

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

Annual Business Plan 2011-2012

June 2011



Ontario

Local Health Integration
Network

Réseau local d'intégration
des services de santé

**Hamilton Niagara Haldimand Brant
Local Health Integration Network**

**Annual Business Plan
2011-12**

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June 3, 2011

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, 2011-12**

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 2011-12 Annual Business Plan (ABP).

The guidelines provided by the Ministry of Health and Long-Term Care (ministry), regarding the 2011-12 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 2011-12 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 May 31, 2011.

Sincerely,



Michael P. Shea
Board Chair

Encl.

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 IHSP is a three year plan for the LHIN, and this ABP (2011-12) represents the second of those three years. As such, some flexibility is required in the ABP to respond to changes in the environment and imperatives emanating from province wide priorities.

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 80 community support services (CSSs), 47 community Mental Health and Addictions (MH and A) programs, seven Community Health Centres (CHCs) (including ten sites), one Community Care Access Centre (CCAC), 86 Long-Term Care Homes (LTCHs) and ten hospitals (including 21 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 (IPC), 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 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 30,000 people (85+ years of age) 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 ten years.
- 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 24,000 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 Aboriginal population has lower incomes, lower life expectancy, and higher rates of illness, compared to the average Canadian.
- In designated communities in Ontario, a person has the right to communicate with, and receive services in French. Both Hamilton and Niagara are designated communities for French language services (FLS). According to Statistics Canada's 2006 census, almost 2.2% of the population (approximately 31,000 people) in the HNHB LHIN is Francophone.
- 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 40,000 people (3.5% of HNHB LHIN residents) do not have a family physician (ministry, February 2010).
- 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 50% of all visits to the Emergency Department (ED) are for non-urgent and less urgent care.

- There is an increased demand for CCAC services, with a 38% increase in referrals over the period of 2005-06 to 2009-10.
- A significant number of patients in complex care (CC) are waiting for alternative care in another setting. In February 2010, for example, alternate level of care (ALC) days accounted for 36% of all CC days (approximately 95,000 of 262,000 days of care).
- 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 (the Faculty), 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 IPC, optimal practice scope and best practices. Other hospitals, community agencies, physician's 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:

1. Patient Flow

- i. Alternate Care Settings
- ii. Emergency Department Capacity
- iii. Clinical Program Integration
- iv. Community-Based Health Service Capacity
- v. Aboriginal Health
- vi. Francophone Health

2. Chronic Disease Prevention and Management

3. Mental Health and Addictions

4. Enablers for Transformation

- i. eHealth
- ii. Interprofessional Care
- iii. Transportation

3.1.i 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 acute hospital care by: 1. reducing the number of patients that wait in hospital to transition to post-acute care settings 2. reducing the time (days) patients wait in hospital for an alternate level post-acute care setting once their acute care is complete.
Current Status:
The HNHB LHIN has ten hospital corporations across 21 sites for a total of 3,384 beds¹. Nine hospital corporations operate acute care beds. The HNHB LHIN CCAC works with hospitals to support patients returning home after their acute phase is over. This Home First approach is based on the philosophy that home provides the best environment for recuperation and post-acute care, and is a less stressful place to make life decisions or experience a life transition. As of December 2010, the HNHB LHIN CCAC reported over 13,000 personal support clients per month receiving CCAC service. In addition, the CCAC provides dedicated Case Managers to hospital emergency departments with over 30,000 emergency room (ED) visits to prevent avoidable admissions.

¹ 2010-11 Q1 Actuals reported on Web-Enabled Reporting System (WERS)

The HNHB LHIN has 86 LTCHs, with over 10,000 beds. The LHIN's LTCH occupancy rate for June 2010 was 99%, and the average length of stay (LOS) was three years (3.1 years)².

In November 2010, the ministry reported an ALC rate for the HNHB LHIN of 16.1%, the lowest rate recorded in five quarters. The LHIN's internal monitoring of the ALC rate indicates that the ALC rate for acute care beds for the same period was 13.3%. However, the LHIN's internal monitoring showed that during Q2 the LHIN's ALC rate has trended up to 15.4%, this in part has been attributed to an increased number of patients newly designated ALC, and a lower placement rate during the Q2 period.

As of November 28, 2010, LHIN hospitals reported 569 individuals waiting in all hospital beds, and 336 individuals waiting in acute hospital beds for an alternate care. Of these, 49% (278) and 31% (104) were waiting for Long-Term Care (LTC) respectively.

Key issues for this client population:

- high LTCH occupancy - 99%
- increased LTCH capacity in Welland approved in 2007 (96 beds), expansion pending
- individuals in hospital waiting for LTCHs with long waits for the right bed (i.e. basic, male/female)
- capacity of LTCHs to care for special populations (i.e. bariatric, behavioral)
- limited access to supportive housing alternatives across the HNHB LHIN
- limited access to CSS in rural areas (i.e. Haldimand/Norfolk)
- high number of individuals waiting in a non-acute hospital bed (complex care, rehabilitation) for alternate care settings.

Successes of the past year:

- decrease in ALC rate as noted above to 16.6% was the lowest of five reporting periods
- five Assess Restore (AR) units (92 beds) across the LHIN – the program reports a 74% to 89% discharge home rate, with 305 clients discharged home as of Q2
- Integrated Program for Complex Care approved by HNHB LHIN Board, LHIN ALC Steering Committee identified to facilitate and monitor implementation - ALC Steering Committee established a subcommittee to implement recommendations
- three slow stream rehabilitation programs (two hospitals and one community) served 196 clients as of Q2
- three LTCHs approved to provide peritoneal dialysis services
- LHIN ALC target incorporated into all Hospital-Service Accountability Agreement (H-SAA) amending agreements
- adoption of Home First philosophy, number of newly designated ALC to LTC decreased from a high of 156 people to 44-55 persons in the latter half of the fiscal year
- 14% decrease in number of LTCH applicants (excluding transfers) from April 2009 (2,956 in April 2009, and 2,547 in June 2010)³
- as of November 17, 2010, CCAC and hospitals had placed 175 long wait patients (identified in ministry July Provincial point in time survey), of whom 40 reported exceedingly long waits ranging from 295 to 1,259 days.

² Ministry, LTCH System Report June 2010

³ Ministry, LTCH System Report June 2010

Together, the 40 patients identified with exceedingly long waits accumulated 18,902 ALC days, which equates to 53 beds (system cost ranges \$3.4 - \$7.8M)⁴

- 18 clients serviced through 17 interim LTCH beds as of November 2010. Ninetieth percentile length of stay 233 days
- 211 imminent and 399 preventable hospital admissions avoided in Q2 by the Nurse Led Outreach Team (NLOT) targeting LTCH residents. This equates to 8,508 ALC days or 23 beds (system cost ranges \$1.5 - \$3.5M).

