

September 22, 2008

Memorandum to: Matt Anderson, CEO, Toronto Central LHIN
Co-Chair, Ministry of Health and Long-Term Care and Local Health
Integration Networks Provincial Programs Working Group

From: John King, Co-Chair, Provincial Program Review Task Group
Bill Manson, Co-Chair, Provincial Program Review Task Group

Re: Final Report of the Provincial Program Review Task Group

On behalf of the *Provincial Program Review Task Group*, we are pleased to submit the final report of the Group.

As you know, the Task Group was convened in June 2008 in response to mounting concerns related to the management, delivery and funding of provincial programs. The group included representation from hospital, LHINs, and the Ministry of Health and Long-Term Care (MOHLTC).

It is our hope that the information and recommendations presented in this document will provide the foundation upon which to:

- Increase awareness of the current and emerging issues impacting on Provincial Programs,
- Catalyze implementation of short-term (stop gap) approaches to address immediate pressures including the need to harmonize funding for Provincial Programs, and
- Provide input into the development of longer term solutions required to support future quality, accessibility and sustainability of these Programs.

Please note that through our membership on the Task Group, the report is also being shared with the Ontario Hospital Association and the Council of Academic Hospitals of Ontario.

We hope that the Ministry of Health and Long-Term Care, the LHINs and other partners will act on the recommendations in this report. We are persuaded that implementation of our recommendations will help to stabilize Provincial Programs and ensure that Ontarians are provided with equitable access to these services when needed.

John King, Co-Chair
Provincial Program Review Task Group

Bill Manson, Co-Chair
Provincial Program Review Task Group

Encl.

Final Report of the Provincial Program Review Task Group

Advice & Recommendations for Change

September 2008

FOR PURPOSES OF THIS DOCUMENT, THE TERM “PROVINCIAL PROGRAMS” WILL BE USED TO REFER TO BOTH CURRENT PROVINCIAL AND FORMER PRIORITY PROGRAMS

- **PROVINCIAL PROGRAMS:** Those programs/services ‘managed’ by the Ministry of Health and Long Term Care in collaboration with LHINs.
- **PRIORITY PROGRAMS:** Those programs/services formerly identified as ‘priority programs’ that are included in the new Ministry-LHIN Accountability Agreement (MLAA) categories. These programs/services were formerly ‘managed by the Ministry’ including planning, service coordination and funding. Some of the former priority programs (such as angioplasty) have been retained to be managed by the Ministry and some have ‘devolved’ to be managed by LHINs (such as CKD).
- **HOSPITAL PROGRAMS:** Those programs/services funded through the base budgets but serve a larger population group and their catchment area.

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PREAMBLE/CONTEXT

Any (and all) changes made with respect to Provincial Programs in Ontario must be made with the view to designing a true provincial system for the future that is sustainable and anchored in quality patient outcomes. The provincial system must be capable of overseeing, reviewing and monitoring volumes, costs, quality and outcomes associated with these [specialized] services.

The intent of this document is to clarify terminology, identify current issues and pressures impacting on the delivery of Provincial Programs and propose some initial recommendations to improve the governance, management (i.e., planning, coordination, organization), funding and evaluation of these Programs.

It is our hope that the information and recommendations presented in this document will provide the foundation upon which to:

- Increase awareness of the current and emerging issues impacting on Provincial Programs,
- Catalyze implementation of short-term (stop gap) approaches to address immediate pressures including the need to harmonize funding for Provincial Programs, and
- Provide input into the development of longer term solutions required to support future quality, accessibility and sustainability of these Programs.

