Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

Annual Business Plan 2010-2011

June 2010

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

Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

264 Main Street East
Grimsby, ON L3M 1P8
Tel: 905 945-4930
Toll Free: 1 866 363-5446
Fax: 905 945-1992
www.hnhblhin.on.ca

264, rue Main Est
Grimsby ON L3M 1P8
Tél : 905-945-4930
866-363-5446
Téléc : 905-945-1992
www.hnhblhin.on.ca

June 30, 2010

Hon. Deb Matthews
Minister of Health and Long-Term Care
Minister's Office
80 Grosvenor Street, 10th Floor Hepburn Block
Toronto ON M7A 1R3

Dear Minister Matthews:

Re: Hamilton Niagara Haldimand Brant Local Health Integration Network – Annual Business Plan, 2010-11

On behalf of the Board of Directors (Board) of the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN), I am pleased to provide a copy of the final 2010-11 Annual Business Plan (ABP).

As per the guidelines provided by the Ministry of Health and Long-Term Care (ministry), the 2010-11 ABP content requirements have been revised to reduce redundancy with other LHIN reporting requirements, concentrating on goals and action plans relating to system change and outcomes.

Our 2010-11 ABP operationalizes the new three-year Integrated Health Service Plan (IHSP), recently approved by the Board, with a focus on the upcoming fiscal year.

Action plans for each of the priorities identified in the IHSP are presented, following the template provided by the ministry.

This ABP was reviewed and approved by the HNHB LHIN Board of Directors on June 29, 2010.

Sincerely,

Juanita G. Gledhill
Board Chair

Encl.

Hamilton Niagara Haldimand Brant Local Health Integration Network

Annual Business Plan 2010-11

TABLE OF CONTENTS

2. Narrative Context:

The Annual Business Plan (ABP) is a key component of the Ministry of Health and Long-Term Care (ministry) and Local Health Integration Network (LHIN) accountability framework. It operationalizes the Integrated Health Service Plan (IHSP) by providing annual goals and action plans for each IHSP priority. The ABP is not intended to repeat detailed information provided in other LHIN planning/reporting documents. It identifies actions and intended changes planned for the upcoming fiscal year.

The information below summarizes the LHIN mandate and the local health system in which the LHIN operates. A more complete discussion can be found in the IHSP and its supporting documents, such as the Clinical Services Plan (CSP).

2a. Mandate and Strategic Directions

The Hamilton Niagara Haldimand Brant (HNHB) LHIN works to ensure the availability of, and access to, linked services to improve the health of the population and the continuity of health care. This is consistent with the HNHB LHIN vision of a health care system that keeps people healthy, gets them good care when they are sick, and will be there for our children and grandchildren. The IHSP is a three year directional report that outlines health improvement goals to achieve the vision. It is developed with input from residents, stakeholders and health services providers (HSPs) and is guided by an understanding of the values and preferences of communities, the issues and solutions, and feasibility.

2b. Overview of Agencies Current and Forthcoming Programs/Activities

The HNHB LHIN funds 88 community support services, 50 community mental health and addictions (MH&A) programs, seven Community Health Centres (CHCs) (including 10 sites), one Community Care Access Centre (CCAC), 86 Long-Term Care Homes (LTCH) and 10 Hospitals (including 23 hospital sites). The LHIN holds accountability agreements with each of these agencies; these agreements describe the range and scope of services provided, LHIN fiscal resources required to sustain services, and expected outcomes.

All organizations are guided by the IHSP priorities for health system improvement. The HNHB LHIN priorities for 2010-11 to 2012-13 are to:

- improve patient flow and ensure people get the right care, in the right place, at the right time
- reduce the prevalence of chronic disease and improve care delivery
- link services for prevention, management and recovery in the area of mental health and addictions
- implement enablers for health system transformation: eHealth, interprofessional care, transportation and continue to engage partners for change.

2c. Environmental Scan *

The HNHB LHIN encompasses Brant, Burlington, Haldimand, Hamilton, Niagara and most of Norfolk County covering approximately 7,000 square kilometres. The HNHB LHIN is home to more

** taken from the HNHB LHIN's Integrated Health Service Plan, December 2009 – available at www.hnhblhin.on.ca*

than 1.4 million people with more than 70% of the population residing in the City of Hamilton and the Regional Municipality of Niagara. The following summarizes some of the key characteristics of the local health system.

Our Population

- More than 220,000 people 65+ years live in the HNHB LHIN, the largest population of seniors of all LHINs in the province. This age group, which accounts for a significant proportion of health care service users, will grow by 30% over the next 10 years.

- The Aboriginal population has lower incomes, lower life expectancy, and higher rates of illness, compared to the average Canadian. Six Nations of the Grand River Territory and Mississaugas of the New Credit are two First Nations in the HNHB LHIN. The total registered Aboriginal population in the LHIN is approximately 24,263 persons (1.7% of the total LHIN population) with about half the population living on Reserve. Non-Status, Métis, and Inuit populations are not included in these population estimates.

- The *Local Health System Integration Act, 2006 (LHSIA)*, entitles people whose first language learned at home is French and who still understood French at the time of the 2006 Census to services in French. Almost 2.5% of the population in the HNHB LHIN is Francophone. Both Hamilton and Niagara are designated communities for French language services, as more than 5,000 people in each area identify French as their mother tongue.

Our Lifestyle and Health

- Obesity, physical inactivity, and smoking are the leading lifestyle factors related to premature death. Relative to the province, there are significantly higher rates of smoking, heavy drinking and obesity in the HNHB LHIN.

- Chronic conditions, such as asthma and heart disease, are often related to lifestyle behaviours such as smoking and physical inactivity. HNHB LHIN residents have higher rates of chronic conditions including arthritis, high blood pressure, and asthma compared to the province as a whole.

Our Health System

- Access to a family physician is variable across the LHIN. It is estimated that approximately 160,000 people (12% of HNHB LHIN residents) do not have a family physician.

- Treatment gaps for children and youth include eating disorders, paediatric rehabilitation, inpatient and ambulatory mental health services, and oncology.

- There are populations with low prevalence conditions that require high-intensity services and whose needs are not adequately met as they age: persons with acquired brain injury (ABI), developmental disabilities, amyotrophic lateral sclerosis (ALS), spina bifida and minor head injuries.

- About half of all visits to the Emergency Department (ED) are for non-urgent and less urgent care.