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal (s)

Improve and maintain patient flow through the acute care system by facilitating residents' access to quality health care services in the most appropriate place. The LHIN will focus on seven main areas:

- reduce the number of individuals waiting in acute care beds for post acute care, as measured by a decreasing ALC rate, target 11% or less
- reduce the number of surgical cases that are cancelled due to bed availability, positively impacting the wait time for select surgical services
- reduce the ED 90th percentile wait time for admitted patients
- reduce the number of patients admitted from ED/home and designated ALC within two days of admission by identifying strategies targeted to specific populations (base line 2009-10 volume 572 clients in a fiscal year)
- reduce the number of newly designated acute ALC-LTC to a stable 40 – 50 per month across all hospitals sites
- reduce the number of patients designated ALC to palliative care in acute care beds (target to be identified) by implementing the palliative stream in complex care and/or explore hospice and community support opportunities
- reduce the number of patients ALC-LTC in complex care beds to 12-15% (note: the success will be impacted by the number of CC beds closed as part of a hospital's plans to balance their budgets).

Consistency with Government Priorities:

Please describe how this goal (these goals) align(s) with key government priorities:

- improve patient flow demonstrated by decreasing the number of patients waiting in an acute bed for an ALC and by reduced ED wait times for admitted patients
- reduce wait times for surgical services (i.e. total joint replacement surgery) through the reduction of cancelled cases due to bed availability. Increase community services to support residents who wish to return home from hospital and be able to stay in their homes as they age safely, aligns with the Government's recent budget announcement in which it plans to provide a three percent increase to community service providers
- increase health system sustainability through the appropriate use of current resources.

⁴ 2009-10 Ontario Cost Distribution Methodology Year (OCMD) Year End (YE) Report: Chronic Inpatient Per Diem Rates (Direct Costs). Based on the final 2009-10 OCMD for HNH B Hospitals, the lowest hospital chronic direct cost per diem rate is \$180, while the highest hospital chronic direct cost per diem rate is \$411.50. Thus these rates translate to a system cost range estimate of \$3.4M - \$7.8M (based on 18,902 days or 53 beds).

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: “We will deliver the following”	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
Assess Restore (AR) Units will: - maintain a discharge home rate in the high 70's - maintain an occupancy rate of 95-97% - maintain or reduce program targeted length of stay. Optimizing AR beds will assist patients discharge home requiring less home care supports.	100%		
Transition appropriate patients to CC restorative settings as part of the integrated CC plan.	50%	50%	
Implement integrated program for CC beds (dependent on availability of resources to support new model).	70%	30%	
Increase access to rehabilitation services (Slow Stream Rehab and AR) in Hamilton, Niagara and Norfolk by improving occupancy rate of available resources.	100%		
Reduce number of patients admitted through the emergency department (ED) that are designated ALC within two days admission to acute care bed.	50%	50%	
Home will be the first place considered for discharge post-acute hospital event.	100%		
Ninety percent of patients identified ALC with a LOS exceeding 41 days will. have a discharge plan documented.	50%	50%	
LHIN ALC target will be included in all hospital and CCAC 2011-12 accountability agreements.	100%		
Support increased capacity in LTCHs (interim beds) as a short-term strategy.	100%		
Facilitate early discharge of seniors back to LTCH through Nurse Practitioners (NP) in LTCH program (target to be identified).	50%	50%	

Describe how you measure success:

- number of individuals waiting in hospital for an ALC will decrease as measured by the LHIN acute ALC rate (target 11%)
- 800 clients served through AR units based on occupancy rates >95% and median LOS of ≤ 30 days
- over 70% of clients admitted to AR units will be able to return to a home that is safe and with the necessary community services in place to provide for their ongoing care as needed. 180 clients will have access to slow stream and rehabilitation services annually based on occupancy rate of >90% and median LOS of 50 days
- detailed admission and discharge criteria and site specific CC streams identified for Integrated Program - Palliative care and restorative care streams implemented
- number of newly designated ALC-LTC will be maintained at 40-50 per month
- decrease number patients admitted through ED designated ALC within two days admission to acute care
- 70% of all patients reported ALC for longer than 41 days will have a discharge plan documented.

What are the risks/barriers to successful implementation?

- hospitals may experience costs associated with negotiating labour costs that exceed their funding increases
- movement of LTCH beds between LHINs. The HNHB LHIN will see a movement of LTCH beds in 2012 from HNHB LHIN to Waterloo Wellington LHIN as a result of approved phase 1 redevelopment projects. In addition, the LHIN has been informed of LTCH operators intention and/or interest of LTCH operators to cease providing LTCH services in Niagara (which has a potential impact of 151 beds)
- availability of access to alternate care settings or supportive housing
- availability of health human resources (HHR) in acute and community settings.

Mitigating Strategies:

- work with ministry to facilitate expansion of LTCH capacity announced in 2007 for Welland
- LHIN providers' ongoing commitment to early discharge and Home First approach, reducing the number of newly designated ALC
- optimize opportunities for ALC settings
- optimize clients' ability to improve functional status post-acute care through admission to AR/convalescent programs
- enhance the range and scope of alternative settings available in the community
- with respect to availability of HHR, the LHIN will encourage service providers to work with HealthForceOntario.

3.1.ii. Emergency Department Capacity

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Improve Patient Flow - Reduce Emergency Department (ED) Wait Times
IHSP Priority Description:
Improve access to hospital ED's by: 1. improving ED performance 2. reducing the number of non-urgent presentations.
Current Status
The HNHB LHIN has 13 hospital EDs across ten hospital corporations. In 2009-10, LHIN EDs saw over 450,000 visits. The majority of ED visits (320,000) are seen at eight EDs, all of which are participating in the Provincial Pay for Results (P4R) strategy. The HNHB LHIN, for Q1, 2010-11, reported ED visits of 91 per 1,000 population, which was slightly lower than the provincial average (99). In 2009-10, 33 % of all ED visits were classified as Canadian Emergency Department Triage and Acuity Scale (CTAS) 4 and 5 (low acuity). In the first six months of fiscal 2010-11, the LHIN has seen an overall 2-3% increase in ED volumes. In November 2010, the ministry reported to the LHIN that the overall ED LOS and the percent of P4R funded site ED visits completed within target for Q2 were as follows: • ED LOS – 90th Percentile • admitted patients - 39.9 hours, which is lower than April 2008 baseline (45.1 hours) • non-admitted high acuity patients – 7.9 hours, an improvement over April 2008 baseline (8.3 hours) • non-admitted low acuity patient – 4.8 hours, an improvement over April 2008 baseline (5.0 hours) • 33% of admitted patients within target, no change over 2009-10 baseline (33%) • 89% of non-admitted high acuity patients within target, no change over 2009-10 baseline (89%) • 79% of non-admitted low acuity within target, improvement over 2009-10 baseline (76%). LHIN hospitals were challenged to improve wait times for admitted patients, in part due to patient flow pressures and the greatest improvement was seen in the low acuity non-admitted ED population. Thirty individuals accounted for approximately 2,200 visits in 2009-10. Key issues for this client population: • availability of acute care beds. As of March 27, 2011, LHIN hospitals reported 449 patients designated ALC in both acute and other inpatient beds, 44% waiting for LTCH placement • hospital strategies to meet financial targets, resulting in closure of 146 beds across the LHIN (majority of closures during Q2) • access to 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 knowledge of, or support for self-managed care
- availability of HHR (i.e. physicians).

