponsored a Benefits Evaluation project on IMS programs
  – Steering committee included EDs, Canada Health Infoway (CHI) and two LHIN CIOs

• Benefits include:
  – Commitment amongst leaders and the centres themselves, to working together and continuing to invest in IMS to create value for clients, clinicians, and for the system as a whole
  – Leadership in the province in comparison to other sectors who are only in the preliminary stages of this type of work
  – Sector-wide agreement that more value will be gained as the sector continues to focus on solution optimization and stabilization

Deloitte’s study highlights that CHCs are on the right track and are aligned to the Provincial, LHIN and sector priorities
IMS Program Value for Money

• **Accurate and reliable data** - Primary care data is available at a click of a button

• **Legacy Management Support** – Developed a read-only EMR viewer ($1.5M savings over 10 years)

• **Reduced prices for provincial integrations** – 15% compared to non-AOHC clients with Nightingale -- annual $47K savings

• **Data sharing with other eHealth applications** such as HNHB LHIN’s IDS system – $115K cheaper to integrate with BIRT than EMR – Scalable at minimal costs

• **10 Year EMR contract** – no licence increases for a decade. Lower annual fees than for Purkinje.

• **Customizations paid for under AOHC contract** with Nightingale must be made available to all Nightingale customers at no additional cost (e.g. Syrian Refugee template, equity SDOH fields, PDGs, etc.)
Charting Profound Changes

Major Milestones & Sector Activities

1. Sector sets goal of EMR implementation in all CHCs within 3 years.
2. ED Network sets procurement guidelines.
3. ED Network agrees to issue a Request for Proposal (RFP) for a CMS solution.
4. ED Network sets criteria for vendor selection.
5. ED Network nominates AOHC as procurement agent.
6. ED Network agrees to explore common MIS solution.

1. ED Network appoints AOHC as IMS host agency.
2. ED Network approves Terms of Reference for IMS Committee.
3. ED Network approves NORA work stream.
4. IMSC approves BIRT procurement approach.
5. Inventory component of CI Tools (pilot).

1. eHealth Ontario approves multi-year funding agreement for IMS.
2. EMR agreement signed.
3. AOHC appoints CIO to oversee IMS.
4. IMSC endorses selection of Connex as BIRT partner.
5. Phase 1 BIRT.
6. OHRSMIS project approved.
7. DPV roll out: 20 CHCs.

1. OHRSMIS RFP/tender.
2. OHRSMIS implementation.
3. CI Tools full implementation.
4. CHC MSAA Reporting via BIRT.
5. BIRT Phase 2.
8. EMR rollout to 34+ organizations.
10. EMR inclusion for NPLCs.
11. EMR inclusion for AHACs.
12. DPV Benefits assessment.
13. OLIS integration with EMR.
14. HRM integration with EMR.
15. CCIM standard assessments in EMR (OCAN/RAI-CHA).
16. Data retention/migration solutions implemented.

IMS Work Streams

2000-2002
2002-2004
2004-2006
2006-2008
2008-2010
2010-2012
2012-2014
2014-2016

Planning Stage
Approval Stage
Implementation Stage
EMR Project Approach

- IMS v.1 strategic priority alignment for EMR
  - ASP
  - OntarioMD-certified
  - RFP process
  - Implementation Approach

- Governance
  - CHC Executive Director Network
    - Information Management Committee
Robust Governance: CHC & AHAC ED Network Committees

CHC and AHAC ED Network Committee Structure

LEGEND
- Organizations
- Active Committees
- MOHLTC & LHIN Committees

Revised: July 2015
What is the EMR Project?