BACKGROUND

During the 2008-2010 Hospital Service Accountability Agreement (H-SAA) negotiations, hospitals that deliver Provincial Programs within the Toronto Central LHIN (TC LHIN) emphasized the need for a new approach to address some of the growing pressures and challenges being faced by hospitals delivering these Programs. In response, the TC LHIN hosted a roundtable of Hospital CEOs in April 2008 to discuss issues related to Provincial Programs. The roundtable confirmed that several of the issues related to Provincial Programs had been explored previously by members of the Council of Academic Hospitals of Ontario (CAHO).¹ In response to the April 2008 roundtable, it was agreed that the reports arising from the April 2008 roundtable and the earlier work undertaken by CAHO should be used as the foundation for initiating further discussion. Subsequently, the TC LHIN established a **Provincial Program Review Task Group** (“Task Group”) in June 2008 co-chaired by Bill Manson, TC LHIN and John King on behalf of

¹ This work was documented in a May 2006 CAHO report – “A Foundation for Provincial Programs in Ontario”

CAHO hospitals. The Task Group was established as a provincial group and included representation from hospital, LHINs, and the Ministry of Health and Long-Term Care (MOHLTC).² The deliberations arising from the work of the Task Group are summarized below.

PROVINCIAL PROGRAM REVIEW TASK GROUP: TERMS OF REFERENCE

The terms of reference guiding the work of the *Provincial Program Review Task Group* are summarized in Figure 1.

Figure 1: Terms of Reference

In order to inform the 2009/10 HAPS planning process, the *Provincial Program Review Task Group* will:

1. Identify emerging issues impacting on Provincial Programs.
2. Clarify terminology and definitions with respect to Provincial Programs.
3. Develop short, medium and long-term approaches to support hospitals with a focus on clarifying and ensuring standardization and consistency with respect to
 - the definition and assignment of programs classified as Provincial Programs,
 - the governance, planning, coordination, management, organization, and funding of Provincial Programs.
4. Provide advice to the LHIN-MOHLTC Working Group(s) on issues and recommendations related to Provincial Programs.

The underlying assumptions guiding the work of the Task Group in addressing the Terms of Reference included the following:

1. The process will build on previous work undertaken by the CAHO, the TC LHIN and other groups that have explored the importance of ensuring appropriate governance, planning, coordination, management, organization and funding of Provincial Programs.³
2. Discussions regarding the governance, management (i.e., planning, coordination, organization), funding and evaluation of Provincial Programs needs to consider a number of factors, namely:
 - patient volumes
 - quality of care (e.g., critical mass, availability of appropriate health care professionals)

² See Appendix 1 for membership of Working Group.

³ The information in this report builds on previous discussions and recommendations contained in earlier documents developed by the Council of Academic Hospitals of Ontario (CAHO) and the Toronto Central LHIN (TC LHIN). HayGroup Report - *Toronto Central LHIN CEO Roundtable on Provincial Programs/Resources – Report on Discussion of Hospital Issues related to Provincial Programs on April 29, 2008*; Council of Academic Hospitals of Ontario. *A Foundation for Provincial Programs in Ontario, May 1, 2006*.

- costs
 - impact of new technology
 - sustainability
 - the geography of the catchment area(s)
 - cross-LHIN issues
 - performance management.
3. Patients will have reasonable access to all Provincial Programs under discussion with the understanding that not all Programs will be offered in all of the LHINs.

CURRENT STATE: A REVIEW OF EMERGING ISSUES

Following is a summary of some of the current and emerging issues impacting on Provincial Programs in Ontario:

1. ***There is an urgent need to strengthen planning for Provincial Programs at a province-wide level.*** Planning at a provincial level is needed to –
 - Confirm the definition and designation of Provincial Programs (including their establishment and/or discontinuation at specific hospitals/sites)
 - Clarify who has the ‘lead’ role with respect to planning and decision-making regarding Provincial Programs
 - Explore (and act upon) opportunities to rationalize and/or consolidate Provincial Programs within LHINs, across LHINs, regions and the province.
2. ***There is a lack of clarity with respect to terminology governing Provincial Programs.*** The terms “Provincial Programs”, “Provincial Resource Programs”, “Provincial Strategy Programs”, and “Priority Programs” continue to be used interchangeably in policy and funding discussions. This has created confusion and presented challenges in achieving consensus about appropriate approaches needed to address governance, management (planning, coordination, organization) and funding of these Programs.
3. ***Provincial Programs in Ontario have evolved significantly.*** This evolution has led to –
 - A growing number of Provincial Programs once managed by the MOHLTC devolved (or in the process of being devolved) to LHINs. The number and nature of Provincial Programs now being ‘managed’ by

LHINs is adversely impacting on the delivery of provincially integrated services and associated planning.

