

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

Annual Business Plan 2012-2013

June 2012



Ontario

Local Health Integration
Network

Réseau local d'intégration
des services de santé

Hamilton Niagara Haldimand Brant
Local Health Integration Network

Annual Business Plan
2012-13

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June 4, 2012

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, 2012-13**

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 2012-13 Annual Business Plan (ABP).

The 2012-13 ABP follows the guidelines provided by the Ministry of Health and Long-Term Care (ministry), to focus on goals and action plans relating to system change and outcomes. Our 2012-13 ABP continues to operationalize the three-year Integrated Health Service Plan (IHSP) approved by the Board in December 2009.

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

The ABP was reviewed and approved by the HNHB LHIN Board of Directors on May 30, 2012.

Sincerely,



Michael P. Shea
Board Chair

Enc.

[http://intranet.lhins.on.ca/doccenter/Operations/IHS/HNHB LHIN/Annual Service Plan-Annual Business Plan/2012-2013/FINAL 2012-13 ABP June 2012/Transmittal Letter re 2012-13 ABP.doc](http://intranet.lhins.on.ca/doccenter/Operations/IHS/HNHB%20LHIN/Annual%20Service%20Plan-Annual%20Business%20Plan/2012-2013/FINAL%202012-13%20ABP%20June%202012/Transmittal%20Letter%20re%202012-13%20ABP.doc)

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 (2012-13) represents the third of those three years.

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. In addition, the HNHB LHIN consistently demonstrates a leadership in provincial projects such as the Integrated Community Care Project – Palliative Care Spotlight and Behavioural Supports Ontario which furthers its mandate and strategic direction.

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&A) programs, seven Community Health Centres (CHCs) (including nine 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 funding 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 2011-12 to 2013-14 are to:

- Improve patient flow and ensure people get the right care, in the right place, at the right time; this includes patients designated as requiring an alternate level of care, Emergency Department (ED) capacity, clinical program integration, community-based health service capacity, aboriginal health, and francophone health.
- Reduce the prevalence of chronic disease and improve care delivery.
- Link services for prevention, management and recovery in the area of MH&A.
- Implement enablers for health system transformation: eHealth, interprofessional care (IPC), transportation, and partners for change.
- Work with HSPs to find opportunities for integration that aligns with their strategic plans.

2c. Assessment of Issues Facing the Agency (Environmental Scan of Opportunities and Risks)

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 (RMON).

The following summarizes some of the key characteristics of the local health system:

Our Population

- More than 230,000 people aged 65 and over 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 35% over the next ten years. ¹
- 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. ² The Aboriginal population has lower incomes, lower life expectancy, and higher rates of illness, compared to the average Canadian. ³
- 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. ⁴
- 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. ⁵ HNHB LHIN residents have higher rates of chronic conditions including arthritis, high blood pressure, and asthma as compared to the province as a whole. ⁶ 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. ⁷
- In 2010-11, falls occurring in the senior population in our LHIN resulted in 13,167 visits to hospital EDs, and 3847 hospitalizations. ⁸

¹ IntelliHealth Ontario, Ontario Ministry of Health and Long-Term Care

² Indian and Northern Affairs First Nation Profile and Registered Indian Population, 2006

³ Health Canada. *A Statistical Profile on the Health of First Nations in Canada: Determinants of Health, 1999 to 2003*. Minister of Health: Ottawa, 2009

⁴ Canadian Community Health Survey, Statistics Canada

⁵ Chronic Conditions in the Hamilton Niagara Haldimand Brant LHIN. Health System Intelligence Project October 2007

⁶ Canadian Community Health Survey, Statistics Canada

⁷ HNHB LHIN Chronic Disease Prevention and Management Diabetes Action Group Report, December 2008

⁸ IntelliHealth Ontario, Ministry of Health and Long-Term Care

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.⁹
- There is variation across the LHIN in the availability of community-based health services. 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.
- Five geographically based community collaborative planning tables have been established to identify opportunities for realigning existing roles and resources to optimize access to care, quality of care and system efficiency.
- 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.
- Unplanned visits to the ED for persons with MH&A accounted for approximately three percent of all visits in 2009-10, with 30 individuals accounting for approximately 2,200 visits.¹⁰ The majority of unplanned visits are in Hamilton and Niagara regions. Key issues facing people with MH&A includes social stigma, access to services and basic supports, including housing, income and social inclusion.
- In 2010, LHIN EDs saw over 463,000 visits.¹¹ In the first quarter (Q1- April 1 to June 30, 2011) of 2011-12, the HNHB LHIN hospitals reported unscheduled ED visits of 90 per 1,000 population.¹² The rate has been relatively consistent over the last year and continues to be lower than the provincial average (99). In 2010-11, 31% of all ED visits were classified as Canadian Emergency Department Triage and Acuity Scale (CTAS) 4 and 5 (low acuity), a 2% decrease from 2009-10.¹³
- In November 2011, the ministry reported an acute Alternative Level of Care (ALC) rate for the HNHB LHIN of 12.94% for Q1 2011-12; the lowest rate reported by the HNHB LHIN since 2007. The LHIN's internal monitoring of the ALC rate indicates that the acute ALC rate for September 2011 was 14.4%.¹⁴ Both measures of ALC demonstrate improvements for this priority area.
- As of October 2011, LHIN hospitals reported 503 patients waiting in all hospital beds and 291 individuals waiting in acute hospital beds for an alternate care setting. Of these 35% (176) were waiting for LTCH, 61 of whom were waiting in acute care beds¹⁵. This represents an improvement of November 2010 when 278 individuals were waiting in all hospital beds for LTCH.