- 73 CHCs, 10 AHACs, 4 NPLCs, cFHTs, others?
- Robust RFP process, Fairness Commissioner, 47 end-users involved
- Provincial license
- OntarioMD spec. 4 certified solution: Nightingale On Demand (NOD)
- Application Service Provider model for EMR
- Vendor development preference (AOHC=\~30\% of customer base)
- Bilingual, PDGs, ENCODE-FM, data migration/retention
- AOHC signed Nightingale Informatix contract – “on behalf of members”
- 2 years to complete EMR roll-out
- eHealth Ontario funding the project 1-time costs
- Project supported by Infoway, MoHTLC, eHealth Ontario & members
- Members fund on-going operational costs
- Four EMR web demos completed: Jan 17/26, Feb 8 (French), Feb 27
- Data Miner web demos scheduled – May/Jun
Aggressive Deployment Schedule for EMR:

- 86 members
- 24 months

Current Focus:
- PDG code development
- Data Migration/Retention
- CHC Evaluation Framework
- Operational Reporting Transition Strategy
- NPLCs approved
Beta: Chigamik CHC EMR Lessons Learned

• Success! On time, on budget, but…;

• Opportunities for Improvement in roll-out process:
  – **Tools and Artifacts** – better training resources, templates, etc.;
  – **Engagement** – earlier is better;
  – **Roles & Accountabilities** – Super User(s), AOHC, Nightingale;
  – **Communications** – SharePoint utilization;
  – **Support Coordination** – pre-live, during, post-live;

  – 33 QI recommendations implemented from Lessons Learned;
Data Migration and Retention Sub-Project

Status:

- Preferred vendor engaged for Regent Park CHC-beta site
- Negotiations finalized March 31/12
- AOHC Board approval Apr 10/12
- eHealth Ontario procurement review completed Apr 13/12
- eHealth Ontario legal review completed Apr 20/12
- eHealth Ontario sign-off completed April 20/12
- Regent Park ADT & scheduling data confirmed: Apr 22/12
- DM/DR contract signed with Nightingale April 24/12
**EMR Project Approach: 1000 line GANTT...**

<table>
<thead>
<tr>
<th>Engagement</th>
<th>Assessment</th>
<th>Preparation &amp; Planning</th>
<th>Deployment</th>
<th>Go Live Activities</th>
<th>Adoption &amp; Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial project planning discussions with centre</td>
<td>Detailed needs analysis to assess centre's readiness</td>
<td>Project planning</td>
<td>Training</td>
<td>Final readiness checklist</td>
<td>Data validation by end users</td>
</tr>
<tr>
<td>Establish project team key resources</td>
<td>Report gap analysis</td>
<td>Budget preparation</td>
<td>Setup and configuration</td>
<td>Go/No-Go decision</td>
<td>Addressing issues</td>
</tr>
<tr>
<td>Agreements in place /signed</td>
<td>Workflow analysis and integration</td>
<td>Pre-production environments allocated</td>
<td>Implementation Acceptance</td>
<td>End user support</td>
<td>Transition to adoption/maintenance phase</td>
</tr>
<tr>
<td>Adoption &amp; Business Continuity plans</td>
<td>Identification and development of reports</td>
<td>Network, infrastructure &amp; facilities readiness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Data Migration & Retention**

- Data analysis
- Data migration preparation
- Data migration trial runs
- Data conversion and validation
- Data retention solution

- 2 months approximately
- 2 months approximately
- 3 days
- Ongoing 6 - 12 months approximately
IMS Participation Agreement Framework

• The agreement framework binds AOHC member organizations (CHCs, AHACs, NPLCs, and CFHTs) to terms that govern their use of, and benefits derived from, the AOHC’s IMS Programs

• There are three agreements that together govern the relationships between AOHC, its members and Vendors (see diagram on next slide)
  – Master agreements are between the AOHC and Vendors
  – Services agreements are between Members and Vendors
  – The IMS Participation Agreement is between the AOHC and members
IMS Participation Agreement Framework

Canada Health Infoway

MOHLTC

eHealth Ontario

AOHC

OntarioMD

IMS Vendors (NIC, Connex, etc.)