Successes of the past year:

- P4R funding supported all eight P4R ED's to implement Rapid Assessment Zones (RAZ), for low acuity patient visits. Refinements in RAZ processes, provided by the ED process improvement plan (PIP) initiatives, have lead to performance improvements in this category of patients for all P4R sites. YTD (Q2) all eight P4R sites have improved over their baselines (Fiscal Year (FY) 2009-10), the proportion of patients treated within the four hour benchmark. The improvements range from 0.25% to 9% improvement.
- another example of improved efficiencies is the ED performance for non-admitted high acuity patients treated within the eight hour ministry target. The LHIN P4R sites continually perform at the 89-90% level, despite treating approximately 9,000 more patients the first two fiscal quarters this year than in 2009-10. Maintaining this high performance level, the higher volumes is evidence that greater efficiencies have been gained.
- 28 ambulance transfers for low acuity clients to Fort Erie and Port Colborne Urgent Care Centres (UCC) from April 2010 to November 2010. The Niagara Health System (NHS) is working with Emergency Medical Services (EMS) to refine transfer criteria.
- 3,021 residents attached to primary care through HealthCareConnect as of December 10, 2010
- 3,291 referrals from ED to CCAC as of Q2, avoiding potential hospital admissions
- 100% presence of CCAC Case Managers in LHIN EDs with over 30,000 visits annually
- two community-based special geriatric assessment clinics established
- 686 Francophone clients seen at the Mobile Primary Care Clinic as of Q2
- 869 new clients with diabetes seen at foot care clinics. These clinics report decrease in ED use, falls and incidence of new and recurrent foot ulcers in Q2
- 200 clients seen across community incontinence clinics, program reports clients report decreased cost of management of incontinence and reduction in falls from 18% to 2%
- see reference to avoidable ED visits/hospitalizations through NLOT under ALC section
- forum held in Fort Erie with health care providers to identify strategies to reduce ED visits for individuals with chronic conditions
- 61% reduction in LTCH ED visits that do not result in admission.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

To reduce ED wait times, LHIN actions will focus on two main areas:

Improving hospital processes:

- increase ED capacity by streamlining internal flow processes (P4R and ED PIP initiatives)
- reduce the ED wait time experienced by individuals identified as needing admission to an inpatient bed by reducing the number of patients waiting in acute care beds to transition to an ALC setting.

Avoiding ED visits:

- reduce the number of avoidable ED visits by increasing access to other appropriate settings (i.e. urgent care settings, primary care)
- identify and implement strategies targeted at select populations (i.e. with chronic conditions) with conditions that could best be managed elsewhere
- expand NLOT to LTCHs
- identify and implement strategies to reduce repeat unplanned visits by individuals with mental health and substance abuse conditions
- expand referral access from primary care to Internal Medicine Rapid Access (IMRA) Clinics in Hamilton.

Consistency with Government Priorities:

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

- improve access to care to acute and post acute care services as measured by:
 - reduce ED wait times
 - reduce ALC rate
- decrease ED visits for non-urgent conditions by increasing access to primary care and urgent care settings
- 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: "We will deliver the following"	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
Implement internal ED processes identified through LHIN PIP initiative.	50%	50%	
Revise and expand pilot ambulance transfer to UCC for low acuity clients.	100%		
Implement P4R strategies.	100%		
Sustain CCAC case managers in LHIN EDs with volumes at or exceeding 30,000 annually.	100%		
Implement eight community assessment clinics a month, adult day programs, family health teams (FHTs) and CHCs.	50%	50%	
Expansion of Specialized Geriatric Services (SGS) to Haldimand-Norfolk.	100%		

Hamilton Health Sciences (HHS) – Access to Best Care (ABC) Plan will open a new UCC in Hamilton.	25%	75%	
ED avoidance – Continued implementation of Community Incontinence Self-Management Program.	100%		
ED avoidance – expanded access to primary care: - mobile primary care for Francophone seniors - diabetic foot care for individuals at high risk.	100%		
Full implementation of IMRA Outreach Clinics for select populations .	100%		
ED avoidance: Continued implementation of Falls Prevention Strategy	75%	25%	
Pilot telepsychiatry for targeted MH population starting in Fort Erie	25%	75%	
Expand LHIN Integrated Decision Support (IDS) tool to include CHCs	75%	25%	
Sustain NP outreach program in LTCHs with high ED transfer volumes.	75%	25%	
Describe how you measure success:			
- ministry-LHIN Accountability Agreement (M-LAA) ED wait time targets are met or below baseline - LHIN hospitals ED P4R wait time targets are met or below baseline - reduce the time admitted patients wait in ED for a hospital bed to 28 hours - reduce the number of ED visits to 90 per 1,000 people from current level of 91 - reduce the number of LTCH ED visits that do not result in admission by five percent 200 clients served through expansion of SGS to Haldimand Norfolk and a three percent reduction in ED visits for this population - six LHIN-funded CHC's inputting data into IDS - refer to Chronic Disease Prevention Management (CDPM) section for outcomes related to targeted population with chronic conditions - second UCC in Hamilton is operational 510 clients referred from ED to Hamilton IMRA outpatient 23 clients referred from ED to specialized geriatric in the ED (Burlington) - outcomes for telepsychiatry expanded program to be determined with program implementation and confirmation of client criteria - refer to ALC section re NLOT outcomes.			

What are the risks/barriers to successful implementation?
• hospitals may experience costs associated with negotiating labour costs that exceed their funding increases • impact of influenza that results in higher ED utilization • availability of HHR, especially physician coverage of ED • capacity of primary care to provide primary care services on evenings and weekends. Mitigating Strategies: • LHIN providers' ongoing commitment to early discharge and Home First approach, reducing the number of newly designated ALC • Hospitals to mitigate the impact of bed closures will, where appropriate work with patients and families to facilitate discharge when the acute care is completed • in the event of pandemic-type illness, the LHIN will encourage providers to maximize use of UCCs • the 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 LHIN's quarterly critical care meetings • with respect to availability of HHR, the LHIN will encourage service providers to work with HealthForceOntario.

3.1.iii 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:
Currently, hospital-based clinical programs are delivered on an organization basis, with varying degrees of linkage between hospitals and across the continuum. The HNHB LHIN CSP identified variation in health outcomes across our LHIN, with inequitable access to health services and variation in the application of best practice guidelines. 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. Integrating and coordinating a standardized approach to service delivery in selected clinical program areas is one of three inter-related themes from the CSP.

Key issues for CPI:

- 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 and variation in use of best practice guidelines
- current hospital utilization rate in our LHIN is high compared to the province, and projected utilization is not sustainable.