⁹ Primary Care Access Survey, Ontario Ministry of Health and Long-Term Care, February 2010

¹⁰ LHIN Integrated Decision Support

¹¹ National Ambulatory Care Reporting System

¹² MOHLTC Provincial Health Database & Canadian Institute for Health Information – National Ambulatory Care Reporting System

¹³ National Ambulatory Care Reporting System

¹⁴ MOHLTC MLPA Report November 2011

¹⁵ ALCIS, October 2011

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 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. Behavioural Supports Ontario
 - iv. Clinical Program Integration
 - v. Community-Based Health Service Capacity
 - vi. Aboriginal Health
 - vii. 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 - Alternative Level of Care (ALC)
IHSP Priority Description:
Access to care – Patient Flow - ALC focuses on the movement of individuals across the health care continuum from the community to acute in-patient hospital care to post acute care. It is not unexpected that situations will occur where individuals will experience a wait across the continuum. This often occurs in hospitals; individuals following acute treatment may experience waits to access a variety of post acute settings such as rehabilitation or even home if community services need to be arranged. This priority focuses on reducing or preventing delays that individuals may experience in hospital once their treatment is complete. This may include post acute areas like complex care or rehabilitation, home with CCAC services or other alternate care settings like supportive housing.
Current Status:
The HNHB LHIN has ten hospital corporations across 21 sites for a total of 3,429 beds. ¹⁶ Nine hospital corporations operate acute care beds.

¹⁶ 2011-12 Q2 Actuals reported on Web-Enabled Reporting System (WERS)

The HNHB CCAC works with health service providers to support individuals returning home from hospital when their acute phase is over.

This Home First approach, practiced throughout the LHIN, reinforces the message that home is the best place to wait for an alternate care setting because 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.

The HNHB LHIN has 86 LTCHs with over 10,000 beds. The LHIN's LTCH occupancy rate for May 2011 was 98.9%, and the average length of stay (LOS) was three years (3.1 years)¹⁷, a decrease from the 3.6 years reported in October 2008¹⁸.

The HNHB LHIN supports 149 transitional care beds, comprised of: 109 Assess Restore (AR) beds situated in hospitals and long term care homes at five locations across the LHIN, 25 Slow Stream Rehab (SSR) beds located in two hospitals and 15 interim long term care beds:

- In November 2011, the ministry reported an acute ALC rate for the HNHB LHIN of 12.94% for Q1 2011-12;¹⁹ the lowest rate reported by the HNHB LHIN since 2007. The LHIN's internal monitoring of the ALC rate indicates that the acute ALC rate for September 2011 was 14.4%.²⁰ Both measures of ALC demonstrate improvements for this priority area.
- As of October 2011, LHIN hospitals reported 503 patients waiting in all hospital beds and 291 individuals waiting in acute hospital bed for an alternate care setting. Of these 35% (176) were waiting for LTCH, 61 of whom were waiting in acute care beds.²¹ This represents an improvement of November 2010 when 278 individuals were waiting in all hospital beds for LTCH.
- As of September 30, 2011, the HNHB LHIN CCAC reported over 15,852 personal support and homemaking clients had received CCAC service.²²

Key issues facing individuals who wait for alternate care settings:

- High LTCH occupancy – 98.8%; less than 0.2% of LTCH beds are idle.²³
- Individuals in hospital waiting for LTCHs with long waits for the right bed (i.e. basic, male/female).
- Individuals waiting in hospital for long term care that have chosen LTCHs with the longest waits (measured in years).
- Limited access to supportive housing alternatives across the HNHB LHIN.
- Availability of CSS services in rural areas (i.e. Haldimand/Norfolk).
- Increasing demand for palliative care services.

Successes of the past year:

- In the first quarter of 2011-12 the LHIN achieved the lowest number of accumulated ALC days in acute beds (12.94%) since 2007.²⁴
- Reduced the number of people waiting in hospital for long-term care (LTC) from 360 in August 2010 to 163 in November 2011.²⁵

¹⁷ Ministry, LTCH System Report May 2011

¹⁸ Ministry, LTCH System Report October 2008

¹⁹ Canadian Institute for Health Information – DAD Q1 11/12

²⁰ Alternate Level of Care Information System, October 2011

²¹ Alternate Level of Care Information System, October 2011

²² HNHB CCAC ALC Report 2011

²³ CCAC Idle Bed Report & Weekly Report

²⁴ MOHLTC MLPA Report November 2011

²⁵ Alternate Level of Care Information System, October 2011

- Reduced the number of newly designated ALC to LTC in acute care from 85 noted in September 2010 to 30 in September 2011. ²⁶
- Reduced the ALC rate in complex care beds from 36.5% in September 2010 to 22.6% in September 2011. ²⁷
- Implemented an ALC strategy that 'bundled' initiatives to achieve sustainable change, these included:
 - A standardized Intensive Case Management Review tool and process at all sites for all patients designated ALC at 30 days with a monthly review thereafter until successful discharge.
 - An escalation process across LHIN hospitals, where senior hospital and CCAC administrator's signoff is required prior ALC-LTC designation. This is to ensure that all options have been explored and that waiting for LTCH in hospital is the only viable care option. Between July and September 2011 (Q2, 2011-12) hospitals reported the lowest number of individuals newly designated ALC- LTC in acute beds (88) since August 2009. ²⁸
 - Focused strategy to assess the impact on clients who are experiencing long waits for LTCH implemented in September 2011. As of November 16, 2011, 41 individuals were discharged to the care setting that would best meet their total care needs (social, cognitive and physical). Together these individuals accumulated 7,609 ALC days (average ALC LOS 185 days), the highest report ALC days for one individual was 532. ²⁹
 - Initiated daily operations groups (transitioned to three weekly calls) between the LHIN, senior hospital administrators and the CCAC to discuss each hospital's ALC population, barriers and solutions to transition.
- Implemented the LHIN's Integrated Complex Care Program in two hospitals.
- 22.35% decrease in number of long stay LTCH applicants (excluding transfers) from June 2010 (2,547 in June 2010 and 1,978 in May 2011). ³⁰
- Since AR and SSR beds were operational: 79.3% of patients have been discharged home. ³¹
- Introduced a new AR stream for individuals that need a long period of restorative care (Assess- Restore Reactivation).
- 24 clients serviced through 15 interim LTCH beds as of September 2011. The 90th percentile length of stay in Q2 344 days. Between April and September 2011, nine individuals admitted and nine discharged. ³²
- 90 imminent and 337 preventable hospital admissions avoided in Q1 by the Nurse Led Outreach Team (NLOT) targeting LTCH residents. ³³
- The number of individuals designated ALC within two days of admission through the ED decreased from 2009-10 baseline of 572 to 440 in 2010-11. ³⁴