- There is increased demand for CCAC services, with the number of individuals served anticipated to grow by five percent in 2010.

- A significant number of patients in complex continuing care (CCC) are waiting for alternative care in another setting.

- Transportation to get to medical care is not equitably available to LHIN residents who need it. There is considerable variability in available public transportation and variability among private and non-profit alternatives by geography, hours, eligibility, user fees, and accessibility.

Education, Training and Research

- The Faculty of Health Sciences, McMaster University, makes a significant contribution to safe, effective and sustainable health services.

- The Faculty provides active leadership for advancing the education and training of future health care professionals in diverse health settings in communities across the LHIN, alongside Mohawk College and Brock University. In this leadership role, the Faculty is advancing interprofessional care, optimal practice scope and best practices. Other hospitals, community agencies, physicians' offices and clinics are official teaching sites for Health Science students, with a Niagara Regional Campus of the Medical School established in 2009.

3. IHSP 2010-13 Priorities:

a. Alternate Care Settings
b. Emergency Department Capacity
c. Clinical Program Integration
d. Community-Based Health Service Capacity
e. Aboriginal Health
f. Francophone Health
g. Chronic Disease Prevention and Management
h. Mental Health and Addictions
i. eHealth
j. Interprofessional Care
k. Transportation

3a. Alternate Care Settings

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Improve Patient Flow – Alternate Level of Care (ALC)
IHSP Priority Description:
Improve access to hospital care by reducing the amount of time (the ALC rate) that patients wait in hospital for an alternate level of care once their hospital care is complete.
Current Status:
The HNHB LHIN has 88 LTCHs, with over 10,000 beds. The LHIN's LTCH occupancy rate for January 2010 was 98.6%. In April 2010, the ministry reported ALC rate for the HNHB LHIN was 18.07% for the period October to December 2009, representing a decline from the two previous quarters. The LHIN's internal monitoring of the ALC rate indicates that the ALC rate for acute care beds continues to decline, and as of March 31, 2010 was 14.3%. As of March 28, 2010, LHIN hospitals reported a total of 602 patients waiting for care in an alternate setting; 55% of these patients were waiting for placement in a LTCH. Key issues for getting people to the right care in the right place: • limited access to supportive housing alternatives across the HNHB LHIN • limited access to community supports in rural areas (i.e. Haldimand/Norfolk) • an equally high number of patients designated ALC are waiting in non-acute hospital beds (i.e. complex continuing care, rehab as in acute care beds for alternate settings). Successes of the past year: • commitment of HNHB CCAC to the LHIN's Ministry-LHIN Accountability Agreement (M-LAA) ALC rate through their multi-service accountability agreement

- shared commitment among HNHB CCAC and hospitals to reduce the ALC rate, and adopt the Home First philosophy
- adoption of Home First philosophy by all LHIN hospitals which resulted in a reduction of patients newly designated ALC–LTC
- establishment of four Assess Restore units across the LHIN
- reduction of the LHIN's ALC rate towards the M-LAA target.

PART 2: GOALS and ACTION PLANS

Goal(s):

Improve patient flow across the continuum so that residents receive quality health services in a timely manner, in the most appropriate place. The LHIN's actions will focus on three main areas:

- reduce the ALC rate in all hospitals by increasing capacity in alternate care settings
- improve access to inpatient hospital services by improving patient flow from hospital to the community
- strengthen capacity of community services to support residents living at home.

Consistency with Government Priorities:

The HNHB LHINs ABP aligns with the Ontario Government's following priorities:

- reduce ED wait times for admitted patients
- reduce ALC rate
- reduce wait times for surgical services
- increase health system sustainability through the appropriate use of current resources.

Action Plans/Interventions:

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next 3 years with concentration on those actions that will be largely implemented within the upcoming year.

Action Plans/ Interventions:	*Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.*		
	2010-11	2011-12	2012-13
Expand Assess Restore model to all areas of the LHIN	100%		
Identify the appropriate model and distribution of CCC beds	50%	50%	
Increase access to rehabilitation services in Hamilton, Niagara and Norfolk	75%	25%	
Realign community-based health service capacity to address service gaps, and improve care across the continuum of care from acute to the community Implement peritoneal dialysis (PD) programs in three LTCHs Identify service models for residents with specialized long-term care needs	25%	50%	25%
Incorporate the LHIN's ALC performance target into hospital accountability agreements	100%		
Implement the LHIN's ALC information system across all LHIN hospitals	100%		
Support increased capacity in LTCHs (over beds) as a short-term strategy	100%		
Facilitate early discharge of seniors back to LTCH through Nurse Practitioner (NP) in LTCH program	25%	25%	25%
Expand the teachings of LEAN methodologies implemented through the FLO collaborative	50%	50%	
Explore opportunities to transition support from an Assess Restore to supportive housing model		25%	25%
Home will be the first place considered for discharge post-acute hospital event	100%	0%	0%

Expected Impacts of Key Action Items:

- Assess Restore units will serve 800 clients annually, based on a median length of stay of 30 days
- 180 clients will have access to rehabilitation services annually, based on a median length of stay of 50 days
- three LTCHs within the LHIN will be designated and accept clients requiring PD (initially the goal for 2010-11 is to have one client on PD in each home)
- hospital and CCAC agreement on the implementation of common admission and discharge criteria for CCC and rehabilitation beds
- service model will be identified for individuals requiring long-term ventilation by 2011-12
- number of patients newly designated ALC to LTC across all hospitals will decrease
- median age of clients entering LTC will increase over three years (base year 2009-10)
- care needs of residents entering LTCH measured by method for assigning priority levels (MAPle) scores will increase over three years (base year 2008).

What are the Risks/Barriers to Successful Implementation?

- reduced acute care bed capacity as LHIN hospitals close beds to achieve a balanced budget
- loss of LTCH beds within the LHIN as a result of LTCH renewal strategy in 2012
- limited access to establish alternate care settings as a result of funding or legislative barriers
- availability of health human resources (HHR) in acute and community settings.

Mitigating Strategies:

- LHIN providers ongoing commitment to early discharge and Home First approach, reducing the number of newly designated ALC
- hospitals that close beds, will where appropriate, reduce length of stay to optimize patient flow
- LHIN is completing an analysis of community-based capacity to identify opportunities offered by the ministry's pending Assisted Living Policy
- LHIN will review opportunities offered by the new *Long-Term Care Act* to ensure individuals entering LTCH have high care needs
- with respect to availability of HHR:
    - the LHIN will encourage service providers to work with Health Force Ontario
- through its CSP, the LHIN will optimize available HHR resources through clinical program integration.