- The introduction of a number of new 'specialized' programs in recent years that are not currently classified as Provincial Programs (but perhaps should be).
- The emergence of a number of hospitals within the province being recognized as "centres of excellence" with respect to the delivery of Provincial Programs. (Some of these centres are the only provider of a Provincial Program and must accept all cases as there is no other resource available in the province.)
- Confusion related to accountabilities between the province, LHINs and hospitals particularly with respect to roles and responsibilities governing the management (planning, coordination, organization, monitoring and evaluation) and funding of Provincial Programs.
- An inherent weakness in the current system of Provincial Programs arising from the absence of collaborative structures to facilitate the development of provincial perspectives and funding flexibility essential to the effective management (planning, coordination, organization, monitoring and evaluation) of these Programs.

4. ***There are growing concerns about the current funding arrangements and the adequacy of funding for Provincial Programs impacting on hospital budgets and patient care. Examples of difficulties with the current system include:***

- Program funding not keeping up with increasing complexity of care,⁴ increasing volume and costs of service delivery⁵ associated with these programs
- Program funding does not provide for the cost of establishing and maintaining programs.
- Program funding models that provide reimbursement for a specific procedure but do not consider pre and post care costs (e.g., transplant surgery).
- Program funding models do not ensure that "funding follows the patient"

⁴ The current funding model does not reflect the increasing complexity of care that requires extensive patient preparation and post treatment management and care. Most provincial program funding focuses on the treatment but does not adequately reflect the care surrounding the treatment. Current rates and/or funding provides for only 30% to 60% of the full cost of service.

⁵ There are some Provincial Programs that are being impacted by technology (e.g., genetic services). These programs are 'unpredictable' in terms of volume and costs creating a situation whereby LHINs have limited ability and capacity (both within and across LHINs) to 'resolve' funding issues arising from these Programs.

(or to be more precise, that “funding follows the costs”).

- Inconsistent program funding models across Provincial Programs.
5. Hospitals that have accountability for Provincial Programs are challenged to continue to subsidize the costs associated with increasing volumes being experienced in a number of program areas.⁶ Hospitals report that subsidizing Provincial Programs is impacting negatively on their ability to adequately resource core services thereby compromising the provision of care to local residents. Examples of Provincial Programs currently being provided in hospital that are putting cost and/or volume pressures on hospitals include:
- Bone Marrow Transplant for Adults & Paediatric
 - Coiling (neuro interventional procedures)
 - Genetics Testing
 - Interventional neurosciences including neurosurgery and neuro modulation: interventional vascular surgery
 - Left ventricular device surgery (Berlin Heart)
 - Trauma
6. ***There are some Provincial Programs that have existing forums (i.e., Cancer Care Ontario (CCO), Critical Care Network, Pediatric Oncology Group of Ontario, Provincial Trauma Network) that represent their issues and concerns.*** There is a wide variation with respect to the mandates, roles and responsibilities of these groups. In addition, there are many Provincial Programs that do not have an existing entity representing their interests.
7. ***Psychiatric facilities are also confronting problems in controlling the volume of their provincial programs.*** The Province is required by law to provide forensic services. There are ten hospitals in the province designated by the MoHLTC to respond to the needs of clients ordered by the Courts and the Ontario Review Board (ORB) to receive these assessment and treatment services. The designated hospitals are not at liberty to reduce these beds in response to hospital-wide budget pressures. As a result, non-forensic mental health services in these hospitals frequently bear a disproportionate share of budgetary reductions. In addition, the clients in the forensic system are often unique in their clinical complexity and require more intense clinical services and supports, services and supports that are also related to the risk management issues presented by these clients. Staffing levels for

⁶ The budgets for many of these programs do not provide for additional cases.

certain disciplines, particularly nursing, must remain constant, and maintaining a robust multidisciplinary team is critical in the assessment and treatment process. These facilities are also faced with higher capital costs in terms of providing secure premises associated with the provision of forensic programs.