Successes in the past year:

- LHIN initiated the development of integrated program frameworks in six hospital-based clinical program areas, including complex care, rehabilitation, laboratory medicine, cancer care, vascular services and thoracic services
- the framework for an integrated program in complex care is complete and currently under implementation
- the LHIN successfully implemented 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
- a common LHIN-wide credentialing and annual reappointment package has been developed for implementation across LHIN hospitals
- all hospitals have committed to work with the LHIN on the development and implementation of CPI frameworks.

PART 2: GOALS and ACTION PLANS

Goal(s):

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

Consistency with Government Priorities:

CPI supports the ministry's priorities to:

- promote equitable access to health and health care for all Ontarians
- reduce wait time in EDs, improve patient flow
- 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: “We will deliver the following”	<i>Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.</i>		
	2011-12	2012-13	2013-14
Complete implementation of integrated program for CC	70%	30%	
Complete frameworks for LHIN-wide integrated programs for cancer care, rehabilitation services, vascular services, laboratory services, and thoracic services	100%		
Implement integrated programs for cancer care, rehabilitation, vascular, laboratories and thoracic	20%	40%	40%
Continue on a phased-in basis the development of other LHIN-wide integrated program plans	20%	20%	20%

Describe how you measure success:
• 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 • identified clear roles, responsibilities and accountabilities adopted • 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.

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 • HR (Human Resources) labour agreements may impact timing of implementation where resources need to move.
Mitigating Strategies:

- ensure integrated plans are cost neutral
- follow local eHealth plan and capitalize on external opportunities
- build principles and processes into transition plans
- engage HR leadership in processes.

3.1.iv. 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 is one CCAC, seven CHCs, 58 CSS programs, three ABI programs, 19 assisted living supportive housing programs and 86 LTCH in the HNHB LHIN. Community-based services are not equitably distributed across the LHIN, the appropriate services can be hard to find and the range of care and support available does not always match people's level of care requirements. With limited resources and a growing population of seniors, new, cost-effective community-based care options will be developed. Key issues for clients of community services include: • navigation: finding the right service at the right time in the right place • transportation: getting to health and related services when required • variation in services available across the LHIN • variation in assessment, care planning, and client outcomes • limited support for self managed care. Successes in the past year: • implementation plan for standardized assessment (CSS, MH and substance abuse services) • developed framework for improved transportation • 3,021 people attached to a family physician • Ontario Telehealth Network (OTN) introduced in 14 LTCHs and all CHCs • six community health centres went live with ClinicalConnect • completed Phase 1 Residents First Advancing Quality LTCHs (27 homes) • implemented Phase 2 Residents First (approximately 30 homes).	

PART 2: GOALS and ACTION PLANS

Goal(s):

- strengthen linkages among service providers to improve quality and continuity of care
- actively advance integration to optimize community-based health resources
- improve access to community-based care and supports and create a more functional continuum of care for seniors.

Consistency with Government Priorities:

CBHSC goals support the government's priorities:

- prevent avoidable ED visits
- improve patient flow by reducing avoidable hospitalizations and ALC days
- prevent premature admission to a LTC home
- improve access to care in the community
- Healthy Ontarians
- enable seniors to live independently in the community
- aligned with the ministry's updated Assisted Living Services for High Risk Seniors Policy, January 2011.

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: "We will deliver the following"	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
Implement assisted living services demonstration model	100%		
Implement enhanced assisted living services across the LHIN	20%	30%	50%
Implement common assessment CSS	10%	70%	20%
Implement transportation model	50%	25%	25%
Implement Integrated Client Care Program for palliative care	20%	60%	20%
Implement Phase 2 Residents First: "Advancing Quality Care in LTCHs"	10%	80%	10%
Implement business process improvements.	10%	40%	50%

Connect unattached persons with primary care	Ongoing	Ongoing	Ongoing
Evaluate and re-align aging at home programs	Ongoing	Ongoing	Ongoing
Describe how you will measure success:			
• people will tell their health story once • reduced wait times for access to community services • improved residents' support and care experience • improved residents' care experience • reduced avoidable ED presentations and hospitalizations • reduced ALC days • 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.			

3.1.v. 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: - two projects completed under the Aboriginal Health Transition Fund (AHTF) envelope (Federal): a) diverse competent discharge planning model for continuity of optimal care post hospital discharge b) community pathways model for children's mental health and wellness. - enhanced community service at Six Nations (homemaking) and New Credit (i.e. Meals on Wheels) for improved independent living - six dialysis stations fully operational at Six Nations - implemented Diabetes Education Program (DEP) at Six Nations - Aboriginal communities participated in LHIN-wide planning including introduction of common assessment, transportation planning, and introduction of nutritional risk assessment tool.	

PART 2: GOALS and ACTION PLANS	
Goal(s):	
- reduce health disparities - improve family and child health - reduce chronic disease.	
Consistency with Government Priorities:	

- Aboriginal population is a priority population
- Provincial LHIN's project charter (Fall 2010).

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: "We will deliver the following"	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
Implement 16 supportive housing units for persons with addictions at Six Nations.	100%		
Connect unattached people to primary care.	Ongoing	Ongoing	Ongoing
Connect aboriginal persons living with mental health issues to sessionals (psychiatric consultation).	Ongoing	Ongoing	Ongoing
Implement common assessment in CSS and MH programs.	65%	35%	
Strengthen the Aboriginal Health Network.	75%	25%	
Complete an environmental scan (including population health analysis, inventory of services, and community engagement).	100%		
Convene Cultural Sensitivity Workshops with local health service providers.	50%	50%	

Describe How You Measure Success:

- increased participation rates of Aboriginal persons in diabetes prevention and management programs
- reduced burden of illness among Aboriginal persons on dialysis
- reduced unplanned presentations to the ED by Aboriginal persons living with MH & A and substance abuse issues
- uptake of common assessment tools among providers
- Aboriginal communities, stakeholders and networks are actively involved in planning and decision-making.

What are the Risks/Barriers to Successful Implementation?

- implementation of e-connectivity

- availability of OTN site at Six Nations
- spread of culturally responsive services.

Mitigating Strategies:

- continue to work with Aboriginal Health Network (AHN) to increase sensitivity.

3.1.vi. 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 (FLSA) Ontario, 1986*, guarantees the right of Ontarians to communicate with the government and receive services in French.

There are over 35,000 Francophone residents in the HNHB LHIN. The LHIN has two agencies designated under the *FLSA* and 30 agencies identified to provide over 40 programs/services in French. 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. In addition, French-speaking health professionals are in short supply; programs and services are not tailored to the needs of Francophone communities and 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 homogeneous (i.e. new Canadians, French-Canadians from Ontario and other provinces where Francophones live in a minority situation) - health status, health needs and health-seeking behaviours are variable.