3b. Emergency Department Capacity

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Improve Patient Flow – Reduce ED wait times
IHSP Priority Description:
Improve access to the ED by reducing the number of non-urgent presentations to the ED, and reducing the amount of time that people spend waiting in the ED.
Current Status:

The HNHB LHIN has 13 EDs across 10 hospital corporations. In 2008-09, these EDs handled over 440,000 ED visits. The majority of ED visits (60%) are seen in seven EDs, all of which are participating in the Provincial Pay for Results (P4R) strategy. HNHB LHIN ED visits are 93 per 1,000 people - slightly lower than the provincial average (96). In 2008-09, 39% of all ED visits were classified as Canadian Emergency Department Triage and Acuity Scale (CTAS) 4 & 5 (low acuity).

In October 2009, the ministry reported to the HNHB LHIN that the percent of clients seen with ED wait time targets for the period from April to June 2009, as:

- admitted - 34%
- non-admitted high acuity - 81%
- non-admitted low acuity - 80%.

Key issues for improved ED capacity:

- poor access to alternate primary care services (i.e. no primary care provider, primary care provider not available, limited access to urgent care/walk-in clinics)
- lack of knowledge of alternate care settings other than EDs
- lack of support for self-managed care.

Successes of the past year:

- seven LHIN hospital sites identified to participate in Provincial P4R and Provincial Process Improvement Program (PIP)
- two EDs converted to Urgent Care Centres (UCC)
- 489 residents attached to primary care through Healthcare Connect.

PART 2: GOALS and ACTION PLANS

Goal(s):

Improve patient flow across the continuum so that residents receive quality health services in a timely manner, and in the most appropriate setting. The LHIN's actions will focus on five main areas:

- increase emergency room (ER) capacity by streamlining internal flow processes
- reduce ED wait time for admitted patients by reducing the ALC rate in all hospital beds
- reduce the number of avoidable ER visits by increasing access to other appropriate settings (i.e. urgent care settings, primary care)
- reduce wait times for non-admitted, high and low acuity ED visits
- identify population groups that most frequent the ED and who could be managed better elsewhere.

Consistency with Government Priorities:

The HNHB LHIN's ABP aligns with the Ontario Government following priorities:

- reduce ED wait times
- reduce ALC
- decrease ED visits for non-urgent conditions
- increase health system sustainability through appropriate use of current resources.

Action Plans/Interventions:

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next 3 years with concentration on those actions that will be largely implemented within the upcoming year.

Action Plans/ Interventions:	*Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.*		
	2010-11	2011-12	2012-13
Implement internal ED process improvements identified through LHIN PIP initiative	50%	25%	25%
Implement P4R strategies	100%		
Pilot ambulance transfer to UCCs for low acuity clients	50%	50%	
Target initiatives for ED avoidance: • expand primary care through mobile team for Francophone seniors • expand diabetic foot care for individuals with diabetes at high-risk • implement Community Incontinence Self-Management Program • implement Falls Prevention Strategy • sustain NP in LTCH program to prevent and reduce ED visits and hospitalization • expand palliative outreach services	75%	25%	

Sustain CCAC case managers in LHIN EDs with volumes at or exceeding 30,000 annually	100%		
Establish eight community-based specialized geriatric assessment clinics	25%	50%	25%
Hamilton Health Sciences (HHS) – Access to Best Care (ABC) Plan will open a new UCC in Hamilton		25%	75%
Expand provider access to LHIN Integrated Decision Support (IDS) tool	25%	25%	25%
Identify population groups at risk for high ED/hospital utilization for targeted interventions – focus on individuals with diabetes and chronic obstructive pulmonary disease (COPD)	25%	50%	25%
Sustain NP outreach program in LTCHs with high ED transfer volumes	75%	25%	

Expected Impacts of Key Action Items:

- achieve M-LAA ED wait time targets
- reduce the time admitted patients wait in ED for a hospital bed
- reduce the number of ED visits to 90 per 1,000 people from current level 93
- 50 LTCHs served by NP.

What are the Risks/Barriers to Successful Implementation?

- uncertainty of hospital funding that may result in hospitals reducing their bed complement impacting ED wait times for admitted patients
- impact of sudden pandemic-type illness that results in higher ED utilization
- availability of HHR, especially physician coverage of ED.

Mitigating Strategies:

- LHIN provides ongoing commitment to early discharge and Home First approach, reducing the number of newly designated ALC
- hospitals that close beds will, where appropriate, reduce length of stay to optimize patient flow
- in the event of pandemic-type illness, the LHIN will encourage providers to maximize use of UCCs
- LHIN will ensure its moderate surge plan for critical care services is updated and reviewed regularly.
    - The LHIN's moderate surge plan is a standing item at the LHINs quarterly critical care meetings.
- In respect to availability of HHR, the LHIN will encourage service providers to work with Health Force Ontario.

3c. Clinical Program Integration

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Clinical Program Integration (CPI)
IHSP Priority Description:
Clinical programs will be reorganized and distributed to improve access, quality, and efficiency. Integrated programs will be led by one or more organizations, and guided by clear roles and shared accountabilities, best practice standards and guidelines, and common protocols for client transitions along the care path.
Current Status:
The HNHB CSP (2009) is an action call for a healthier population, improved ways of working together for better health outcomes and integration for sustainability. One of three strategies to achieve these goals is CPI. Currently, clinical programs are delivered on an organization basis, with varying degrees of linkage between hospitals and across the continuum. There is variation in health outcomes across our LHIN. Inequitable access to health services and variation in the application of best practice guidelines contribute to these outcomes. Hospitals have, in many cases, become the default health system treating people with preventable health conditions, and for whom other supports and self-care could have prevented serious illness. A more coordinated and standardized approach to care is needed, with all providers accountable for outcomes. A uniform mechanism for clarifying roles, responsibilities and accountabilities, such as a memorandum of understanding (MOU), is needed. It is critical that an electronic connectivity (e-connectivity) system be implemented as soon as possible. Key issues for clinical program integration: • high rates of ED visits for conditions that could be managed elsewhere, and high rates of hospitalization for ambulatory care-sensitive conditions • variation in access to the full continuum of care, including specialized health services • the current hospital utilization rate in our LHIN is high compared to the province, and projected utilization is not sustainable. Successes in the past year: • MOUs are formalizing roles, responsibilities and accountabilities among organizations (i.e. HHS, Niagara Health System (NHS), and Cancer Care Ontario (CCO) have signed a MOU to create an integrated cancer program between the Juravinski Cancer Centre (Hamilton) and the Walker Family Cancer Centre (St. Catharines). In addition, HHS, St. Joseph's Healthcare Hamilton (SJHH), and the NHS are developing a template MOU for integrated programs). • significant ground work has already been laid (i.e. HHS's ABC plan, NHS Hospital Improvement Plan (HIP), and ministry frameworks for regional programs in Diabetes and Chronic Kidney Disease (CKD)) • through the CSP Planning Advisory Group (PAG) process, a number of clinical groups have begun to reach consensus on models for LHIN-wide program coordination.