PART 2: GOALS and ACTION PLANS

²⁶ Alternate Level of Care Information System, October 2011

²⁷ HNHB CCAC ALC Report 2011

²⁸ HNHB CCAC ALC Report 2011

²⁹ CCAC – Weekly Report

³⁰ Ministry, LTCH System Report May 2011

³¹ HNHB LHIN Monthly AR Reports

³² HNHB CCAC

³³ NLOT Quarterly Report

³⁴ ALC Highlights Report

Goal (s):

The LHIN analyzed the findings and recommendations of the two ALC reviews (conducted by PricewaterhouseCoopers (PwC) & Dr. Walker) and recognized a strong message resonating in both reports around the systematic changes required in the planning and delivery of health care services to address the needs of an increasing aging population.

The HNHB LHIN Patient Flow 2011-13 Action Plan is a living document and is built on key fundamental elements to facilitate systematic change:

- Improve the management of care for frail seniors across the healthcare continuum.
- Seniors experience seamless transition of care as they move through the system.
- Seniors receive the right care and support in the right place.
- Services are aligned and reliable.
- Senior friendly practices, processes and designs are incorporated into hospital systems.
- Health care services/programs are based on evidence and incorporate best practices.
- Existing capacity and resources are optimized.
- Plan provides for both immediate and sustainable long term impact on patient flow.

In 2012-13 the LHIN's goal is to improve patient flow through the acute care by facilitating residents' access to quality health care services in the most appropriate place. To do this the LHIN will focus on eight main areas:

- Reduce the number of patients that wait over 30 days in hospital to transition to a post acute care setting (baseline data and target to be identified).
- Reduce the number of days patients who wait in acute care beds for an alternate level of care as measured by a decreasing acute ALC rate, target 11% or less.
- Reduce the number of patients that wait in hospital to transition to LTC.
- 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 (baseline 2009-10 volume 572 clients in a fiscal year).
- Reduce the number of newly designated acute ALC to LTC to a stable 40 per month across all LHIN hospitals.
- 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 to LTC in complex care beds to 20%.

Consistency with Government Priorities:

The HNHB LHIN's ALC Goals align with the following government priorities:

- Improve patient experience by reducing the time individuals wait for an alternate care setting.
- Improve patient flow as 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.

• Increase health system sustainability through the appropriate use of current resources.						
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.					
	2012-13		2013-14		2014-15	
Examples:	Status	%	Status	%	Status	%
Home will be the first place considered for discharge post acute treatment – Recommitment to Home First Philosophy.	Initiated	100				
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.	Ongoing	100				
All hospitals will undertake intensive case management reviews using standardized tool and process on all patients with ALC > 30 days, with a discharge plan documented on the chart. Compliance target 80%.	Initiated	100				
All LHIN hospitals will follow an escalation process for designation patients ALC – LTC.	Initiated	100				
Implement integrated program for Complex Care (CC) beds (dependent on availability of resources to support new model).	Initiated	30		30		40
Transition appropriate patients to CC restorative settings as part of the integrated CC plan.	Initiated	20		30		50
Implementation of risk screening tool in the ED for individuals at high risk of admission and if admitted being designated ALC (percent of hospitals implemented).	Initiated	40		20		40
Implementation of Increased CCAC services for High Risk Seniors (pending confirmation of continued funding in 2012-13).	Piloted in 2011-12					
	Initiated	100				
Continue to support increased capacity in LTCHs (interim beds) as a short-term strategy.	Ongoing	100				
Facilitate early discharge of seniors back to LTCH through Nurse Practitioners (NP) in LTCH program (target to be identified).	Ongoing	25		50		25
Expand Assisted Living Services across the LHIN as described in Community section.	TBD					

Describe how you measure success:

- Reduce the number of days patients wait in acute care beds for an alternate level of care as measured by a decreasing acute ALC rate, target 11% or less.
- Reduce the number of patients that wait >30 days in hospital to transition to a post acute care setting (baseline data and target to be identified).
- Decrease the number of individuals that wait in hospital for LTCH (draft target to be confirmed < 180).
- Clients served through AR units based on occupancy rates >95% will have a median LOS of ≤ 45 days.
- Over 70% of clients admitted to AR units will be able to return to a home 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 an occupancy rate of >90% and median LOS of 50 days.
- Decrease number of patients admitted through ED designated ALC within two days admission to acute care (new baseline 2010-11 440).
- 80% of all patients identified as requiring ALC for longer than 30 days will undergo intensive case management review and have a discharge plan documented.
- LHIN ED 90th percentile wait time for admitted patients will be < 28.3 hours.
- Reduce the number of newly designated acute ALC-LTC to a stable 40 per month across all hospitals.
- 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 (baseline and target to be determined).
- Reduce the number of patients ALC-LTC in complex care beds to 20%.

What are the risks/barriers to successful implementation?

- Demand and success of Home First resulting in increased pressure on CCAC resources.
- Hospitals may experience costs associated with negotiating labour costs that exceed their funding increases.
- LHIN demographics and availability of LTCH resources.
- Availability of health human resources (HHR) in acute, LTCH and community settings.
- Ongoing funding to support initiatives that were funded with one time funds i.e. NLOT to LTCH.
- Individuals/families 'sense of entitlement' that they can wait in a hospital bed until their choice of discharge destination is available.