EMR Funding Agreements

Program Agreement(s)

Master Agreements

Certification ASP Agreements

Services Agreements

IMS Participation Agreements

CHCs, AHACs, NPLCs, CFHTs
IMS Participation Agreement

- Principles supported by IMC, ED Network & AOHC Board;
- Legal review delayed due to holidays;
- Draft agreement approved by IMC Mar 30/12;
- AOHC Board review April 10/12;
- AOHC Board approval April 16/12;
- Regional ED Networks review April-May/12;
- Discussion May ED Network meeting May 17/12
## IMS PA: Costs and Payment Responsibilities

<table>
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<tr>
<th>Cost Area</th>
<th>One-Time Project</th>
<th>On-Going Annually</th>
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<tr>
<td></td>
<td>AOHC</td>
<td>Member</td>
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<tr>
<td>Provincial Licence</td>
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<td>X</td>
</tr>
<tr>
<td>EMR Vendor Implementation Services</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Data Migration Vendor Services</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Annual Account Set Up Fee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local EMR “Readiness” e.g. hardware requirements, WAN, LAN</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>IMS Program Services including BIRT and EMR Maintenance and Support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Sustainment Costs Over the Years

Factors that could change the costs are identified in the next slide.

If all things remain the same - No planned increase From Y3 – Y4*
Calculating the Cost Factor Fees

- **EMR Fixed Factor (per AOHC Nightingale Master Agreement)**
  - Based on the initial 73 CHC and 10 AHAC members, the total Member compensation budget is $308.4M
  - For the EMR Fixed Cost Factor, the total cost is calculated by dividing the Annual base Nightingale Maintenance & Support cost by the total Member compensation budget
    - $1.26M/$308.4M = 0.0041

- **EMR IMS Factor:**
  - The total cost which includes the staff required to support the IMS Program Management Services for EMR, as well as the costs for ENCODE-FM and the Nightingale Account Management Fee, which is divided by the total participating Member compensation budget
    - $1.388M/$311.3M = 0.0045

- **BIRT IMS Factor:**
  - The total cost which includes the annual maintenance & support costs, as well as the IMS Program Management costs for the staff required to support BIRT which is divided by the total participating Member Compensation Budget
    - $596K/$284.3M = 0.0021

- **CI Factor**
  - The total cost which includes the annual maintenance & support costs, as well as the IMS Program Management costs for the staff required to support CI which is divided by the total participating Member Compensation Budget
    - $50K/$308.4M = 0.0002

- **Development Factor:**
  - The total amount of the Development Fund of $500K is divided by the total participating member Compensation Budget
    - IMS: $500K/$311.3M = 0.0016
How the Cost Calculation Translates

• Member Compensation budget was multiplied by each of the Cost Factors to determine Total Annualized Fees; communicated April 25/12 by email
• Apportioning of the use of the Development Fund is determined by IMC
• Member billing begins at EMR Go Live and prorated according to billing cycle (Jul–Dec, Jan–June)

<table>
<thead>
<tr>
<th>Participating Organization</th>
<th>Apportion Budgets</th>
<th>EMR NIC Factor (M&amp;S)</th>
<th>EMR IMS Factor (Staff)</th>
<th>NORA/BIRT IMS Factor (Staff &amp; M&amp;S)</th>
<th>CI IMS Factor (Staff &amp; M&amp;S)</th>
<th>Total IMS Program Management Services and M &amp; S including NIC</th>
<th>Combined Development Factor</th>
<th>Total Annualized Fees</th>
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<tbody>
<tr>
<td>CHC # 1</td>
<td>1,282,091</td>
<td>0.0041</td>
<td>0.0045</td>
<td>0.0021</td>
<td>0.0002</td>
<td>0.0016</td>
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<td>CHC # 2</td>
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<td>0.0025</td>
<td>0.0003</td>
<td>0.0016</td>
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<td>AHAC # 1</td>
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<td>0.0053</td>
<td>0.0025</td>
<td>0.0003</td>
<td>0.0016</td>
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</table>