8. ***Tuberculosis cases have increased significantly in recent years without corresponding resources and infrastructure to support care for this patient population. While these cases were once concentrated in downtown Toronto, they are now dispersed across the GTA and beyond. In addition, there are an increased number of TB patients who receive treatment orders and are confined (sometimes under guard) to a single inpatient unit for the province.⁷ This unit is at capacity. As this unit serves the province and required significant resources, consideration should be given for tuberculosis care to be a provincial program.***
9. ***Transition from specialized paediatric to adult care is becoming a significant problem.*** Previously most children with some complex disorders did not survive into adulthood. With better survival, these children are now living well into adulthood; however, adult specialized care is not readily available. Examples of diseases where this is now a significant problem include Thalassaemia, Sickle Cell Disease, PKU, and other complex metabolic and hematologic disorders.

TERMINOLOGY

The programs referred to in this paper can be grouped into the following three categories:

1. Hospital programs funded through base budgets,
2. Hospital programs that are either partially funded and/or not funded through base budgets including Provincial Resources and Provincial Strategies, and
3. Hospital programs not listed in the Ministry-LHIN Accountability Agreement that provide services to the province and that have been identified by hospitals as 'issues' related to Provincial Programs (i.e., "non-assigned" programs).

Clarifying the definitions and responsibilities with respect to these three categories of programs is one of the important challenges that need to be addressed. The following are the definitions contained in the MLAA and H-SAA Schedule 3 – Local Health System Management^{8,9} related to –

⁷ This unit is located at West Park Health Centre.

⁸ The purpose of Schedule 3 is to identify, in alignment with the Primary Purpose, the scope of the LHIN's

- Hospital programs that are either partially funded and/or not funded through base budgets including provincial resources and provincial strategies
- Hospital programs funded through base budgets in addition to core inpatient, outpatient, and surgery programs

HOSPITAL PROGRAMS FUNDED THROUGH BASE BUDGETS		
TERMS	DEFINITION/DESCRIPTION	MOHLTC / LHIN RESPONSIBILITIES
HOSPITAL PROGRAMS Source: MLAA Schedule 3 Section 6,7,8	HOSPITAL PROGRAMS FUNDED THROUGH BASE BUDGETS ARE: (a) Core inpatient, outpatient and day surgery programs, Hospital-based Acquired Brain Injury (ABI), Cochlear Implants, Regional Geriatrics Program, Cleft Lip and Palate / Craniofacial Dental Services; (b) Stable priority services including cardiac catheterization, cardiac surgery and Chronic Kidney Disease; and (c) Specialized Hospital Services, which include Trauma, Sexual Assault and Domestic Violence Treatment Centres, Provincial Regional Genetic Services, HIV Outpatient Clinics, Hemophiliac Ambulatory Clinics, Regional and District Stroke Centres, Cardiac Rehabilitation Services, and Permanent Cardiac Pacemaker Services.	The MOHLTC will: (a) Notify the LHIN of any provincial or regional service delivery models for Hospital Programs Funded through the Base Budget that must be maintained in or for the local health system; (b) Notify the LHIN of designated service coordination functions for Hospital Programs Funded through the Base Budget in the local health system as of April 1, 2007 that must be maintained; (c) Determine the Dedicated Funding Envelope for Permanent Cardiac Pacemaker Services; and (d) Determine, in consultation with the LHIN, the hospitals that will provide these services and hospital-specific volumes for these services until April 1, 2011, and notify the LHIN of these hospitals and volumes. The LHIN will: (a) Maintain the provincial or regional service delivery models of which it is notified under paragraph 7(a), subject to any agreement with the MOHLTC for changes to those models; (b) Maintain the service coordination functions of which it is notified under

decision-making and responsibility in managing its local health system under the Act and the MOHLTC's role in supporting the LHIN, over the term of this Agreement.