PART 2: GOALS and ACTION PLANS

Goal(s):

To integrate clinical program service delivery across organizations in order to ensure equitable access to safe, accessible and sustainable services.

Consistency with Government Priorities:

Clinical program integration supports the ministry's priorities to:

- promote equitable access to health and health care for all Ontarians
- reduce wait time in EDs
- reduce hospital stays for people requiring alternate care.

Action Plans/Interventions

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next 3 years with concentration on those actions that will be largely implemented within the upcoming year.

Action Plans/ Interventions:	*Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.*		
	2010-11	2011-12	2012-13
Adopt a LHIN-wide charter for CPI endorsed by stakeholder leadership	100%		
Establish LHIN-wide hospital credentialing for physicians, dentists, midwives and nurses	50%	50%	
Develop a functional program for LHIN-wide integrated laboratory medicine	50%	50%	
Develop LHIN-wide integrated program plans for selected clinical programs, such as Complex Care, Cancer Care, Rehabilitation, Vascular, Laboratory Medicine, Thoracic, and Maternal/Newborn	75%	25%	
Continue on a phased-in basis the development of other LHIN-wide integrated program plans		25%	50%

Expected Impacts of Key Action Items:

- adoption of common assessment, referral, placement/admission and discharge criteria for LHIN-wide integrated programs, starting with those identified above
- implementation of best practice clinical standards and guidelines across the LHIN
- establishment of clear roles, responsibilities and accountabilities

- implementation and ongoing monitoring of evaluation and performance monitoring metrics
- identification of program size, scope, and distribution for clinical services with defined implementation plan
- elimination of duplicated low volume, high complexity services
- improved client/patient experience
- reduced wait times for health care services (i.e. reduction in ED wait times to meet LHIN performance targets)
- ongoing monitoring of LHIN-wide performance indicators for clinical program integration.

What are the Risks/Barriers to Successful Implementation?

- cost of restructuring – lack of availability of one-time funding for restructuring may impede ability to participate
- information technology (IT) – success depends upon the availability of shared patient information; significant investment in eHealth is required to facilitate integration
- practice and cultural barriers – different styles of practice, culture, and administration may lead to conflict.

Mitigating Strategies:

- ensure integrated plans are cost neutral
- follow eHealth plan
- build principles and processes into transition plans.

3d. Community-Based Health Service Capacity

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Community-Based Health Service Capacity (CBHSC)
IHSP Priority Description:
Align community services for health, wellness and recovery with population health improvement goals.
Current Status:
There are 64 community support services programs, three ABI programs and 21 assisted living supportive housing programs in the HNHB LHIN. The CSP identified challenges in terms of: • navigation • transportation • variation in availability and access • variation in assessment, care planning, and outcomes • The CBHSC project will be designed to address these challenges. Key issues for clients of community services: • no equitable distribution of services across the LHIN • little support for self-managed care. Successes in the past year: • identified readiness for standardized assessment, referral, and placement tools • introduction of nutritional risk assessment screening tool in all LHIN-funded food programs • identified action plan to improve access to LHIN-funded transportation programs.

PART 2: GOALS and ACTION PLANS
Goal(s):
• strengthen linkages among service providers to improve continuity of care • optimize community-based health resources • improve access to community-based care and supports.

Consistency with Government Priorities:

CBHSC supports the government's priorities:

- enhanced ED capacity
- improved patient flow
- equitable access to services and supports
- healthy Ontarians
- independent living.

Action Plans/Interventions:

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next 3 years with concentration on those actions that will be largely implemented within the upcoming year.

Action Plans/ Interventions:	*Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.*		
	2010-11	2011-12	2012-13
Implement community service access points	10%	20%	70%
A business plan for range, scope and distribution of assisted living services in the LHIN	50%	50%	
Evaluate the Aging at Home strategy and specific programs	30%	30%	50%
Implement *Residents First: Advancing Quality in Long-Term Care Homes*, a quality improvement initiative in partnership with the Ontario Health Quality Council (OHQC)	30%	30%	40%
Use results of LHIN-wide demand modeling tools to enable proactive planning (e.g. performance-based assessment model (PBAM), resource matching and referral (RMR)	50%	50%	
Implement process improvements across programs and services for assessment, care planning, referral, and outcomes evaluation	30%	30%	40%

Expected Impacts of Key Action Items

- people will tell their health story once
- reduced wait times for access to community services
- improved residents' care experience
- reduced ED presentations and hospitalizations due to falls
- community services' adoption of evidence-based, best practices in service delivery.

What are the Risks/Barriers to Successful Implementation?
• implementation rate of e-connectivity in the community services sector. Mitigating Strategies: • follow eHealth plan and identify opportunities for early implementation.

3e. Aboriginal Health

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Aboriginal Health
IHSP Priority Description:
Healthy Families, Healthy Children, Healthy Communities
Current Status:
There are two reserves in the HNHB LHIN: Six Nations of the Grand River Territory, and Mississaugas of the New Credit First Nation. Approximately half of the Aboriginal population residing in the LHIN lives on-reserve. As of August 2006, the total registered Aboriginal population living on or off-reserve in the HNHB LHIN was 24,263, or 1.7% of the total LHIN population. Population data for non-status, Métis, and Inuit Aboriginal peoples are not precise; people are mobile, homelessness is high, and some Aboriginal persons choose not to self-identify. Key issues for Aboriginal health: • the Aboriginal population has lower incomes, lower life expectancy and higher rates of illness, compared to the average Canadian. Successes in the past year: • fostered working relationship with local Aboriginal Health Network (AHN) • participated in collaborative planning towards expansion of dialysis, diabetes, and supportive housing services.
PART 2: GOALS and ACTION PLANS
Goal(s):
• reduce health disparities • improve family and child health • reduce chronic disease.
Consistency with Government Priorities:
Aboriginal Health is consistent with the government's priorities: • Aboriginal population is a priority population.