Mitigating Strategies:

- CCAC and hospitals to work together to maintain a bed management strategy that supports system flow.
- LHIN providers' ongoing commitment to early discharge and Home First approach, reducing the number of newly designated ALC.
- Optimize opportunities for ALC settings.
- LHIN communication strategy as to what services people can expect in hospital and LTC.
- Optimize clients' ability to improve functional status post-acute care through admission to AR/convalescent /Restorative streams in CC programs.
- Transition on CCAC low acuity clients waiting for personal support and home care to CSS providers.
- 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.

What are some of the key enablers that would allow us to achieve our goal?

- Increased collaboration and accountability of primary care for identification of high risk seniors prior to presentation in a hospital ED.
- Increased integration of community support services.
- Process that ensures minimum time to placement in LTCH once bed is available.

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:

Access to Care – Patient Flow ED Access to Care – focuses on improving access to emergency services by

- Improving ED performance.
- Reducing the number of non-urgent or avoidable presentations.
- Reducing time individuals admitted through the ED wait for an inpatient bed.

Current Status:

The HNHB LHIN has 13 hospital EDs across ten hospital corporations. In 2010, LHIN EDs saw over 463,000 visits.³⁵ The majority of ED visits (327,000) are seen at eight EDs, all of which are participating in the Provincial Pay for Results (P4R) strategy.

The HNHB LHIN hospitals in the first quarter (Q1- April 1 to June 30, 2011) of 2011-12, reported unscheduled ED visits of 90 per 1,000 population. The rate has been relatively consistent over the last year and continues to be lower than the provincial average (99).³⁶ In 2010-11, 31 % of all ED visits were classified as Canadian Emergency Department Triage and Acuity Scale (CTAS) 4 and 5 (low acuity), a 2% decrease from 2009-10.³⁷

In the last two fiscal years, 2009-10 and 2010-11, the LHIN has seen an overall 2-3% increase in ED volumes.

In November 2011, the ministry reported to the LHIN that the ED LOS at the 90th percentile for all sites and those P4R funded sites for Q2 were as follows:³⁸

All Sites:

- Admitted patients - 31.1 hours, which is lower than 2010-11 Fiscal Year Baseline (38.9 hours).
- Non-admitted high acuity patients – 7.7 hours, an improvement over 2010-11 Fiscal Year Baseline (7.9 hours).
- Non-admitted low acuity patient – 4.8 hours, no change since 2010-11 Fiscal Year Baseline (4.8 hours).

³⁵ National Ambulatory Care Reporting System

³⁶ MOHLTC Provincial Health Database and CIHI – National Ambulatory Care Reporting System

³⁷ National Ambulatory Care Reporting System

³⁸ Public Reporting and Year 4 Hospital Comparison Report, November 2011

P4R Sites:

- Admitted patients - 30.9 hours 2010-11 baseline (40.7 hours).
- Non-admitted high acuity patients - 8 hours 2010-11 baseline (8.2 hours).
- Non-admitted low acuity - 5.4 hours 2010-11 baseline (5.3 hours).
- Despite the challenges LHIN hospitals faced to improve wait times for admitted patients, related to patient flow pressures, the greatest improvement was seen with the admitted ED population. For non-admitted high acuity patients, the LHIN has decreased wait times by 6.5 hours (33% improvement) since Q2 2008/09 despite a 19% (12,973) increase in high acuity visits.

Key issues for this client population:

- Availability of acute care beds. As of October 30, 2011, LHIN hospitals reported 503 patients designated ALC in both acute and other inpatient beds, 35% (176) waiting for LTCH placement, 21% (105) Home with CCAC services.³⁹
- Infection control protocols and facility outbreaks further compound current flow challenges for admitted patients, LHIN hospitals report individuals admitted through the ED requiring isolation can experience wait times twice as long as those who do not require isolation (55 vs. 24 hours).⁴⁰
- 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:

- Two LHIN funded General Internal Medicine Rapid Access Clinics at Q2 2011-12 reported 1,765 first visits and 623 follow up visits, 314 ED diversions and 171 early hospital discharges. For this program's target population there was a reduction in ED LOS of 59.5%-69% and an admission rate reduction of 62.5%.⁴¹
- As of Q2 2011-12 LHIN ED wait time for admitted patients was 31.1 hours, which is lower than 2010-11 Fiscal Year Baseline (38.9 hours).⁴²
- Four LHIN hospitals implemented Medical Short Stay Units (MSSU), three of which were funded through the P4R strategy. These units are intended to increase acute in-patient bed capacity, targeted to individuals admitted through the ED and are expected to be discharged from hospital within 72 hours.
- The LHIN has piloted an early intervention screening tool (a modified interRAI ED screener) for individuals aged 75 years and older in the community in Burlington (targeted at primary care) and at two LHIN hospitals (Brant Community Healthcare System and Norfolk General Hospital).
- Preliminary data from the community pilot demonstrated that 100% of the referred clients using the screening tool required services in the community. Although no data is yet available from the hospital pilots, clients scoring high enough with the tool are referred to CCAC to be seen in the ED. Clients scoring high enough for a referral to CCAC and those admitted to hospital are followed up. P4R funding supported all eight P4R EDs 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. Year to date (YTD) (Q2) all eight P4R sites have improved over their

³⁹ Acute Level of Care Information System

⁴⁰ NHS 90th percentile Wait time during C-Diff outbreak April 2011

⁴¹ HNHB LHIN Aging at Home Quarterly Performance Reports

⁴² Canadian Institute for Health Information – National Ambulatory Care Reporting System

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.⁴³

- For non-admitted high acuity patients LHIN P4R sites report 89-90% seen within target, despite treating approximately 9,000 more patients the first two fiscal quarters this year over those seen 2009-10.⁴⁴
- 5,234 residents were attached to primary care through HealthCareConnect since February 2009.
- 2,036 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.
- Continued implementation of community ED avoidance programs funded through Aging at Home, for example:
 - o 726 Francophone clients seen at the Mobile Primary Care Clinic (MPCC) or in their home as of Q2.
 - o 887 new clients with diabetes seen at foot care clinics. These clinics report a decrease in ED use and falls.
 - o Specialized Geriatric Services expanded to Haldimand and Norfolk, at Q2 2011-12, 301 new clients served, 110 clients served by Intensive Geriatric Services Worker. Median wait time from referral to assessment for crisis is two days.⁴⁵

⁴³ Public Reporting and Year 4 Pay4R Hospital Comparison Report

⁴⁴ Public Reporting and Year 4 Pay4R Hospital Comparison Report

⁴⁵ HNHB LHIN Aging at Home Quarterly Performance Reports

PART 2: GOALS and ACTION PLANS

Goal (s):

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

- Improving hospital processes:
 - o Increase ED capacity by streamlining internal flow processes (P4R and ED PIP initiatives).
 - o 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.
 - o Increase acute care capacity for short stay inpatient admissions.
 - o Enhanced accountabilities and reporting from senior administration at poor performing hospitals.