⁹ MOHLTC, Hospital Annual Planning Submission (HAPS) Guidelines 2008-2010. Schedule 3 of the Ministry-LHIN Accountability Agreement.

		<p>paragraph 7(b);</p> <p>(c) Use the Dedicated Funding Envelope for Permanent Cardiac Pacemaker Services and require the hospitals that deliver Permanent Cardiac Pacemaker Services to provide the volumes, where the LHIN is notified under paragraph 7(c).</p> <p>(d) Consult with the MOHLTC on any proposed service changes regarding Specialized Hospital Services.</p>
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HOSPITAL PROGRAMS THAT ARE NOT FUNDED THROUGH BASE BUDGETS INCLUDING PROVINCIAL RESOURCES AND PROVINCIAL STRATEGIES		
TERMS	DEFINITION/DESCRIPTION	MOHLTC / LHIN RESPONSIBILITIES
<p>PROVINCIAL RESOURCES</p> <p><i>“...selected, stable, low volume, specialized services that depend on expensive physical infra-structure and highly skilled clinical resources.”</i></p> <p>Source: MLAA Schedule 3 Section 9, 10</p>	<p>PROVINCIAL RESOURCE [PROGRAMS]</p> <ul style="list-style-type: none"> - Bone Marrow Transplants - Adult Interventional Cardiology for Congenital Heart Defects - Cardiac Laser Lead Removals, - Pulmonary Thromboendarterectomy Services, and - Thoracoabdominal Aortic Aneurysm Repair <p>The Ministry has indicated that:</p> <ul style="list-style-type: none"> - Hospitals funded for Provincial Resources must maintain volume and scope of service at levels set in the hospital’s 2007/08 HAA. - Provincial Resources have no automatic entitlements to incremental funding - Discontinuation or reduction of Provincial Resources must be approved by LHIN and all associated funding will be recovered. 	<p>The LHIN will:</p> <p>(a) Maintain the funding for the hospitals that provide Provincial Resources at the minimum levels set out in the 2007-2008 Hospital Accountability Agreement (“HAA”); and</p> <p>(b) Require hospitals that provide Provincial Resources to:</p> <ul style="list-style-type: none"> (i) Maintain the volume or activity levels and scope of service delivery at least at the levels set out in the hospital’s 2007/08 HAA; and (ii) Submit a plan for any reductions or discontinuation in Provincial Resources for LHIN approval and the LHIN will work with the MOHLTC to reallocate funding to another hospital

<p>PROVINCIAL STRATEGIES</p> <p><i>“...emerging services still in pilot or development phase that have been approved by MOHLTC for dedicated funding (one time or base) to complete implementation planning, assess merits of delivery approach or service, or to inform final policy.”</i></p> <p>Source: MLAA Schedule 3 Section 11, 12, 13</p>	<p>PROVINCIAL STRATEGY PROGRAMS</p> <ul style="list-style-type: none"> - 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. <p>The Ministry has indicated that:</p> <ul style="list-style-type: none"> - Provincial Strategy services are planned, managed, funded and reconciled by the LHIN in consultation with the MOHLTC. - The designation period for Provincial Strategies is time limited. At end of designation period, if decision is made to continue, the service (and funding for) Provincial Strategies would be rolled into base budget as an ongoing service. - Conditions of funding such as volumes or other standards may also be confirmed. 	<p>The MOHLTC will:</p> <ul style="list-style-type: none"> (a) Determine the strategic and operational program policy including funding methodologies, accountability frameworks, performance indicators, volumes and service delivery models for Provincial Strategies; and (b) Work with one or more of the LHINs to identify hospitals to deliver the Provincial Strategies. <p>The LHIN will:</p> <ul style="list-style-type: none"> (a) Incorporate the applicable funding methodologies, accountability frameworks, performance indicators, volumes and service delivery models in service accountability agreements with hospitals funded to deliver Provincial Strategies; and (b) Provide advice to the MOHLTC about Provincial Strategies.
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NON-ASSIGNED PROGRAMS