Action Plans/Interventions:

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next 3 years with concentration on those actions that will be largely implemented within the upcoming year.

Action Plans/ Interventions:	*Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.*		
	2010-11	2011-12	2012-13
Implement welcoming environments for Aboriginal persons among HSPs	25%	25%	50%
Implement supportive housing for persons with addictions	75%	25%	
Implement six dialysis stations at White Pines Wellness Centre (Six Nations)	75%	25%	
Implement diabetes education program at White Pines Wellness Centre (Six Nations)	75%	25%	
Collaborate with the AHN to implement the recommendations of the 2008 Search Conference	25%	25%	50%
Connect more aboriginal people without access to primary care to culturally responsive primary care	25%	25%	50%

Expected Impacts of Key Action Items:

- increased access to prevention and management of diabetes and chronic renal disease
- reduced avoidable ED visits and hospitalizations
- programs and services deemed priorities by Aboriginal communities are available
- improved client/patient satisfaction
- Aboriginal communities, stakeholders and networks are included in planning and decision-making.

What are the Risks/Barriers to Successful Implementation?

- implementation rate of e-connectivity
- ensure Six Nations included in CHC ClinicalConnect phase
- readiness among HSPs to provide culturally responsive services.

Mitigating Strategies:

- continue to work with AHN to increase sensitivity.

3f. Francophone Health

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Francophone Health
IHSP Priority Description:
Healthy Families, Healthy Children, Healthy Communities.
Current Status:
The *French Language Services Act, Ontario, 1986,* guarantees the right of French-speaking Ontarians to communicate with the government and receive services in French. There are over 28,000 Francophone people in the HNHB LHIN (i.e. the LHIN has 38 identified organizations and two designated organizations for French Language Services (FLS)). Access to services is challenged in the following ways: people are not comfortable asking for services in French; people do not know what services are available in French and where; French-speaking health professionals are in short supply; programs and services are not tailored to the needs of Francophone communities; there is variable commitment among stakeholders to meeting the needs of French speaking people. Key challenges facing this population: • the Francophone population is dispersed across the LHIN • the population is not homogenous (i.e. new Canadians, Canadian Francophones) and health-seeking behaviours and needs are variable. Successes this past year: • a LHIN-wide French Language Forum (June 2009), with participation from FLS HSPs and other stakeholders • a comprehensive Mobile Team Program for Francophone seniors, which focuses on primary care and health and wellness for Francophone residents in Hamilton, Welland, Port Colborne, Niagara Falls and St. Catharines.

PART 2: GOALS and ACTION PLANS
Goal(s):
Every door leads to services in French
Consistency with Government Priorities:
Francophone Health is consistent with the government's priorities: • Francophone population is a priority population as are French language services.

Action Plans/Interventions:

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next 3 years with concentration on those actions that will be largely implemented within the upcoming year.

Action Plans/ Interventions:	*Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.*		
	2010-11	2011-12	2012-13
Link HSPs to best practices for welcoming and responsive organizations	30%	30%	40%
Assess French language capacity in community-based health service organizations	40%	40%	20%
Establish an HNHB LHIN FLS Advisory Committee	100%		
Collaborate with the ministry-appointed local planning entities for FLS	30%	30%	40%

Expected Impacts of Key Action Items:

- programs and services deemed priorities by Francophone communities are available in French
- improved access to FLS
- improved client/patient satisfaction with FLS
- French-speaking stakeholders and entities are included in planning and decision-making
- connect more Francophones without a family doctor to culturally appropriate primary care.

What are the Risks/Barriers to Successful Implementation?

- supply of French language health professionals.

Mitigating Strategies:

- work with FLS Advisory Committee on recruitment strategy.

3g. Chronic Disease Prevention and Management

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Chronic Disease Prevention and Management (CDPM)

IHSP Priority Description:

Improve care and outcomes of individuals with a focus on prevention, early-detection and self-management.

Current Status:

Within the HNHB LHIN, over one million people report having a chronic condition, a number that is consistently rising due to our aging population. Due to the large demand for CDPM-related services, many of our HSPs provide services for the prevention and management of chronic conditions. Among residents with diabetes, complications are experienced by many; each year more than 200 people in the HNHB LHIN have a foot or lower limb amputated due to complications with diabetes.

Successes in the past year:

- in 2009, the LHIN hosted two "Raising the Bar in Chronic Disease Prevention and Management" Continuing Health Science Education Events (CHSEE)
- the CDPM Collaborative Advisory Committee identified guiding principles; a priority setting framework; an approach to implementing the CDPM model using the Triple Aim framework; and initiated a collaboration with Institute for Clinical and Evaluative Sciences (ICES) on sub-LHIN analysis to define target population
- new diabetic foot care programs were started at North Hamilton CHC and LHIN Dialysis Centres, following the identification of a risk classification and management approach for diabetic foot care based on a review of best practice guidelines
    - diabetic foot care was included as a performance indicator in LHIN Multi-Sector Service Accountability Agreement (M-SAA) for CHCs.

TEMPLATE A:
PART 2: GOALS and ACTION PLANS

Goal(s):

The LHIN will use the Triple Aim approach of balancing population health, quality of care and cost in order to:

- reduce the prevalence of chronic disease
- provide a local health care system that meets the needs of people with chronic disease
- align the LHIN municipalities, and other ministries to improve the health of the population.

Important to the Triple Aim approach is the development of Change Coalitions in identified local communities to guide a local approach to intervention.

Consistency with Government Priorities:

The Ontario Diabetes Strategy's stated objectives include:

- improve access
- decrease the percentage of people with diabetes who are unattached to a primary care provider
- increase the number of people with diabetes evaluated by a qualified inter-disciplinary diabetes team
- improve management of diabetes according to clinical practice guidelines
- reduce complications and improved outcomes.