Avoiding ED visits:

- Reduce the number of avoidable ED visits by increasing access to other appropriate settings (i.e. urgent care settings, primary care) and implementation of a risk screening tool by primary care for high risk seniors.
- Identify and implement strategies targeted at select populations (i.e. with chronic conditions) with conditions that could best be managed elsewhere (refer to Chronic Disease Prevention Management (CDPM) section).
- Expand existing NLOTs to LTCHs.
- Continue to support Internal Medicine Rapid Access (IMRA) Clinics in Hamilton.
- Expand use of Community Referrals by EMS (CREMS) to improve supports for clients in the community.
- Implementation of the Integrated Provincial Falls Prevention (FP) Framework and Toolkit as mandated by the ministry.
- Identify and implement strategies to reduce repeat unplanned visits by individuals with mental health and substance abuse conditions (refer to MH&A section).

Consistency with Government Priorities:

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

- Improve access to care to acute and post acute care services as measured by:
 - o reduce ED wait times
 - o 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: "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.					
	2012-13		2013-14		2014-15	
Examples:	Status	%	Status	%	Status	%
Implement internal ED processes identified through LHIN PIP initiative.	Ongoing	100				

Assess expansion of pilot ambulance transfer to Urgent Care Centre (UCC) for low acuity clients in Hamilton (pending outcome of pilot results).	TBD					
Implement P4R strategies (pending confirmation of P4R funding in 12-13).	Ongoing	100				
Sustain CCAC case managers in LHIN EDs with volumes at or exceeding 30,000 annually.	Ongoing	100				
Implement six community assessment clinics for SGS Niagara.	Ongoing	100				
Increased transitions of non-urgent cases from ED to UCC as a result of Hamilton Health Sciences - Access to Best Care Plan.	Ongoing	100				
Expand use of CREMS to improve supports for clients in the community.	Ongoing	25		25		25
Implementation of risk screening tool in primary care (target to be identified).	Ongoing	TBD		TBD		TBD
Implementation of strategies to facilitate an integrated approach to falls prevention, consistent with the Provincial FP Framework.	Ongoing	40		40		20
Continued implementation of LHINs Fall Strategy with modifications to programs.	Ongoing	50		25		25
Sustain NP outreach program in LTCHs with high ED transfer volumes (pending confirmation of ongoing one-time funding).	Ongoing	25				
Expand NP outreach program in LTCHs with high ED transfer volumes (pending confirmation of ongoing one-time funding).	Ongoing	25				
Facilitate early discharge of seniors to LTCH through NP in LTCH (target to be identified).	Ongoing	25		25		25

Describe how you measure success:

- Ministry-LHIN Performance Accountability Agreement (MLPA) ED wait time targets are met or below baseline.
- LHIN hospitals ED P4R wait time targets are met or below baseline.
- Reduce the number of ED visits to 88 per 1,000 people from current level of 90.
- Reduce the number of LTCH ED visits that do not result in admission by 5%.
- Refer to CDPM section for outcomes related to targeted population with chronic conditions.
- MSSU achieve targets by improving or maintaining “time to admission decision” and by reducing “time to inpatient bed” to eight hours.
- 510 clients referred from ED to Hamilton IMRA outpatient.
- CREMS expanded to Niagara.
- Percent of seniors identified as high risk through screening tool referred to CCAC that needed new or enhanced services.
- Number of hospital EDs implemented risk screening tool.
- Number of primary care settings that implemented risk screening tool.
- Fewer seniors are admitted to hospital as a result of a preventable fall.
- Reduction in avoidable ED visits as a result of a fall.
- Reduction in premature admissions to LTC homes and ALC days as a result of a fall.

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.
- Impact of infection control outbreaks that result in increasing ED wait times.
- 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 implement strategies to improve patient flow for admitted patients.
- 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.

What are some of the key enablers that would allow us to achieve our goal?

- Collaboration with HealthforceOntario to prevent ED closures due to physician staffing challenges.
- Continued financial support for the P4R initiatives.

3.1. iii. Behavioural Supports Ontario (BSO)

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Patient Flow – Improve patient flow and reduce ED visits for individuals with challenging and responsive behaviours in the BSO target population.

IHSP Priority Description:

- Improve patient flow by reducing the time individuals (BSO target population) with history of responsive behaviours wait in hospital for an alternate care setting.
- Reduce the number of presentations to ED by individuals due to behaviours in BSO target population, from LTCHs or the community.

Current Status:

In August 2011, HNHB LHIN was identified, along with three other Ontario LHINs, as an Early Adopter LHIN to implement the BSO Framework and operational program model.⁴⁶ This approval marked the beginning of phase two of the BSO project.

To guide local health system redesign for behavioural support services within the BSO Framework the LHIN developed an Action Plan that identifies improvements which will result in a desired future state by addressing current gaps and duplications in the system and enhancing and reconfiguring existing services.

This future state will address the client's needs and support client and family-directed care along the continuum. The improvement plans have been developed based on the following client value statement:

"I am who I am so help me continue to be me".