<table>
<thead>
<tr>
<th>Program Management and Development Enhancement Fees by System</th>
<th>Total EMR Fee</th>
<th>Total NORA/BIRT Fee</th>
<th>Total CI Fee</th>
<th>Total Annualized Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHC # 1</td>
<td>12,542</td>
<td>3,139</td>
<td>271</td>
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<td>CHC # 2</td>
<td>25,232</td>
<td>6,315</td>
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<td>32,091</td>
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<td>CHC # 3</td>
<td>39,850</td>
<td>9,974</td>
<td>860</td>
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<td>CHC # 4</td>
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<tr>
<td>AHAC # 1</td>
<td>31,198</td>
<td>0</td>
<td>674</td>
<td>31,872</td>
</tr>
</tbody>
</table>

Association of Ontario Health Centres 33
IMS Apportionment Fee Rationale

• The budget and IMS Program Management approach was taken to:
  – Ensure continuous product effectiveness through the development enhancement budget:
    • Purkinje costs did not increase annually, nor did ECR functionality.
    • ECR was unable to meet current needs of the Sector or provincial EMR standards
  – To provide some predictability in pricing
  – To provide fairness and cost equity across all Member Organizations:
    • Older CHCs paid lower 1999 rates, new CHCs paid significantly higher costs
    • Some organizations had negotiated reduced rates (beta testers, etc.)
  – To reduce the time spent by each Member in effectively managing:
    • Vendor Contracts
    • Vendor Performance & Responsiveness
    • Enhancements (with shared costs)
  – To provide resources to work with LHIN, MOHLTC, and other potential provincial funders for increase opportunities for information sharing and to continue to enhance alignment with the provincial and federal eHealth agenda:
    • Creates additional funding opportunities
    • Shows funders members are unified providing a stronger voice
Summary of AOHC IMS HR Resources

- **CIO**
  - Includes Privacy Officer function
- **Director of Corporate Services**
  - 50% to manage IMS HR, Legal, Financials and Agreements
- **IMS Executive Assistant**
  - Admin Support to CIO, Director of Corporate Services (50:50)
- **IMS PMO/Business Lead**
  - Program and Policy Management for IMS Products
  - Stakeholder Relations and Communications
  - New project management as required
- **IMS Vendor & Operations Manager**
  - Vendor Management (SLAs)
  - Privacy Breaches & Management, IT Service Management
- **IMS Admin Assistant**
  - Admin Support to IMS Staff
- **IMS Governance Secretariat**
  - IMC/PMC, IMS Advisory Groups, BACs, etc.

- **Business Analyst**
  - User Adoption
  - IMS Product Enhancements (e.g. Change Advisory Board)
    - eHealth ON EMR Spec Process
  - Sector Communications
- **Agreement and Financial Analyst**
  - Agreements w/ CHCs (EMR, BIRT, etc.)
  - Contract Management (Vendors)
  - Financial Analysis (ensure funds are flowed appropriately to/from members)
  - Report-back on funding
  - Support any development of new agreements as a result of new projects
- **IMS Technical Coordinator**
- **Help Desk Analysts (2)**
  - Tier 1&2 Support for IMS Products
  - Service Level Management
  - IMS IT Support
Staff Perspective

• Member staff vs AOHC staff
• Beta experience: 30 items for improvement....
• You’re unique, like everybody else...
• Square peg in round hole?
• Slow down!
• Client - then provider?
• Click, click, click...
• Language/culture trumps strategy...
EMR Project Lessons Learned

1. Best-laid plans of mice and men...
2. Rome wasn’t built in a day...
3. Who moved my cheese?!?...
4. But that wasn’t what the brochure promised!...
5. Fact or fiction...
6. In God we Trust, all others bring data...
7. Hindsight is 20:20...
8. Leadership...
9. Communicate, communicate, communicate...
10. Training, training, training...
11. Business is business...
IMS v.1 Summary