Action Plans/Interventions:

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next 3 years with concentration on those actions that will be largely implemented within the upcoming year.

Action Plans/ Interventions:	*Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.*		
	2010-11	2011-12	2012-13
Expand diabetes education centres	50%	50%	
Expand foot care services for persons with diabetes at high risk	30%	30%	40%
Implement PD units in three LTCHs	25%	50%	25%
Continue annual sponsorship of the continuing health sciences education event to increase uptake of best practice	100%		
Implement standardized practice guidelines	30%	30%	40%
Establish change coalitions to achieve Triple Aim outcomes that enhance the prevention and management of chronic conditions	75%	25%	

Expected Impacts of Key Action Items:

- improved client/patient experience
- risk factors associated with diabetes and COPD in defined populations are identified
- avoidable ED visits and hospitalizations for populations with diabetes and COPD are reduced
- incidence of diabetes and COPD in new populations are reduced
- by 2013, achieve a 10% reduction in lower limb amputations in the HNHB LHIN for individuals with diabetes.

What are the Risks/Barriers to Successful Implementation?

- many primary care providers are not connected to electronic medical records (EMRs)
- adherence to self-management
- current lifestyle behaviours of many residents.

Mitigating Strategies:

- the LHIN is collaborating with the LHIN eHealth lead to increase the number of primary care providers with EMR
- the LHIN is partnering with the new Regional Coordinating Centre for diabetes to develop a LHIN-wide, integrated approach to diabetes self-management
- the LHIN is participating in Healthy Communities Approaches with various Public Health Departments throughout the LHIN to address risk factors for chronic conditions.

3h. Mental Health and Addictions

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Mental Health and Addictions (MH&A)
IHSP Priority Description:
Every Door is the Right Door.
Current Status:
There are 50 community MH & A providers in the HNHB LHIN, and 10 hospital corporations providing inpatient and outpatient MH & A services. One in five persons in the HNHB LHIN will be affected by mental illness at some point in their lives (280,000 people). Three per cent currently depend on alcohol or illicit drugs in a given year (42,000 people in the HNHB LHIN). Between 10% and 20% of LHIN residents will have a substance use disorder in their lifetime. Approximately 70% of people with mental health issues have been diagnosed before the age of 18. In the HNHB LHIN, 98,000 children and youth do not get the mental health treatment they require. Key issues facing people with mental health and addictions include social stigma, access to services and basic supports including housing, income and social inclusion. Successes this past year: • 250 LHIN residents/clients and family members participated in focus groups and identified opportunities to address the need for community care and housing for persons with long-term MH & A issues • a renewed HNHB LHIN Mental Health and Addictions Network • introduction of a Young Carers support program to support health and well-being of young people living with a family member with a chronic disease, including mental health.

PART 2: GOALS and ACTION PLANS
Goal(s):
To provide integrated and linked services for the prevention, management and recovery for MH & A: • implement initiatives to achieve the goals of the 10-year strategy • reduce the prevalence of mental illness and addictions • optimize person-directed care and choice.
Consistency with Government Priorities:
• "Every Door is the Right Door" of the ministry's 10-year Strategic Plan • equitable access • healthy Ontarians.

Action Plans/Interventions

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next 3 years with concentration on those actions that will be largely implemented within the upcoming year.

Action Plans/ Interventions:	*Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.*		
	2010-11	2011-12	2012-13
Collaborate with area networks to implement the ministry's 10-year Strategic Plan	100%		
Expand the participation of people living with mental illness and addictions in program governance, design, and evaluation	ongoing		
Continue to sponsor best practice forums in partnership with the Centre For Addictions and Mental Health (CAMH)	30%	30%	25%
Increase the adoption of evidence-based screening tools and best practice in primary care	10%	40%	50%
Implement supportive housing for persons with addictions	75%	25%	
Expand crisis services and early intervention of psychosis programs (as identified in the provincial budget)	20%	80%	

Expected Impacts of Key Action Items:

- reduced avoidable ED visits, hospitalizations and readmissions
- improved client and patient experience
- increased meaningful consumer participation in program governance, design, and evaluation
- improved early detection and appropriate intervention
- improved local access to specialized mental health geriatric services
- expand the participation of people living with mental illness and addictions in program governance, design, and evaluation.

What are the Risks/Barriers to Successful Implementation?

- level of resources attached to provincial priority directions.

Mitigating Strategies:

- implementation plans geared to timing and level of provincial resources.

3i. eHealth

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
eHealth
IHSP Priority Description:
Linked information for effective care and health system decision-making.
Current Status
The HNHB LHIN released its eHealth Strategic Plan in October 2006. This plan outlined how the LHIN would deliver a comprehensive, patient-focused and secure electronic system. Progress to date: • CCAC common case management tool (CHRIS) (March 2008) • a centralized incident reporting and risk management system implemented at LHIN hospitals and CCAC (2008) • interim Right Level of Care Information System (RLCIS) (November 2009) • Integrated Decision Support Strategy (November 2009) • provider-patient reminders in Ontario Multi-Strategy Prevention Tools (P-Prompt) - Hamilton family health team (FHT) and 12 participating rural physicians are participating • drug profile viewer – implementation in process • common clinical viewer (ClinicalConnect) – implementation in process • regional Diagnostic Imaging repository (DI-r) – 100% participation (June 2010).
PART 2: GOALS and ACTION PLANS
Goal(s):
• improve people's ability to make informed decisions • improve patient care delivery • improve health system management.
Consistency with Government Priorities:
• eHealth is a critical success factor for health system transformation, and is a government priority • in March 2009, eHealth Ontario announced its focus on three clinical priorities over the next three years: diabetes management, medication management, shortening wait times in hospital emergency departments.

Action Plans/Interventions:

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next 3 years with concentration on those actions that will be largely implemented within the upcoming year.

Action Plans/ Interventions:	*Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.*		
	2010-11	2011-12	2012-13
Participation in the DI-r by all hospitals in both HNHB and Waterloo-Wellington (WW) LHINs	75%	25%	
Participation in the common clinical viewer 'ClinicalConnect' by all HNHB hospitals, HNHB CCAC, CHCs and FHTs	25%	25%	25%
Implement integrated eHealth cancer strategy (Juravinski Centre, Walker Centre, community hospital clinics)	25%	25%	50%
Continue to implement initiatives outlined in HNHB LHIN eHealth Strategic Plan	25%	25%	25%

Expected Impacts of Key Action Items:

- reduced repeat diagnostic tests
- improved work flow
- improved communication among health care providers
- improved patient safety and reduced medical errors.