Key improvement strategies for the HNHB LHIN Action Plan include; capacity building for primary care to effectively manage clients in the community; a centralized information and referral process designed to link the client/family with appropriate services; the establishment of an integrated community lead agency model to coordinate services and create a single point of contact for clients/families; and interdisciplinary mobile teams in the community and long term care who will build capacity and support smooth transitions for clients across the system.

Key issues for this client population:

- Lack of a centralized intake process to provide timely access to the appropriate services and supports.

⁴⁶ Behavioural Supports Ontario, Implementation Kick Off Presentation, Alzheimer Society Ontario, Alzheimer Knowledge Exchange, Ontario LHINs: August 2011

- Absence of a coordinated integrated system of care, managed through formalized partnerships with assigned accountability for the clients'/caregivers' care needs.
- Communication among HSPs (primary care, geriatric specialists, acute care, community agencies and LTC) specific to a client's health status or care plan is delayed, inconsistently shared or nonexistent.
- Absence of a system to respond to crisis in the community or long term care setting.
- Absence of support during key transition points.

Successes of the past year:

- HNHB LHIN was approved as an "early adopter LHIN" to implement the Behavioural Supports Ontario (BSO) framework.
- Endorsement of the LHIN Action Plan by BSO Provincial Resource Team and Health Quality Ontario (HQO) team.
- Development and pilot testing of three LHIN BSO Improvement Plans.
- Identification of lead LTCH for new LTCH staff, with recruitment of 100 percent of new BSO staff complete.

PART 2: GOALS and ACTION PLANS

Goal (s):

To improve the quality of life and quality of care for individuals (and caregivers) of seniors with challenging and responsive behaviours regardless of where they live by:

- Improving access to information and support services and system coordination for individuals (caregivers) with responsive behaviours as measured by reduced number of ED visits for behaviour related issues.
- Reducing resident transfers from LTC to acute or specialized unit for behaviours.
- Delayed need for more intensive services, reducing ED visit, hospital and behaviour unit admissions and risk of alternate level of care (ALC).
- Reduced length of stay (LOS) for persons in hospital who can be discharged to a LTC Home with enhanced behavioural resources.

Consistency with Government Priorities:

Supports ministry priorities to:

- Support seniors with behaviour changes to remain in their homes longer.
- Reduce the time individuals with behaviours wait for an alternate level of care in hospital.
- Increase LTCH capacity to care for individuals with responsive behaviours.
- Reduce ED visits for individuals for behaviour related issues from LTCH or home.

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.					
	2012-13		2013-14		2014-15	
<i>Examples:</i>	Status	%	Status	%	Status	%
Implement Five LTCH Mobile BSO Teams across the LHIN.	Roll out of pilot model	75		25		
Implement a Community Lead Agency model of clients (caregivers) in the community with behaviour related issues.	Roll out of pilot model	25		50		25
Implement a BSO Community Mobile Response Team Model across the LHIN.	Roll out of pilot model	25		50		25
Uptake of Primary Care Tool Kit for responsive behaviours (number to be determined by subcommittee).	Roll out of pilot model					
Identify a single point of entry process for information and referral.	Roll out of pilot model	75		25		
Describe how you measure success:						
- Reduced resident transfers from LTC to acute or specialized unit for behaviours. - Delayed need for more intensive services, reducing admissions and risk of ALC. - Reduced LOS for persons in hospital who can be discharged to a LTCH with enhanced behavioural resources. - Specific measures related to each improvement plan project.						
What are the risks/barriers to successful implementation?						
- Availability and successful recruitment of additional BSO staff. - Time needed to train new staff may interfere with roll out of new models. - Timelines to develop and test improvement protocols. - Timeline for full implementation. - Sustaining improvement gains once model has been implemented. - Union and labor related issues re mobile team model in LTCHs. Mitigating Strategies: - LHIN Human Resources (HR) Working Group to identify issues and resolutions. - Optimize one-time funds to develop and test models in 2011-12. - Share learnings between LHINs on successful and unsuccessful models/strategies.						

What are some of the key enablers that would allow us to achieve our goal?

- Ministry revised funding policy for BSO services in LTCH.

3.1. iv 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 coordinated across hospital sites to improve access, quality, and efficiency. Integrated service delivery models 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 of care. 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 LHIN Board has now approved the integrated service delivery model frameworks for all, except rehab, which is in process.
- A common LHIN-wide credentialing and annual reappointment package has been implemented 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 develop integrated clinical service delivery models 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 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.					
			2012-13		2013-14		2014-15	
<i>Examples:</i>			Status	%	Status	%	Status	%
Complete implementation of integrated program for CC.			In progress	100				
Implement integrated programs for cancer care, rehabilitation, vascular, laboratories and thoracic.				60		40		
Continue on a phased-in basis the development of other LHIN-wide integrated program plans.				20		20		20
Determining Clinical Service Plans for 2012-13 in conjunction with HNHB LHIN Clinical Vice Presidents (VPs) and Chief Medical Leaders.			In progress	100				

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. • Improved access with care provided closer to home.
What are the risks/barriers to successful implementation?
• Cost of restructuring – lack of available 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 labour agreements may impact timing of implementation where resources need to move. • Inadequate resources may be allocated to change management strategies to build coherent new teams and units. Mitigating Strategies: • Ensuring integrated plans are cost neutral. • Follow local eHealth plan and capitalize on external opportunities. • Build principles, processes and sustainability into transition plans. • Engage physician and human resource leadership in processes.
What are some of the key enablers that would allow us to achieve our goal?
• Physician engagement. • Consistent integration tools, templates and processes utilized throughout each planning and integration process will ensure success of our goals.