TERMS	DEFINITION/DESCRIPTION	MOHLTC / LHIN RESPONSIBILITIES
<p>NON ASSIGNED PROGRAMS</p> <p><i>Programs that are not identified in the MLAA or H-SAA schedules that fit the definition of Provincial Programs as set out by the Task Group.</i></p>	<p>NON-ASSIGNED PROGRAMS</p> <ul style="list-style-type: none"> - Bariatric surgery - Burns – severe - Cancer – not funded by CCO - EVAR with fenestrated grafts - External ventricular devices (Berlin Heart) - Forensic mental health - Hand and foot reattachment - Hand transplant - Interventional radiology - In Vitro Fertilization - Lithotripsy - Neurological Coils – use of coils for treating inter-cranial aneurysms - Neurological modulation - Organ transplant bridge services - Paediatric oncology - Paediatric surgery - Small bowel transplant - TB Inpatient Units & Clinics 	

DRAFT RECOMMENDATIONS

GOVERNANCE & MANAGEMENT RECOMMENDATIONS

The Provincial Program Review Task Group recommends that:

R-1: The MOHLTC establish a permanent group known as the *Provincial Program Planning Council* with representation from hospitals, LHINs and the MOHLTC. The role of the Council would be to provide oversight with respect to planning, coordination, organization, and monitoring/evaluation of Provincial Programs. (Draft terms of reference are outlined below.)

Terms of Reference

1. To undertake a review of current definitions outlined in Schedule 3 of the H-SAA with respect to Provincial Programs and provide advice to the MOHLTC on:

- Revisions required to the definitions and MOH/LHIN responsibilities for hospital programs, provincial resources, and provincial strategies.
- Recommendations concerning which of the current 'non-assigned programs' should be included in the list of hospital programs, provincial resources, and provincial strategies outlined in Scheduled 3 of the H-SAA.
- Clarification concerning a process for determining which Provincial Programs should be 'managed' at the province-wide level (i.e., by the MOHLTC or another provincial group).

2. To advise on the relationship [including reporting structure] of existing provincial planning and advisory bodies (e.g., Provincial Council for Children's Health, Cardiac Care Network, etc.) to the provincial/LHIN structure.

3. To determine which of the Provincial Programs would benefit from a provincial coordinating body (i.e., a renal coordinating committee, trauma coordinating committee).¹⁰

4. To develop improved processes/mechanisms to support the management (i.e., planning, coordination, organization), funding and evaluation of these Programs,

5. To advise on changes required to further streamline the process for management of provincial programs [vs. the current three streams of provincial programs (hospitals, LHINs, MOHLTC funded)].

6. To develop an *Evaluation Framework* to ensure that programs/ services classified as Provincial Programs (either currently existing or in the future) are fairly and

¹⁰ Key questions to be addressed: What programs are currently in the global budget that should be removed? What programs need to be managed at a provincial level? What programs can be managed at a hospital/ LHIN level?

equitably assessed.¹¹ As a starting point, the Council should use the principles outlined below to inform development of the framework.

6. To use the Evaluation Framework as the basis for undertaking an annual review to ensure the list of Provincial Programs continues to remain relevant. The review should include:

- A review of the current Provincial Programs that are part of the LHIN-MOHLTC Accountability Agreement to determine if they 'fit' criteria for classification as a Provincial Strategy program
- Assessment of new programs to be added and/or deleted from the list of Provincial Programs.