• CHC sector priorities are closely aligned to LHIN and MOHLTC priorities
• The CHC sector is the only primary care model that reports to the LHINs
• The CHC sector’s Information Management Strategy has been guided by LHIN CEO and CIO involvement
• LHINs endorsed the CHC sector-based Information Management Strategy v1 and provided 1-time funding support over multiple years to help build the BIRT solution
• The CHCs agreed to become Information Management Owners as a sector and have done so successfully
• An independent review by Deloitte noted the validity of the CHC IM Strategy and its early achievements
• Incremental operating costs of the IM Strategy of $13.6M are impacting CHCs from realizing their IMS objectives
• CHCs have grown programs and services without additional budget
• CHCs have only received a 7% increase to base budget over 20 years
Part III

INFORMATION MANAGEMENT STRATEGY V2.0
### IMS v2.0 & Patients First Action Plan Alignment

<table>
<thead>
<tr>
<th>IMS v2.0 Initiative</th>
<th>ACCESS</th>
<th>CONNECT</th>
<th>INFORM</th>
<th>PROTECT</th>
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<td>✓</td>
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<tr>
<td>BIRT</td>
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<td>✓</td>
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<td>e-Referral</td>
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Part III

ALIGNMENT WITH LHINS
LHIN Provincial Strategic Framework
A Provincial Snapshot of Health System Priorities for Ontario

Support to Become Healthier
Faster Access and a Stronger Link to Family Health Care
The Right Care, at the Right Time, in the Right Place

Leading with Quality and Safety
Strengthening and Enhancing Access to Primary Care
Enhancing Coordination and Transitions of Care
Maintaining Achievements in Access, Accountability, and Safety

PREVENTION & PROMOTION
ACUTE
RECOVERY & MAINTENANCE

Chronic Disease Management
Seniors Strategy (SFH, BSO)
Health Links
Mental Health & Addictions Strategy
Palliative Care
Standardization & Sustainability (HSFR)
ED/ALC (Home First, etc.)
Wait Times Strategy

Accessible
Effective
Safe
Patient-Centred
Equitable
Integrated
Efficient
Population Health Focus
Appropriately Resourced

Improve Population Health
Improve Experience with the Health System
Improve Sustainability of the Health System

Association of Ontario Health Centres
Part IV

ALIGNMENT WITH EHEALTH BLUEPRINT AND MSAA
The MSAAs states that CHCS must comply with the e-Health strategy

3.4 e-Health/information Technology Compliance The HSP agrees to:

(a) assist the LHIN to implement provincial e-health priorities for 2013-15 and thereafter in accordance with the Accountability Agreement, as may be amended from time to time;

(b) comply with any technical and information management standards, including those related to data, architecture, technology, privacy and security set for health service providers by the MOHLTC, eHealth Ontario or the LHIN within the timeframes set by the MOHLTC or the LHIN as the case may be;

(c) implement and use the approved provincial e-health solutions identified in the LHIN e-health plan;

(d) implement technology solutions that are compatible or interoperable with the provincial blueprint and with the LHIN e-health plan; and

(e) include in its annual planning submissions, plans for achieving eHealth priority initiatives, including full adoption of Ontario Laboratory Information System by March 2015.
Downloaded costs for CHCs

• Community Health Centres have taken on additional costs without additional funding
  – Direct Costs
    • $1.1 Million for WAN services from eHealth Ontario
    • Operating costs for replacing hardware/software and training
    • eHealth Integrations (e.g. HRM)
    • Ontario Telemedicine Network (OTN)*
    • Hardware refresh ($1.5M)
    • Network services ($4.5M)
  – Indirect Costs
    • Ministry CHC-ISS vendor management (est. $1M per year) funded through IMS fees. Function supported by AOHC IMS Team