What are the Risks/Barriers to Successful Implementation?

- timing of provider access to integrated decision support tool data and reports

Mitigating Strategies:

- availability of:
    - implementation plan to ensure key provider data availability
    - resources to build eHealth capacity for LHIN health service providers and key stakeholders
    - implementation plan geared to resource availability.

3j. Interprofessional Care

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Interprofessional Care (IPC) – an enabler for transformation
IHSP Priority Description:
Improve access to interprofessional primary care to improve the client experience, health outcomes, and provider satisfaction.

Current Status:

The overall health of the population is characterized by an aging population, high illness burden, a changing labour force and increasing dependency on the social safety net. Among primary health and primary health care entities, there is a lack of communication, coordination and use of best practices for optimal health outcomes. There are significant gaps in the areas of chronic disease management, mental health care and care for frail elderly, wherein no practitioner/entity can alone manage optimal care. Not all provincial screening targets are being met in the LHIN, public health program mandates and physician roles are not well aligned, and health professionals' knowledge of scopes of practice is not well understood.

Many primary care practitioners want timely access to other health care providers, specialists, appropriate diagnostics, and best practice. Primary care practitioners lack timely access to robust patient information for decision-making.

Residents indicate that they want to be involved in decisions about their care, adopt healthy lifestyles and participate in health care teams that respect diversity.

Key issues for implementing interprofessional practice:

- perceived liabilities for physicians working in an interprofessional care setting.

Successes of the past year includes:

- high participation among primary care providers in the CSP
- physician offices and pharmacies participated in LHIN outreach strategies making available resident comment cards for planning and decision making
- opening of the distributive medical school campus in St. Catharines.

PART 2: GOALS and ACTION PLANS

Goal(s):

- teamwork for quality care and effective practice
- improve people's ability to make informed decisions
- improve patient care
- improve provider satisfaction.

Consistency with Government Priorities:

The HNHB LHIN's ABP is consistent with the Ontario Government priorities:

- Interprofessional Care: A Blueprint for Action in Ontario. HealthForceOntario (July 2007)
- connect more people without a family physician to primary care
- healthy Ontarians.

Action Plans/Interventions:

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next 3 years with concentration on those actions that will be largely implemented within the upcoming year.

Action Plans/ Interventions:	*Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.*		
	2010-11	2011-12	2012-13
Implement and evaluate an IPC "virtual team" pilot among health care providers	50%	50%	
Establish LHIN-wide screening targets	30%	30%	40%
Develop an IPC best practice toolkit for dissemination and uptake	50%	50%	
Sponsor continuing health science education events (one event annually)	100%		
Advance uptake of P-Prompt and ClinicalConnect	30%	30%	40%

Expected Impacts of Key Action Items:

- patients and their families are part of the care giving team
- patients are confident in the care giving team's ability to take care of their health care needs
- health caregivers collaborate and communicate effectively
- health care settings embrace IPC
- infrastructure, funding models and policies exist to support IPC

- increased number of health professional learners exposed to interdisciplinary, collaborative and team-based models.

What are the Risks/Barriers to Successful Implementation?

- implementation rate of e-connectivity
- implementation plan that builds on available eHealth connectivity
- multiple interpretations of client-centred or client-directed care
- development of common definitions through pilot project.

3k. Transportation

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Transportation
IHSP Priority Description:
A transportation business model that is accountable for safe, accessible, and efficient transportation.

Current Status:

LHIN residents identified transportation as one of three top key issues. For persons without a vehicle of their own or ready access to one, transportation services provide access to health services and enable people to participate in community life enhancing their health, well-being and independence.

Among LHIN-funded programs, there is considerable variation in their distribution, eligibility criteria, user fees, and availability by days and hours. Persons with mobility issues, persons with behavioral challenges and children and youth under the age of 16 are not eligible for many services. There is a lack of affordable regional transit which is a barrier to getting to specialized health services either within or outside a region.

- There are currently 58 programs, provided through 38 organizations, identified in the HNHB LHIN transportation survey. The number of LHIN-funded programs is 23 or about 40%. These programs comprise community-based services with emphasis on volunteer transportation, and a limited number of paid driver services. Clients served by transportation services include seniors and persons with disabilities (physical, behavioral and cognitive). The annual estimated number of clients served by LHIN-funded programs exceeds 4,000.

Key issues facing client groups include:

- limited availability of accessible vehicles for persons with mobility issues
- lack of local public transit for intra- and inter-regional transportation
- limited hours of operation, priorities that favor medical transportation vs. access to the other broad determinants of health (i.e. social activities)
- barriers including eligibility criteria, fees, geography, and limited capacity of some services to meet requests for services
- limited availability of volunteers.

Successes this past year:

- HNHB LHIN transportation survey (late Spring 2009) provided baseline information on transportation programs, issues, and opportunities for improvement
- HNHB LHIN transportation forum (November 2009) early action strategies.

PART 2: GOALS and ACTION PLANS

Goal (s)

- advance equitable access to LHIN-funded transportation programs
- optimize community-based transportation services.

Consistency with Government Priorities:

- independent living (Aging at Home strategy) .

Action Plans/Interventions:

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next 3 years with concentration on those actions that will be largely implemented within the upcoming year.

Action Plans/ Interventions:	*Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.*		
	2010-11	2011-12	2012-13
Link implementation of community-based dialysis stations with local transportation authorities and providers	100%		
Integrate transportation access requirements with CSP	20%	40%	40%
Integrate transportation funders and planners with local health planning	80%	20%	
Identify guidelines for transportation programs to be funded in the pending M-SAAs	60%	40%	
Harmonize client eligibility criteria	30%	70%	
Implement business improvement processes to improve sector capacity, effectiveness and efficiency	20%	40%	40%
Use results of LHIN-wide demand modeling tools to enable proactive planning (e.g. PBAM)	50%	50%	
Reduce avoidable ED visits and hospitalizations	20%	40%	40%
Align LHIN-funded transportation services with population health and system improvement goals	40%	60%	

Expected Impacts of Key Action Items:

- equitable access to LHIN-funded transportation services
- improved client satisfaction
- improved coordination of transportation within and between LHIN municipalities.