3.1. v. 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:
LHIN IHSP: improve access to care by enhancing community capacity. Capacity to be enhanced by actively advancing integration as a means to realign existing resources to optimize access, quality and efficiency of services.
Current Status:
Five community-sector led, inter-sectoral planning tables – referred to as Community Continuum Collaboratives, have been convened covering the LHIN geography. Representation includes: community support services, CCAC, housing, hospital, primary care, community mental health and addiction agencies, as well as non-LHIN funded organizations that provide human services and social supports in the community. The role of these Collaboratives is as follows: • Align initial planning with the ministry's 'Updated Assisted Living Policy for High Risk Seniors', January 2011. • Describe the health service needs of the local population, with an initial focus on maintaining frail/high risk seniors in the community. • Describe current state: barriers, gaps and duplications in services for the target population. • Describe an ideal future state for an integrated service delivery model. • Identify opportunities for realigning existing roles and resources to optimize access to care, quality of care and system efficiency. Key Issues: • It is a challenge to facilitate collaborative planning among a large number of community sector agencies with different mandates and varying levels of expertise and capacity. • Advancing the realignment and integration of services across the community sector will require strong guidance and support, and potentially resources from the LHIN. • Clear direction from the ministry and LHIN is needed to address community sector perception that the ministry's 'Updated Assisted Living Policy for High Risk Seniors', January 2011 is still in draft stages as well as the lack of clarity regarding the impact of implementation of the enhanced role of CCAC in providing intake for assisted living/supportive housing. • Lack of clarity regarding the expectations of ministry and LHIN regarding 'integration'. Successes: • Community agencies are actively chairing and participating in the work of the community continuum collaboratives.

PART 2: GOALS and ACTION PLANS

Goal(s):

- Strengthened partnerships and shared accountability among health service providers to sustain collaborative, inter-sectoral and evidence-based planning and delivery of services.
- Improved coordination of services across the continuum of care to support seamless transitions across care settings.
- Improved access to care to enable frail/high risk seniors to live independently in the community.
- Optimize the use of existing resources by reducing duplication, realigning roles, sharing back office functions and advancing integration.
- Implementation of the common assessment tool InterResident Assessment Instrument (InterRAI) Community Health Assessment (CHA) across the CSS sector to streamline the assessment function, facilitate inter-agency communication, care planning and system navigation.

Consistency with Government Priorities:

The Collaboratives will identify health service and community support needs of high risk seniors, service gaps/duplications and opportunities for improved coordination and integration of services. This work is consistent with government priorities to reduce ALC - as per the recommendation by Dr. David Walker, Provincial ALC Lead, in the Report to Minister of Health and Long-Term Care (Minister): "Caring for our Aging Population and Addressing Alternate Level of Care", 2011. The recommendation is as follows: "To support the principle of caring for seniors and others with complex needs in their homes, investments must be realigned and refocused to build and sustain the capabilities of community-based providers and programs."

The work of the Collaboratives will align the health service and community support sector with the ministry's 'Updated Assisted Living Services for High Risk Seniors (ALSHRS) Policy', January 2010.

The Collaboratives will be leveraged to implement the community sector component of the LHIN's Behavioural Support Action Plan to align with BSO project.

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.					
	2012-13		2013-14		2014-15	
Examples:	Status	%	Status	%	Status	%
Implement a pilot project in one geographic area of the LHIN to develop an integrated service delivery model aligned with the ministry's ALSHRS policy.	completed	100				
Describe unmet service needs of high risk seniors within sub-LHIN geographic areas.	Initiated	100				
Undertake an environmental scan to identify opportunities for shared back office functions.		100				
Develop system inventories to identify service gaps/duplications.		100				
Identify opportunities to address unmet needs and to align with ALSHRS policy and LHIN BSO Action Plan within existing		100				

resources through realignment of mandates/catchment areas/programs/services, integration, shared services, etc.						
Develop implementation plans to realign, integrate and share services.		50		50		
Identify performance measures to sustain shared accountability among HSPs across the continuum of care for common patient/client populations.		50		50		
Implementation of realignments, integrations, etc.		20		50		30
Continued implementation of the InterRAI CHA with the CSS sector.	In progress	50		50		
Implementation of the Integrated Assessment Record (IAR) which will allow HSPs to share assessment results if they are in the client's circle of care.	initiated	25		25		25
Describe how you will measure success:						
- Local Collaboratives are meeting regularly to sustain system responsiveness to evolving service needs in the community. - Complementary performance measures are in Service Accountability Agreements to support shared accountability among health service providers. - Fewer seniors are presenting to hospital with preventable conditions. - Reduction in avoidable ED visits and inpatient admissions among high risk seniors. - Reduction in premature admissions to LTCHs. - HSPs have realigned their mandates, programs and services to provide distinct roles in an integrated system of care which supports seamless transitions across care settings. - A greater range of community based care options that enable frail/high risk seniors to live independently in the community. - Reduced duplication of services and more cost effective use of resources.						
What are the Risks/Barriers to Successful Implementation?						
- Resistance to change mandates/programs/services. - Accountability for implementation and sustaining gains of collaboration. - Knowledge gaps for quality and health information methodologies. - Resistance to integration opportunities, (e.g. shared back office functions). - Cost of restructuring – lack of available one-time funding for restructuring may impede ability to participate. - Practice and cultural barriers – different styles of practice, culture and administration may lead to conflict. - HR labour agreements may impact timing of implementation where resources need to move. Mitigating Strategies: 'Reward' those agencies that are proactive in realignment and integration activities that contribute 'value' (i.e. improved quality for least cost) to the system, (e.g., resources for program expansion).						

Leverage the service accountability agreements and Quality Improvement Plan (QIP) roll out to community sector to facilitate implementation of required realignments and quality improvement objectives, respectively.
What are some of the key enablers that would allow us to achieve our goal?
Funding incentives to HSPs who collaborate, integrate, share services, realign programs/services, etc.