R-2: The Provincial Program Planning Council immediately recognize and designate the following services currently funded out of hospital-based budgets as Provincial Programs to be funded at a provincial level beginning with the following:

- Bone Marrow Transplant
- Interventional radiology (e.g., EVAR and coiling)
- Provincial Regional Genetic Services (specialized hospital services)
- Trauma

R-3: The Provincial Program Planning Council immediately initiate a review of non-assigned programs that may warrant consideration as Provincial Programs beginning with the following:

- Bariatric surgery
- Burns
- External ventricular devices (Berlin Heart)
- Hip and knee replacement
- Small bowel transplant
- Tuberculosis

¹¹ The purpose of the evaluation framework will be: (i) To confirm the identification, selection, and evaluation of Provincial Programs, and (ii) To inform development of policies with respect to the governance, management (planning, coordination, organization), funding and evaluation of Provincial Programs.

Principles to Guide Establishment of an Evaluation Framework for Provincial Programs and Future Designation of These Programs

1. Evaluations of potential providers of Provincial Programs should be conducted by a body or group comprised of major stakeholders that are not biased to a particular provider.
2. Evidence must be used to support the assessment of potential providers of Provincial Programs.
3. Providers of Provincial Programs must meet performance targets.
4. Provincial Programs require a provincial planning perspective that ensures they are provided in a limited number of locations due to factors related to critical mass/quality/safety issues, high costs, low volumes, and/or reliance on specialized technology and expertise including availability of appropriate manpower and health human resources.
5. Provincial Programs should be distributed [i.e., planned, coordinated, organized and funded] in a manner that ensures reasonable access across the province.
6. Given the rapid introduction and changes related to new health care technologies the Provincial Program basket of services and evaluation criterion should be reviewed on an annual basis to determine:
 - When Provincial Programs should be moved from provincial to LHIN based / hospital based global budgets.
 - When new Provincial Programs should be included in the provincial 'basket' of services
7. Solutions to the issues related to Provincial Programs should not disadvantage residents of the LHIN where the program is located.
8. Once a service is designated as a Provincial Program:
 - The Program will be funded at a sustainable level.
 - Service accountability agreements between the funding body and the providers will become a mandatory component of Provincial Program designation. .
 - Periodic assessment of the designated Provincial Program will be required to ensure it still qualifies.

FUNDING RECOMMENDATIONS

The Provincial Program Review Task Group recommends that:

R-4: The MOHLTC ensure that LHIN budgets reflect the cost of the types of services that are most appropriately provided within each LHIN. Planning and funding should involve consideration of parameters such as:

- **Critical mass of services needed to ensure safety, quality, access and efficiency**
- **Appropriate location of specialized or provincial-level services**
- **Existing and projected “market share” of providers within LHINs**
- **Coordination of planning for capital, operating expense and health human resource supply (Source: OHA, Shaping the Future Through Funding Strategies, January 2007)**

R-5: The JPPC undertake an annual review of funding rates with respect to Provincial Programs with a view to achieving the following:

- **Ensuring that they are appropriate (i.e., adjusted for inflation, changing practices, etc.)**
- **Ensuring that funding rates recognize and incorporate costs associated with setting up a program (e.g., staff recruitment and training, initial inventory of materials, supplies and drugs, renovations equipment acquisition, etc.) and the costs of maintaining capacity to deliver service when volumes are not sufficient to allow for workload-workforce balancing.**
- **Identifying opportunities for program alignment/consolidation of Provincial Programs including pooling of funds and the allocation of funding to hospitals based on volumes. This would allow for flexibility in the movement of resources among programs/ hospitals in relation to relative need.**

CONCLUSION

We hope that the Ministry of Health and Long-Term Care, the LHINs and other partners will act on the recommendations in this report. We are persuaded that implementation of our recommendations will help to stabilize Provincial Programs and ensure that Ontarians are provided with equitable access to these services when needed.