What are the Risks/Barriers to Successful Implementation?
• ease of collaboration among multiple transportation providers and funders • build time into process to allow for collaboration based on trust • reliance on a changing voluntary sector • leverage LHIN-funded services to provide stability.

4. LHIN Staffing and Operations

LHIN Staffing Plan Full-Time Equivalents (FTEs)

Position Title	2009/10 Actuals as of March 31/09 FTEs	2010/11 Forecast FTEs	2011/12 Forecast FTEs	2012/13 Forecast FTEs	2013/14 Forecast FTEs
Chief Executive Officer	1	1	1	1	1
Senior Director	2	2	2	2	2
Team Lead	4	4	4	4	4
Business Manager	1	1	1	1	1
Corporate Coordinator	1	1	1	1	1
Executive Assistant	2	2	2	2	2
Administrative Assistant	1	1	1	1	1
Program Assistant	3	3	3	3	3
Receptionist	1	1	1	1	1
Office Assistant	1	1	1	1	1
Information Controller	1	1	1	1	1
Advisor, Funding & Allocation	3	3	3	3	3
Controller/Advisor, Funding & Allocation	1	1	1	1	1
Advisor, Community Engagement	2	2	2	2	2
Advisor, Performance & Contract Management	3	3	3	3	3
Advisor, Planning & Integration	4	4	4	4	4
Communication Assistant	1	1	1	1	1
Physician Lead	0	0	.4	.4	.4
Total FTEs	32	32	32.4	32.4	32.4

LHIN Operations Spending Plan					
LHIN Operations Sub-Category ($)	2010/11 Forecast	2010/11 Allocation	2011/12 Planned Expenses	2012/13 Planned Expenses	2013/14 Planned Expenses
Salaries and Wages	*2,848,544*	*2,848,544*	*2,905,514*	*2,963,625*	*3,022,897*
Employee Benefits					
Hospitals of Ontario Pension Plan (HOOPP)	250,922	250,922	255,940	261,059	266,280
Other Benefits	370,356	370,356	377,763	385,318	393,025
Total Employee Benefits	*621,278*	*621,278*	*633,703*	*646,377*	*659,305*
Transportation and Communication (T & C)					
Staff Travel	49,400	49,400	50,388	51,396	52,424
Governance Travel	21,750	21,750	22,185	22,629	23,081
Communications	47,412	47,412	48,360	49,327	50,314
Other T & C	4,555	4,555	4,646	4,739	4,834
Total Transportation and Communication	*123,117*	*123,117*	*125,579*	*128,091*	*130,653*
Services					
Accommodation	272,594	272,594	278,045	283,606	289,278
Advertising					
Banking					
Community Engagement					
Consulting Fees	299,325	299,325	305,312	311,418	317,646
Equipment Rentals	10,364	10,364	10,571	10,783	10,998
Governance Per Diems	130,000	130,000	132,600	135,252	137,957
Insurance	18,171	18,171	18,534	18,905	19,283
LHIN Shared Services Office (LSSO) Shared Costs	359,495	359,495	366,685	374,019	381,499
LHIN Collaborative (LHINC)	50,000	50,000	51,000	52,020	53,060
Other Meeting Expenses	64,500	64,500	65,790	67,106	68,448
Other Governance Costs	7,700	7,700	7,854	8,011	8,171
Printing & Translation	42,481	42,481	43,331	44,197	45,081
Staff Development	64,600	64,600	65,892	67,210	68,554
Total Services	*1,319,230*	*1,319,230*	*1,345,614*	*1,372,526*	*1,399,977*
Supplies and Equipment					
IT Equipment	70,180	70,180	71,584	73,015	74,476
Office Supplies & Purchased Equipment	123,524	123,524	125,994	128,514	131,085
Total Supplies and Equipment	*193,704*	*193,704*	*197,578*	*201,530*	*205,560*
LHIN Operations: Total Planned Expense	5,105,872	5,105,872	5,207,989	5,312,149	5,418,392
Annual Funding Target			5,207,989	5,312,149	5,614,842
Variance			0	0	0

5. Communications Plan

This communications plan describes the methods the HNHB LHIN may use to release the post-budget, ministry-approved ABP, including its funding and allocation details. Guidelines will be provided by the ministry for the LHIN to consider regarding media releases, funding announcements, etc., related to the ABP.

Objective: To demonstrate the HNHB LHIN's responsiveness to community needs.

To communicate, to stakeholders and the broader community, the HNHB LHIN's transformation activities and initiatives.

Audiences: There are primary and secondary audiences to be considered.

Primary Audience: Broader health sector including HSPs and media outlets.

Secondary Audience: Communities of Hamilton, Niagara, Haldimand, Brant, Norfolk and Burlington including elected officials (MPPs, Mayors and Regional Chairs).

Messaging: The ABP will assist the public in understanding how the HNHB LHIN is planning to address the needs of its community.

The ABP is based on numerous discussions the HNHB LHIN has had with members of the public, HSPs, and stakeholders.

In December 2009, the HNHB LHIN released its IHSP 2010-13. The IHSP is the HNHB LHIN's three-year strategic plan that aligns with provincial ministry strategic directions. It will guide the HNHB LHIN's ABPs, integration priorities, and funding decisions for the local health system.

Strategy: Highlight the focus of the ABP and any special considerations required in meeting the identified needs of the LHIN as well as HSPs and community stakeholders.

Tactics: Many province-wide tactics will need to be coordinated between all LHINs and the ministry to ensure same day release across LHINs (release date to be confirmed).

As per ministry direction to date: No direction or information has been provided.

"Day of" Morning: The HNHB LHIN will notify its HSPs and community stakeholder groups via email distribution. The email will notify them of the ABP release and provide a link to the document on the HNHB LHIN website.

"Day of" Afternoon: The HNHB LHIN will post the ABP to the website.

The HNHB LHIN will issue a media release. The media release template will be provided by the ministry's LHIN Communications Team.

Follow-up:

- HNHB LHIN hosted community meetings with HSPs and community stakeholder groups

- matte article provided to HSPs and hospitals for inclusion in their newsletters
- Editorial Board meetings to discuss
- fact sheet development
- inservice session with HNHB LHIN staff.

Timetable: To be confirmed based on timing from the ministry

The ABP will become a public document and will therefore need to be available in both English and French.