* Information about downloading OTN cost to the centres arrived after the survey. Costs are conservative estimates
IMS Program Annual Cost Structure

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<th>IMS Program Cost Category</th>
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<td>AOHC Operating Cost</td>
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<td>EMR vendor</td>
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<td>BIRT vendor</td>
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<td>CI vendor</td>
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<tr>
<td>ENCODE-FM vendor</td>
<td>62,400</td>
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<tr>
<td>Total IMS Fees</td>
<td>3,855,698</td>
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</table>

IMS Program Fees Breakdown
Information Management Funding Pressures: Required Investment for 74 CHCs, 2014

### All CHCs - Annual Costs

- **IMS Program Management Fees**: $2.6M
- **Known eHealth Integrations (M&S costs)**: $0.3M
- **Downloading of costs (e.g. WAN, ENCODE-FM, etc)**: $1.1M
- **OTN network services downloading (OTN member CHCs)**: $4.5M

**TOTAL CHC ANNUAL IM/IT COST PRESSURES**: $8.5M

### Some CHCs – Annual Costs

- **Data Management Coordinators (20 newer CHCs)**: $1.7M

### One Time Costs

- **IT Refresh Costs**: $1.9M
- **OTN hardware refresh**: $1.5M

**TOTAL 1-TIME COSTS**: $3.4M

**TOTAL CHC IM/IT COST PRESSURES**: $13.6M
Details for the $13.6M

1. **IM Program Fees**: $2.6M is due to the CHC IMS program specifically. This is the incremental costs required to pay for the extensive services provided through the IMS program, including vendor costs. MOHLTC funded all 10 AHACs for IM Program fees into their base budgets.

2. **eHealth Integration costs**: reflect licensing costs to use the new systems i.e. HRM and the cost per clinician to access.

3. **Downloading costs**: resulted from policy decisions without accompanying funding. The major impact is the Wide Area Networks – previously paid by eHealth Ontario is valued at $1.1M.

4. **OTN**: Many CHCs are offering OTN access as a very important service. OTN is unilaterally shifting the cost of network services to its members.

5. **Data Management Coordinators**: 20 newest CHCs that did not getting funding for DMCs – a funded role in the older CHCs. MOHLTC recently approved DMC funding for all 10 AHACs.

6. **IT Refresh**: Best practices suggest that equipment should be refreshed on a five year plan. Recently the TC LHIN and the Champlain LHIN completed an IT refresh plan for all CHCs (and in TC LHIN all community programs). This is not a consistent practice across all LHINs. The identified pressure of $1.9M represents the approx. cost for the remaining CHCs.

7. **OTN Refresh**: Many CHCs are offering OTN access as a very important service. However, the equipment needs to be replaced to be supported by OTN. There is no source of funding to do so.
Concluding Thoughts: IM Strategy

- CHCs have become Information Management Owners as a sector and have done so successfully and cost-effectively.
- The new 5-year Strategic Plan and IMS Program v2.0 remain aligned to provincial and LHIN priorities.
- IMS was/is supported and endorsed by LHINs through CEO and CIO involvement.
- Evidence shows the benefits are being realized.
- AOHC is committed to finding a solution that brings 100% of CHCs into the IMS Program.
- Modest IM/IT investment will enable CHCs to move LHIN and ministry priorities forward.
- Funder leadership is required to ensure sustainability and on-going value realization.
CHCs - Positioned for Success

• Alignment with MOHLTC and LHIN priorities
• A new 5-year Strategic Plan 2015-2020
• IMS v2.0 aligned with the Model of Health and Wellbeing and the Strategic Plan
• A robust Performance Management Program
• A Community Health and Wellbeing Strategy
• An excellent opportunity to lead Primary Care Reform
Questions & Answers (maybe)…
Thank-you/Merci