Successes this past year:

- successfully brought together The Centre de Santé Communautaire de Hamilton-Niagara (CSCHN) and HHS to discuss FLS issues and set priorities for hospital services that should be provided in French
- HHS identifying FLS capacity within the organization with an increasing level of engagement of staff and departments
- increase knowledge and awareness of FLSA, and government, LHIN and HSP obligations through presentations and discussions
- French Language Planning Entity (FLPE) for HNHB and Waterloo-Wellington (WW) LHINs approved.

French Language Community Engagement (CE):

- the CSCHN sponsored engagement activities on behalf of the LHIN with Francophone teens and young adults, seniors, newcomers, Francophone community partners and other health provider partners. Outcomes include health issues and trends information, best practice services provision to different Francophone populations and identified candidates for advisory committees that would continue to provide advice
- LHIN staff held several key informant interviews in the sectors of primary care and LTC homes to learn more about issues and needs in these sectors
- FL perspectives integrated at the onset of planning processes at the LHIN (i.e. Rehabilitation Task Group).

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal (s)

- improve Francophone health
- improve Francophone's health experience
- sustained capacity for French language health services.

Consistency with Government Priorities:

- Access: Ensure that Francophone population can access health services in French within reasonable reach.
- Accessibility: Ensure the 'active offer' of health programs in French as well as availability of French-speaking health human resources.
- Community Engagement: Support the active participation of Francophones in public consultations and citizen/community engagement activities.
- Integration/Coordination: Address the needs of Francophones, and ensure that programs and HSPs incorporate the principles of the *FLSA* and *Local Health System Integration Act (LHSIA)*, in their business processes to address the needs/concerns of Francophone clients.
- Evidence-Based Policy/Program Development: Use the best information available about the needs of Francophones, demographic trends and the enhancement of Francophone-specific research to inform policy and program development.

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 three years with concentration on those actions that will be largely implemented within the upcoming year.			
Action Plans/ Interventions: “We will deliver the following”	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
Link HSPs to best practices for welcoming and responsive organizations. Increase awareness and knowledge of enablers for FLS capacity. The Healthy Communities Consortium Webinars on Engaging Francophone Communities in Ontario, Canadian Institute for Research on Linguistic Minorities. Access to FL training and translation and Francophone specific research.	25%	25%	25%
Engage the newly appointed Waterloo Wellington Hamilton Niagara (WWHN) FLS Planning Entity (PE) and work with WWNH PE to meet objectives set out in LHSIA regulations.	Ongoing	On-going	On-going
Assess capacity to provide services in French in community-based health service organizations.	Phase 1: With identified agencies 100%	Phase 2: All LHIN HSPs 50%	Phase 2: All LHIN HSPs 50%
Promote and monitor the use of ministry French Language Health Services (FLHS) translation service and opportunities to increase language capacity through French language training (FLT).	Ongoing	Ongoing	Ongoing
Contribute to development of performance measures for FLS.	25%	25%	25%
Describe how you measure success:			
These may be operational/outcome metrics (i.e. number of new clients serviced is an operational metric; reduction in ALC LOS is an outcome metric). Impacts should be stated quantitatively where possible. Phase 1: - number of agencies who completed and submitted French Language Implementation Plan (FLIP) - starting point from which to build FLS capacity: - number of FL-identified agencies who have a mechanism in place to identify Francophone client			

○ number of FL-identified agencies who have French speaking staff/health professionals • steady increase in these numbers from year to year • improved health status of Francophones • number of FL-identified agencies using translation services • Francophone clients have increased access to health information in French • number of FL-identified staff taking FLT • improved Francophone health.
What are the risks/barriers to successful implementation?
Lack of French language health professionals able to provide services in French, variable commitment among stakeholders to meeting the needs of French speaking people. Mitigating Strategies: • FLIP from each agency identified to provide FLS • link HSPs to best practices and resources • operationalize planning entity (PE).

3.2. 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 on the rise due to our aging population and rates of obesity. 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. Success in the Past Year: • Hosted the Third Annual Raising the Bar in CDPM; a Continuing Health Sciences Education Event (CHSEE). This year's event focused on early recognition of chronic conditions, increased adoption of evidence-based practices (i.e. Opioid Guidelines) and Interprofessional Care (IPC) to increase seamless transitions across care settings. • Implemented peritoneal dialysis (PD) in three LTCHs.

- The CDPM Collaborative Advisory Committee used a priority setting framework and data analysis completed by the Institute for Clinical Evaluative Sciences -Ontario (ICES) to determine communities to begin applying the Triple Aim approach for CDPM.
- Hosted “Aiming for Better Health Fort Erie”, a two day forum to enhance CDPM in Fort Erie. As a result of the Forum four working groups have emerged comprised of local stakeholders. These working groups are implementing a made-in-Fort Erie approach to impacting the goals of decreasing avoidable ED visits for residents of Fort Erie with chronic conditions and decreasing the obesity rate in Fort Erie.
- Diabetic foot care programs continue to operate. This community program is now operational in five communities, exceeding original plans.
- Fostered strong relationship with Diabetes Regional Coordinating Centre (DRCC) to work collaboratively to achieve goals of Ontario Diabetes Strategy (ODS) within our LHIN.
- Participated on the Self-Management Provincial Working Group to contribute to the development of a Provincial Self-Management Strategy.
- Identified host agency for the implementation of the LHIN wide Self Management Coordinator and collaborated to facilitate training in self-management.
- Early development of a Primary Care Network to facilitate linkages with CDPM priorities and other Ministry/LHIN priorities began

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal (s)

The LHIN will continue to 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
- align the CDPM Collaborative Advisory Committee with Provincial Strategies DRCC, Ontario Renal Network (ORN)
- engage family physicians and primary care nurse practitioners to provide input on local initiatives resulting from provincial strategies.

Important to the Triple Aim approach is the development of Change Coalitions in identified local communities to guide a local approach to intervention. Stakeholders in Fort Erie have begun to assume this role and are working towards implementing local changes to decrease ED visits and obesity rates among Fort Erie residents with chronic conditions.

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
- improve access to ED care by reducing the number of non-urgent presentations to the ED and reduce the amount of time that people spend waiting in the ED
- focusing on ED avoidance among individuals with chronic conditions
- improve access to care for people with chronic conditions.

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: “We will deliver the following”	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
Expand DEPs.	25%	25%	25%
Expand foot care services for persons with diabetes at high risk for complications.	60%	40%	
Implement standardized practice guidelines.	25%	25%	25%
Establish change coalitions to achieve Triple Aim outcomes that enhance the prevention and management of chronic conditions.	25%	25%	25%
Develop a action oriented Primary Care Network.	50%	50%	

Describe how you measure success.

- improved client/patient experience
- risk factors associated with diabetes and Chronic Obstructive Pulmonary Disease (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
- achieve a 10% reduction in lower limb amputations in the HNHB LHIN for individuals with diabetes by 2013.

What are the risks/barriers to successful implementation?

- many primary care providers are not connected to electronic medical records (EMRs)

- with the exception of CHCs, primary care is not accountable to the LHIN and most CDPM happens in collaboration with primary care
- adherence to self-management practices (i.e. patient and provider)
- 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 EMRs
- the LHIN is partnering with the new DRCC 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
- the LHIN is developing an action oriented Primary Care Network.