APPENDIX 1 - PROVINCIAL PROGRAM REVIEW TASK GROUP: MEMBERSHIP

NAME	ORGANIZATION
John King (Co-Chair)	St. Michael's Hospital
Bill Manson (Co-Chair)	Toronto Central LHIN
Michael Young	Sunnybrook Health Sciences Centre
Gino Picciano	The Ottawa Hospital
Murray Glendining	Hamilton Health Sciences
Seonag Macrae	Hospital for Sick Children
Theresa Nowak	Ministry of Health & Long-Term Care
Patricia Knapp	Ministry of Health & Long-Term Care
Mary Catherine Lindberg	Council of Academic Hospitals for Ontario
Lou Reidel	Ontario Hospital Association
Steve Issak	Joint Policy and Planning Committee
Shaukat Moloo	Central LHIN
Gwen Dubois-Wing	Central LHIN
Nan Brooks	University Health Network
Beverley J. Nickoloff, Consultant/ Writer	BJN Consulting & Communications

APPENDIX 2 – LIST OF PROGRAMS

HOSPITAL BASED PROGRAMS	PROVINCIAL RESOURCE PROGRAMS	PROVINCIAL STRATEGY PROGRAMS
<p>Hospital based programs funded through base budgets in addition to core inpatient, outpatient, and surgery programs</p> <ul style="list-style-type: none"> - Hospital-based ABI - Cardiac Catheterization - Cardiac Rehab Services - Cardiac Surgery - Chronic Kidney Disease (CKD) - Cleft Lip and Palate/Craniofacial Dental Services - Cochlear Implants - Hemophiliac Ambulatory Clinics - Hemophiliac Ambulatory Clinics - HIV Outpatient Clinics - Permanent Cardiac Pacemaker Services (PPM) - Provincial Regional Genetics - Regional and District Stroke Centres - Regional Geriatric Program - Sexual Assault and Domestic Violence Treatment Centres - Trauma 	<ul style="list-style-type: none"> - Bone Marrow Transplants, - Cardiac Laser Lead Removals - Cardiology - Adult Interventional for Congenital Heart Defects - Pulmonary Thromboendarterectomy Services, and - Thoracoabdominal Aortic Aneurysm Repair. 	<ul style="list-style-type: none"> - Ablation Therapy - Dialysis – Daily Nocturnal Home Haemodialysis - Electrophysiology Studies (EPS) - Endovascular Aortic Aneurysm Repair (EVAR) - Implantable Cardiac Defibrillator (ICD) - Living Organ Donation and Transplantation Services - Newborn Screening Program - Percutaneous Coronary Intervention (PCI) (Angioplasty) - Provincial Peritoneal Dialysis Initiative

MINISTRY MANAGED PROGRAMS RELATED TO HOSPITAL PROGRAMS	UNASSIGNED (non-assigned) PROGRAMS
<ul style="list-style-type: none"> - Cardiac Care Network (CCN) - Cancer Care Ontario (CCO) - Child Health Network (CHN) - Chronic Disease Programs - Eye Bank - Eating Disorders Network - Trillium Gift of Life - Pediatric Oncology Group of Ontario (POGO) - Provincial Council for Children’s Health (PCCH) - Visudyne Therapy (Note: recently transferred back to Ministry) 	<ul style="list-style-type: none"> - Bariatric Surgery - Burns – severe - Cancer – not funded by CCO - Cataracts - End stage renal - EVAR with fenestrated grafts - External Ventricular Devices (Berlin Heart) - Forensic mental health - Hand and foot reattachment - Hand transplant - Hip and knee replacement - Interventional radiology - IVF – In Vitro Fertilization - Lithotripsy - MRI/CT - Neurological Coils – use of coils for treating inter-cranial aneurysms - Neurological modulation - Organ transplant bridge services - Paediatric oncology - Paediatric surgery - Small bowel transplant - TB Inpatient Units and Clinics