Rodney Burns, CHE, CPHIMS-CA
Chief Information Officer

rodney@aohc.org
(416) 236-2539 x 249
Appendix

MORE RELATED STUFF
Part I

LHIN & MINISTRY ALIGNMENT
Part I: MOH/LTC & LHIN Alignment

Key Messages

• The new AOHC 5-year Strategic Plan advances Primary Care Reform;
• The CHC IM Strategy was and remains closely aligned to ministry and LHIN priorities – hence endorsement;
• The largest sector-based approach in Ontario based on robust governance – including LHIN and ministry participation;
• Ministry, LHIN, 3rd party reviews have confirmed value for money in the IM Strategy:
  – EMR: less expensive EMR, 25% less cost to implement, higher adoption
  – BIRT: high DQ, primary care dataset for CHCs, LHIN/MOHLTC access
  – CI Tool: document and share community development programming
  – License-free Legacy Chart Viewer System cost avoidance: $150K/yr
  – Robust Performance Management Program
• Modest base funding is required to enable CHCs to meet obligations
The Model of Health and Wellbeing

- People and community centered
- Values and principles:
  - Health equity and social justice
  - Community vitality and sense of belonging
  - High quality
- An integrated service delivery model with 8 integrated attributes
• Culture as healing
CHCs participating with the solution

CHCs participation In progress
LHIN Benefits from the IM Strategy

• **MSAA Dashboard:** being rolled out now. Need LHIN support for roll-out, training, and development

• **Data Quality:** BIRT = CHC source of truth

• **Lower Costs:** ‘Develop once, deploy many’ (e.g. BIRT-IDS, EMR enterprise contract, reduced fees, etc.)

• **Privacy & Security:** Promoting best privacy and security practices for all members including developing tool kits, webinars, etc.

• **Primary Care Reform:** CHC can be leaders, AHACs already aligned, and supported for transition to LHINs
LHIN Benefits: EMR Project

• Implemented Canada’s largest EMR project.
  • 84 members are live on shared Nightingale-On-Demand
  • 6 Francophone centres are awaiting the multilingual product

• Financial benefits
  • Cost approximately 25% less to implement
  • 10 year agreement to freeze license costs – saves of over $200K
  • More centres live at lower overall operating cost
  • OntarioMD certification reduces integration costs
  • Any paid EMR enhancements must be made available to all Nightingale customers in Ontario

• Successes
  • Meaningful Use of the EMR at the centres are 37.5% greater than the provincial averages*
  • Only EMR in the world with Traditional Healing minimum dataset -- developed by the AHACs and Indigenous CHCs
The Advantages of a common EMR

- The Electronic Medical Record (EMR) Nightingale on Demand is an ASP meaning the current model and costs of supporting many local systems is no longer required. A single shared EMR reduces costs and improves performance.
- The EMR procurement provided an opportunity to specify data extraction requirements.
- The first CHC using the EMR went live Mar/12 with #85 live in Jun/16.

<table>
<thead>
<tr>
<th>AOHC Member</th>
<th>NOD Live</th>
<th>Pending</th>
<th>Not Participating</th>
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<tbody>
<tr>
<td>CHCs</td>
<td>68</td>
<td>6</td>
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<tr>
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</table>

- Alignment with MOHLTC and LHIN initiatives ensures integrated information will result in an effective model of care, to meet service, accountability and reporting requirements in a consistent sector wide manner.
EMR Project: Less Money – Greater Value

- Planned for 73 CHCs – Implemented 84 organizations
- Annual s/w maintenance has stayed the same/slightly less for Nightingale on Demand EMR with more organizations for a certified product with much more integration and features
- Higher quality data centre services and uptime Service Level Agreements (SLAs) are in place

Note: 2012 Legacy EMR S&M does not include funds required for hardware refresh
Integration with Provincial EHR Blueprint and LHIN/MOHLTC eHealth Strategy

• BIRT has been designated the data set of truth for CHC MSAAs by the MOHLTC. Other data sources (i.e. direct from CHCs) will not be recognized as official sources for reliable, accurate data.