3.3. Mental Health and Addictions

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Mental Health and Addictions (MH and A)

IHSP Priority Description:

Linking Services for Prevention, Management and Recovery

Current Status:

There are 47 community MH&A programs in the HNHB LHIN, and ten hospital corporations providing inpatient and outpatient MH and 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 percent 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.

The number of unplanned presentations to the ED by persons experiencing MH and A issues reflects the lack of a continuum of care and support in the health system, and little sustained access to supports for daily living and illness recovery – housing, social network, meaningful activity, and income. Unplanned visits to the ED for persons with MH and A accounted for approximately three percent of all visits in 2009-10, with 30 individuals accounting for approximately 2,200 visits. The majority of unplanned visits are in Hamilton and Niagara regions. Key issues facing people with MH and A include social stigma, access to services and basic supports, including housing, income and social inclusion.

Successes this past year:

- implemented a centralized psychiatric sessional fee access model to optimize timely client access, integrate residents, and increase telepsychiatry
- modelled the use of the HNHB LHIN IDS tool used to analyse emergency room presentation for persons who

live with mental health and addictions problems, for improved solution building • implemented enhanced SGS program (interdisciplinary and multi-partner) in Haldimand-Norfolk and Niagara • expanded day program in Brantford for persons with early onset dementia • approved for Alternatives in Youth (Hamilton) to introduce the Rebound Program which is designed to strengthen prevention and early detection among youth at risk for substance abuse • implementation plan for common assessment – Ontario Common Assessment of Need (OCAN)-developed. • pilot tested consistent chart audit approach across the LHIN to address individuals with a mental health and/or addiction who are repeat users of hospital emergency departments.
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PART 2: GOALS and ACTION PLANS
Goal(s):
Improving the quality of care for people with mental health and addictions issues and their families by: • integrate and link services amongst HSPs across the continuum for prevention, management and recovery • optimizing person-directed care and choice • Improving access to primary care, psychiatrists, community and hospital-based services decreasing demand on EDs, which means shorter wait times for people with other emergencies • reducing hospitalizations and readmissions increasing access to stable housing and decreasing demand on shelters and ALC beds.
Consistency with Government Priorities:
Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy" (released December 2010) "the ministry's ten-year Strategic Plan" • stop stigma and discrimination • equitable access by inclusion of consumers in planning through agency engagement • improve mental health and well being for all Ontarians identify problems early and intervene appropriately implement common assessment tool in mental health agencies • increase capacity for independent living for persons living with substance abuse issues • increase access to psychiatric diagnosis and treatment • increase capacity of mental health professionals to detect and support illness and recovery.

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 three years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
Collaborate with local (sub-LHIN) MH and A networks to implement the recommendations of the Minister’s Advisory Group on the 10-Year Mental Health and Addictions Strategy (December 2010).	Ongoing	Ongoing	Ongoing
Expand the participation of people living with mental illness and addictions in program governance, design, and evaluation.	Ongoing	Ongoing	Ongoing
Continue to sponsor best practice forums in partnership with the Centre For Addictions and Mental Health (CAMH).	Ongoing	Ongoing	Ongoing
Implement OCAN with MH providers.	40%	40%	20%
Implement 128 supportive housing units and 16 case management positions for people with problematic substance abuse (i.e. high repeat users of withdrawal management services).	80%	20%	
Increase psychiatric care in underserved areas of the LHIN (via telepsychiatry and face to face) for high-risk individuals.	Ongoing	Ongoing	Ongoing
Identification and solution building of mental health and addictions related service gaps and issues, resulting from the collaborative system planning underway (working with LHIN and sub LHIN Networks).	Ongoing	Ongoing	Ongoing
Implement a 24/7 crisis call service and mobile MH crisis outreach service in Niagara.	80%	20%	
Implement a strength based prevention and early intervention program targeting youth at risk of substance abuse (Hamilton and Niagara) – based on timing of funding flowed from the Ministry.	40%	40%	20%
Continued implementation of an intensive case management approach for individuals with a mental health/addiction who frequently use hospital EDs.	Ongoing	Ongoing	Ongoing

Describe how you measure success:

- reduced avoidable ED visits, hospitalizations and readmissions
- improved client experience
- higher rates of early detection
- improved local access to specialized mental health geriatric services
- higher participation rates for people living with mental illness and addictions in program governance, design, and evaluation
- frequency of admissions to withdrawal management services will be reduced
- increased housing stability for people with problematic substance abuse who are homeless or at risk
- standardized, consumer-led decision making assessment tool will identify individual needs and help match these to existing services and identifies service gaps
- aggregate data from OCAN assessments will inform organizational, regional and provincial level planning and decision-making that is consistent with a recovery approach
- inter-agency communication and collaboration through common data standards and sharing of assessment results (with required privacy arrangements in place) as a result of OCAN implementation.

What are the Risks/Barriers to Successful Implementation?

- level of resources attached to provincial priority directions
- adherence to treatment plans given the nature of the illnesses
- access to primary care for persons with a mental health and/or addictions issues
- access to and distribution of mental health and addictions services varies considerably across the LHIN
- distribution of and access to psychiatrists in the LHIN.

Mitigating Strategies:

- implementation plans geared to timing and level of provincial resources
- submitted proposal to Ministry to fund support clients before and after psychiatric intervention
- development of Primary Care Network to advise on strategies for primary care to build their capacity to support mental health and addictions clients
- a centralized model for sessional fees will result more effective and efficient use of resources to engage psychiatrists in increased care and treatment.

Enablers for Transformation

3.4.i. 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 that would improve the way patients receive care. It proposed principles to guide business planning and grow eHealth. • build on existing and scalable solutions • seize opportunities and align with current or planned initiatives and resources • choose solutions that promote ease of integrations and operation with other systems • equip stakeholders with a minimum level of computerization to enable their participation • share implementation costs between all providers who stand to benefit and improve patient care. Successes of the past year: • ClinicalConnect (common clinical information viewer) – implementation in process • IDS Strategy – fully operational and continuing to expand data sets • Developed low cost interface to implement an ALC Information System tool on Meditech systems (nine of ten hospitals in the LHIN) • Implementation of Joint Regional eHealth Steering Committee partnership between HNHB and WW LHINs • creation of connect South West Ontario (cSWO) eHealth cluster: Erie St. Clair (ESC), South West (SW), WW and HNHB LHIN. Key issues for eHealth implementation: • ongoing changes in leadership at the ministry • Ontario's financial crisis impacting funding and cash flow for eHealth projects • changing timelines and mandates impacting approvals and funding for Canada Health Infoway (CHI) sponsored projects • HSP financial constraints to balance budgets impacting availability of funds to support local eHealth implementation • impact of recent federal election on health transfer payment and the impending outcome of the October provincial election.

PART 2: GOALS and ACTION PLANS

Goal(s):

- improve access to health information across the health care continuum
- improve patient care delivery through improved, timely access to information
- improve the ability of health professionals to access information to make informed decisions
- improve quality of care and reduce errors
- improve health system management.

Consistency with Government Priorities:

- eHealth will allow seamless and secure exchange of patient information between healthcare organizations and their clinicians
- eHealth is a critical success factor for health system transformation, and is a government priority
- eHealth Ontario is playing the lead role in harnessing IT and innovation to improve patient care, safety and access in support of the government's health strategy
- in May 2011, eHealth Ontario announced funding for the Connecting Greater Toronto Area (cGTA) project that will connect 700 health service providers to securely share patient health information across the five GTA LHINs. Planning is underway for future implementation in cSWO and connect North East Ontario (cNEO).

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.		
	2011-12	2012-13	2013-14
Participation in the common clinical viewer ClinicalConnect by all HNHB hospitals, HNHB CCAC, CHCs and FHTs, expansion to WW LHIN • add St. Joseph's Healthcare Hamilton (SJHH) data and WW LHIN Oncology and CCAC data • roll out application to additional providers (>1,000) • develop mobile version of application • EMR download goes live to four vendors • integration of numerous other data sources to improve functionality.	50%	25%	25%
Implement IDS tool into all HNHB LHIN hospitals, expand data sets to include additional healthcare sectors • rehabilitation and CC data is being added and targeted for completion by July 2011 • consider addition of other data sources: FHTs • tool utilization is being monitored and popular reports are being designed as part of the data cubes on an ongoing basis • currently 200 users, add additional 100 users over next year.	60%	20%	20%
Participation in the Diagnostic Imaging Repository (DI-r) by all hospitals in both HNHB and WW LHINs • CHI-sponsored initiative to create standard Ontario Diagnostic Imaging Terminology (ODIT) “reference set” • eHealth Ontario sponsored initiative to lead diagnostic imaging (DI) Common Services project – building infrastructure for future provincial sharing of information • 100% of HNHB LHIN hospitals will be operational in 2011-12, with remainder of WW LHIN hospitals (two) participating in next fiscal.	90%	10%	
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 • improved quality of care.
What are the Risks/Barriers to Successful Implementation?
• Loss of momentum due to (cGTA) announcement by eHealth Ontario, i.e. lack of public recognition by eHealth Ontario of significant achievements by the HNHB LHIN Project Management Office (PMO) • timing of provider access to integrated decision support tool data and reports • availability of funds • competing patient care priorities in a time of financial and economic constraint. 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.

3.4.ii. Interprofessional Care

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Interprofessional Care (IPC)
IHSP Priority Description:
Improve access to interprofessional care to improve the client experience, health outcomes, and provider satisfaction.
Current Status
IPC is the provision of comprehensive health services to patients by multiple health care providers. These providers work collaboratively to deliver the best quality of care in any health care setting. HNHB LHIN has the largest proportion of seniors in the province, higher than the average rates of many chronic health conditions and subsequent ED visits and the number of residents over 65 years of age will grow by 30% over the next ten years. Although it is difficult to quantify accurately, HealthForceOntario estimates that two to three percent of the HNHB LHIN population do not have access to primary care especially in the lesser urbanized areas of the LHIN. Success in the past year: • August 2010, Geriatric Assessment Intervention Team (GAIT) opened at Joseph Brant Memorial Hospital (JBMH). This IPC provides rapid consultation by a variety of allied health professionals to assist seniors stay at home and avoid emergency room visits. Over 90% patient and family satisfaction with the GAIT clinic and the virtual IPC nature of this clinic provides information to the referring family physician within 48 hours • Health Professional Advisory Committee (HPAC) developed five key recommendations for enhancing the uptake and acceptance of allied health professional's scope of practice • ongoing expansion of ClinicalConnect (common clinical information viewer) across the HNHB LHIN hospitals, CCACs and pilot FHTs • annual CHSEE with multiple allied health and family physicians attending. Topics included education of the new Opioid guidelines and management of diabetic patients • development of screening targets underway with Cancer Care Ontario (CCO) and Diabetes Primary Care leads • development of virtual IPC model for implementing telepsychiatry underway through partnership with Niagara Health System, SJHH and Fort Erie family physicians.

TEMPLATE A: 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:

- IPC: A Blueprint for Action in Ontario. HealthForceOntario (May 2010)
- connect more people without a family physician to primary care
- improve access to healthcare by enhancing interprofessional 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: “We will deliver the following”	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.		
	2011-12	2012-13	2013-14
Establish LHIN-wide screening targets.	30%	30%	40%
Develop an IPC best practice toolkit for dissemination and uptake.	100%		
Advance update of P-Prompt and ClinicalConnect.	30%	30%	40%
Development of an additional virtual IPC (Fort Erie).	50%	50%	

Describe how you measure success.

These may be operational/outcome metrics (i.e. number of new clients serviced is an operational metric; reduction in ALC LOS is an outcome metric). Impacts should be stated quantitatively where possible.

What are the risks/barriers to successful implementation?

- implementation rate of e-connectivity
- multiple interpretations of client-centred or client-directed care.

Mitigating Strategies:

- implementation plan that builds on available eHealth connectivity
- development of common definitions through pilot project.

3.4.iii. Transportation

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Transportation
IHSP Priority Description:
Review of a business case submitted by community transportation stakeholders for the provision of a LHIN-wide coordination model for LHIN funded transportation to improve access, the quality of the patient experience, and to improve cost efficiencies
Current Status
The LHIN provides \$2.5 million to support transportation across 12 organizations. In 2009-10, 91,000 one-way trips were completed providing service to 4,481 individuals. Successes this past year: • stakeholder working group developed a transportation framework for coordinated, accessible and sustainable LHIN-funded services, inclusive of: ○ asset inventory (staff and volunteer capacity, vehicles, sources of funding) ○ two-week trip census (date/time, purpose, destinations, client demographics, and special needs) ○ common transportation eligibility guidelines ○ consensus on coordinated model for transportation in HNHB LHIN.

TEMPLATE A: 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 • client experience and access • sustainability.

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: “We will deliver the following”	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.			
	2011-12	2012-13	2013-14	
	Develop a business case for coordinated transportation model	100%		
	Implement coordinated access to LHIN-funded transportation services consistent with approved blueprint.	50%	50%	
Link transportation model with other planning and integration activities.	50%	50%		
Describe how you measure success.				
• 100% matched trips for access to health/medical appointments • improved client experience • reduced unit costs.				
What are the risks/barriers to successful implementation?				
Risks: • capacity to absorb front-end integration costs • provider readiness for re-aligned roles, responsibilities and accountabilities • sustained volunteer capacity in a change environment. Mitigating strategies • leadership accountability structure that centralizes some elements of delivery, while maintaining local volunteer presence.				