• As the CHC EMR (NOD) becomes integrated with other eHealth products, (i.e. OLIS, HRM, CSWO, interRAI-CHA etc.) the CHCs that are not on NOD will not be included. Purkinje is not an OntarioMD certified EMR and therefore MOHLTC and eHealth Ontario have no intention to include these centres in the integration projects.

• CHCs who have opted out may be willing to provide the cost to pay for this integration – but it is a risk to know if the MOHLTC and the eHealth would approve the integration even if they do not pay for it.
EMR eHealth Integrations

- Ontario Laboratory Information System (OLIS)
- Drug Profile Viewer (DPV)
- Hospital Report Manager
- Regional HRM solutions (SPIRE, TDIS, POI)
- ClinicalConnect
- ConnectingOntario

In Progress: ONE ID, Single Sign-On, eConsult, e-Referral, Care Coordination Tool, OCAN and InterRAI-CHA, and Personal Health Record integration with EMR
Bending the Cost Curve Down

EMR Agreement saves $47K per year on eHealth Integrations

Even with preferred vendor pricing*, annual IM costs are still rising due to integration into provincial assets and cost downloading

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* Assumes 600 connections across the CHCs at $21.70 per month per integration. The number of connections can increase dramatically with proposed prescribing RNs gaining access to these systems

** 15% discount over non-AOHC Nightingale on Demand EMR clients
Performance Management Think Tank

• An optimized Performance Management Program is required to achieve the strategic directions
• Our program is strong in structure and process
• We need to improve in the areas of governance & management and resource optimization.
CHC Sector Performance Management Program
Guiding Principles and Goals

• Enhance sector, LHIN and local accountability
• Support evidence-based decision making
• Create a culture of Performance Management
• Ensure access and sustainability
• Measure the impact of the MHWB/MWHWB
• Deliver on the 5-year Strategic Priorities
Demonstrating the Value and Impact of the Model of Health and Wellbeing

PMC is tasked with developing approaches to measure and evaluate the areas of the Model that are delivered via programs and community initiatives:

- Health promotion
- Civic engagement
- Community development/vitality
- Sense of Belonging
- Focus on addressing the social determinants of health
- Health Equity approach
Community Health and Wellbeing Strategy

• Initial focus on poverty mitigation
• Testing indicators aligned with Canadian Index of Wellbeing (CIW) through the Be Well Survey
• Use of the CI Resource to capture the work and help to demonstrate impact
• Develop a bank of indicators to measure health promotion and community development
PERSONAL VALUES
Rodney J. Burns, CHE, CPHIMS-CA

The values I live by include:

HONESTY, TRANSPARENCY, INTEGRITY: I am obliged to share my thoughts and insights;
PERSONAL RESPONSIBILITY: If I can help, I will offer to do so;
TEAMWORK: More heads are better than one;
BALANCED EFFORT: I will give 100% - 100% of the time;
PERPETUAL LEARNING: I expect to learn something new everyday;

What I look for in those around me:

HONESTY & INTEGRITY:
TWO-WAY COMMUNICATION:
PERSONAL RESPONSIBILITY AND COMMITMENT:
CALCULATED RISK-TAKING: We all learn from our mistakes;
CONTINUOUS IMPROVEMENT: personally and professionally;

PERSONAL VALUES STATEMENT
Rodney J. Burns, CHE, CPHIMS-CA

My covenant to all with whom I work is:

➢ To conduct myself with integrity and professionalism;
➢ To treat others as I wish to be treated;
➢ To acknowledge and respect the unique skills of those around me;
➢ To provide active support in overcoming barriers to success;
➢ To challenge those I work with to be creative in finding solutions to opportunities that arise;
➢ To coach and counsel those in need of support;
➢ To encourage personal and professional development;
➢ To foster systems thinking; and
➢ To help others to feel comfortable with being uncomfortable.