4. LHIN Staffing and Operations

LHIN Staffing Plan Full-Time Equivalents (FTEs)

Position Title	2010-11 Actuals as of Mar. 31/10 FTEs	2010-11 Forecast FTEs	2010-11 Forecast FTEs	2011/-12 Forecast FTEs	2012-13 Forecast FTEs
Chief Executive Officer	1	1	1	1	1
Physician Lead		1	1	1	1
Senior Director	2	1	1	1	1
Director	5	5	5	5	5
Health System Advisor	3	5	5	5	5
Performance Advisor	3	3	3	3	3
Funding Advisor	3	3	3	3	3
Quality & Risk Advisor	0	1	1	1	1
Information Controller	1	2	2	2	2
FLS Advisor	0	1	1	1	1
Communications Advisor	3	1	1	1	1
Corp Coordinator	1	1	1	1	1
Executive Assistant	2	2	2	2	2
Project Assistant	1	1	1	1	1
Program Assistant	3	4	4	4	4
Receptionist	1	1	1	1	1
Finance Clerk	1	1	1	1	1
Corporate Services Assistant	1	1	1	1	1
Controller	1				
Account Manager	1				
Total FTEs*	33	35	35	35	35

* Increase result of addition of the Physician Lead Clinical Health System Transformation

LHIN Operations Spending Plan					
LHIN Operations Sub-Category (\$)	2009-10 Actuals	2010-11 Allocation	2010-11 Interim Actuals	2011-12 Planned Expenses	2012-13 Planned Expenses
Salaries and Wages	2,843,718	2,848,544	2,969,996	3,119,199	3,119,199
Employee Benefits					
Hospitals of Ontario Pension Plan (HOOPP)	210,063	250,922	261,094	309,197	309,197
Other Benefits	316,526	370,356	338,337	357,976	357,976
Total Employee Benefits	526,589	621,278	599,431	667,173	667,173
Transportation and Communication (T & C)					
Staff Travel	46,720	49,400	42,062	45,344	45,344
Governance Travel	20,920	21,750	17,260	21,580	21,580
Communications	154,224	47,412	42,187	70,670	70,670
Other Benefits	4,842	4,555	6,561	6,650	6,650
Total Transportation and Communication	226,706	123,117	108,070	144,244	144,244
Services					
Accommodation	299,058	272,594	322,050	354,070	354,070
Advertising					
Banking					
Community Engagement		50,000			
Consulting Fees	358,828	362,840	47,967	307,668	307,668
Equipment Rentals	12,054		11,327	13,000	13,000
Governance Per Diems	128,800	130,000	123,275	140,000	140,000
LHIN Shared Service Office (LSSO) Shared Costs	375,000	359,495	409,495	445,268	445,268
Other Meeting Expenses	45,135	64,500	31,465	30,635	30,635
Other Governance Costs	7,430	7,700	7,122	6,500	6,500
Printing & Translation	43,819		10,356	13,000	13,000
Staff Development	96,756	64,600	55,580	51,700	51,700
Total Services	1,366,881	1,311,729	1,018,637	1,361,842	1,361,842
Supplies and Equipment					
IT Equipment	114,055	70,180	107,115	71,000	71,000
Office Supplies Purchased Equipment	142,400	123,524	71,710	54,850	54,850
Total Supplies and Equipment	256,455	193,704	178,825	125,850	125,850
LHIN Operations: Total Planned Expense	5,220,349	5,098,372	4,874,959	5,418,308	5,418,308
Annual Funding Target	5,227,198	5,098,372	5,387,042	5,418,308	5,418,308
Variance	6,849	0	512,083	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 meet with HSPs and community stakeholder groups
- Article in LHINsight (LHIN e-newsletter) and LHInfo Minute (bulletin to Members of Provincial Parliament (MPPs))
- 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.

APPENDIX i

Glossary of Acronyms

ABC	Access to Best Care
ABI	Acquired Brain Injury
ABP	Annual Business Plan
AHN	Aboriginal Health Network
AHTF	Aboriginal Health Transition Fund
ALC	Alternate Level of Care
ALS	Amyotrophic Lateral Sclerosis
AR	Assess Restore
CAMH	Centre For Addictions and Mental Health
CBHSC	Community-Based Health Service Capacity
c	Connect or Connecting
CC	Complex Care
CCAC	Community Care Access Centres
CDPM	Chronic Disease Prevention Management
CE	Community Engagement
CHC	Community Health Centres
CHSEE	Continuing Health Sciences Education Event
CHI	Canada Health Infoway
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CPI	Clinical Program Integration
CSP	Clinical Services Plan
CSCHN	Centre de Santé Communautaire de Hamilton-Niagara
CSS	Community Support Services
CTAS	Canadian Emergency Department Triage and Acuity Scale

DEP	Diabetes Education Program
DI	Diagnostic Imaging
DI-r	Diagnostic Imaging Repository
DRCC	Diabetes Regional Coordinating Centre
ED	Emergency Department
EMRs	Electronic Medical Records
EMS	Emergency Medical Services
ESC	Erie St. Clair
FHT	Family Health Team
FLHS	French Language Health Services
FLIP	French Language Integration Plan
FLPE	French Language Planning Entity
FLS	French Language Services
FLSA	French Language Services Act
FLT	French Language Training
FTE	Full-Time Equivalent
FY	Fiscal Year
GTA	Greater Toronto Area
HHR	Health Human Resources
HHS	Hamilton Health Sciences
HNHB	Hamilton Niagara Haldimand Brant
HOOPP	Hospitals of Ontario Pension Plan
HR	Human Resources
HSP	Health Service Provider
ICES	the Institute for Clinical Evaluative Sciences – Ontario
IDS	Integrated Decision Support
IHSP	Integrated Health Service Plan

IMRA	Internal Medicine Rapid Assessment
IPC	Inter-professional Care
IT	Information Technology
LHIN	Local Health Integration Network
LHSIA	Local Health System Integration Act
LOS	Length of Stay
LSSO	LHIN Shared Services Office
LTC	Long-Term Care
LTCH	Long-Term Care Homes
MH	Mental Health
MH&A	Mental Health and Addictions
Ministry	Ministry of Health and Long-Term Care
MLAA	Ministry-LHIN Accountability Agreement
NEO	North East Ontario
NHS	Niagara Health System
NLOT	Nurse Led Outreach Team
NP	Nurse Practitioner
OCAN	Ontario common Assessment of Need
ODIT	Ontario Diagnostic Imaging Terminology
ODS	Ontario Diabetes Strategy
ORN	Ontario Renal Network
OTN	Ontario Telehealth Network
P4R	Provincial Pay for Results
PAG	Planning Advisory Group
PD	Peritoneal Dialysis
PE	Planning Entity
PIP	Process Improvement Plan

RAZ	Rapid Assessment Zones
SGS	Specialized Geriatric Services
SJHH	St. Joseph's Healthcare Hamilton
SW	South West
SWO	South West Ontario
UCC	Urgent Care Centre
WW	Waterloo Wellington
WWHN	Waterloo Wellington Hamilton Niagara
YTD	Year To Date