3.1. vi. 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:
The LHIN currently provides funding to two Aboriginal health service providers – De dwa da dehs nye>s (The Aboriginal Health Access Centre) and Native Horizons Treatment Centre – and to two First Nations – Six Nations of the Grand River Territory, and Mississaugas of the New Credit. There are a number of other Aboriginal health service providers in our LHIN, such as the three friendship centres, that are not currently eligible to receive funding from the HNHB LHIN. The HNHB LHIN and the Aboriginal Health Network (AHN) are currently undertaking an inventory of programs and services to better understand the scope of services provided and the numbers and types of providers who deliver health services to Aboriginal people in our LHIN. We are also working with mainstream providers to understand the use and/or lack of use of these services among Aboriginal people. As described in 'Our Health Counts: Urban Aboriginal Health Database Research Project' which is a community report on First Nations Adults and Children in the City of Hamilton, the key issues for Aboriginal health are identified below. When compared to other Hamilton residents: - Socioeconomics - The Aboriginal population has higher rates of transient housing, homelessness, and crowded housing. They have higher rates of spending more income on shelter-related costs giving up important things to meet shelter-related costs, and higher rates of not having enough food to eat. They have lower levels of education and dramatically lower incomes. - Health Status - The Aboriginal population has much lower self-reported health status. They also have three times the diabetes rate, twice the asthma rate, and higher rates of high blood pressure, arthritis, and hepatitis C. - Health Behaviours - The Aboriginal population has three times the rate of smoking and twice the rate of heavy drinking. - Health Utilization - over 50% of the Aboriginal population had visited the ED at least once in the past two years (22%). 10.6% report six or more visits (1.6%). Successes of the past year: - The Aboriginal Health Network has found new energy and focus. They are meeting monthly and are actively planning for the priorities they have identified: Children and Youth Mental Health and Addictions (CYMHandA), Sexual Health, and Traditional Healing.

- De dwa da dehs nye>s has successfully recruited four interim physicians – this is a dramatic change from the one physician they previously had. This will help address issues with long waits to see primary care.

PART 2: GOALS and ACTION PLANS

Goal(s):

- Reduce health disparities.
- Improve family and child health.
- Reduce chronic disease.
- Connect more Aboriginal people without a family doctor to primary care.

Consistency with Government Priorities:

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

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.					
	2012-13		2013-14		2014-15	
Examples:	Status	%	Status	%	Status	%
Connect Aboriginal people to primary care.	ongoing		ongoing		ongoing	
Connect Aboriginal persons living with mental health issues to appropriate services through sessional fees (psychiatric consultation).	ongoing		ongoing		ongoing	
Implement common assessment in CSS and MH programs.	In progress	50		50		
Work with the AHN to plan for the needs of the Aboriginal population.	In progress	25		25		25
Convene Cultural Sensitivity and ‘Planning for Aboriginal Health’ Workshops with local health service providers.	In progress	50		50		

Describe How You Measure Success:

- Reduced burden of illness among Aboriginal people.
- Increased rates of self-management by Aboriginal people with chronic diseases.
- Increased rates of successful referrals between Aboriginal primary and secondary care providers.
- Increased participation rates of Aboriginal people in diabetes prevention and management programs.

- Reduced unplanned presentations to the ED by Aboriginal people:
 - living with MH&A and substance abuse issues
 - who otherwise do not have access to primary care.
- Uptake of common assessment tools among Aboriginal providers.
- Increased participation by Aboriginal communities, stakeholders and networks in planning and decision-making.
- Increased accountability and capacity among mainstream health service providers to provide services that meet the needs of Aboriginal people.
- Improved experience of care by Aboriginal people receiving health services in our LHIN.

What are the Risks/Barriers to Successful Implementation?

- High turnover of staff in both Aboriginal HSPs and mainstream HSPs.
- Lack of qualified HHR that are culturally competent.
- Negative preconceived notions of the capacity of Aboriginal providers.
- A lack of understanding of the effect of historical legacies and the social determinants of health in the Aboriginal population.
- Continued impact of socioeconomic factors on aboriginal health beyond mandate of providers.

Mitigating Strategies:

- Formalize relationships with HSPs so that there are clear pathways of communications that are not as reliant on personal connections, reducing the impact of high staff turnover.
- Continue to work with AHN to increase sensitivity and awareness (both at the LHIN level and local level) of the needs of the Aboriginal population and the successes of Aboriginal providers in addressing some of those needs.
- Facilitate the building of relationships that:
 - Help people and providers develop an understanding of the effect of historical legacies and the social determinants of health in the Aboriginal population.
 - Help connect Aboriginal and mainstream providers, enabling them to work together to plan for accommodating the needs of Aboriginal people.
 - Encourage all providers to consider and mitigate the impact of socioeconomic factors on how Aboriginal people access health services.

What are some of the key enablers that would allow us to achieve our goal?

- Time and commitment to building positive relationships:
 - between the LHIN and Aboriginal providers
 - between Aboriginal providers and mainstream providers.
- Building appropriate accountabilities into Service Accountability Agreements (SAAs) for considering and planning for the needs of their Aboriginal clients.

3.1.vii. 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 <i>French Language Services Act (FLSA) Ontario, 1986</i>, 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 <i>FLSA</i> 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 Language (FL) speaking health professionals are in short supply; programs and services are not sensitive 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: The <i>Entité de planification pour les services en français dans les régions de Waterloo, Wellington, Hamilton, Niagara</i>, the French Language Health Planning Entity (FLPE) for HNHB and Waterloo-Wellington (WW) LHINs is operational: • A Joint Liaison Committee was created with a mandate to develop appropriate mechanisms for collaboration and ongoing dialogue and to develop a Joint Annual Action Plan (JAAP). • The JAAP was developed and sets out, priorities and actions for each LHIN and the Entity. • The LHINs and the FLPE are establishing positive working relationships which will facilitate reaching our mutual goal of improving access to health services in French for our francophone communities. Presentations and discussions with FLS-identified agencies increased knowledge and awareness of the <i>FLSA</i>, the LHINs role and mandate and the obligations of HSPs. As a result, the following have been noted: • An increasing level of engagement of staff and departments as seen by responses in reports and increased request for information on FLS. • 100% of agencies that are identified to provide services in French have completed a FLS report. • Increased number of agencies are requesting translation services. • FLS perspectives are becoming integrated in processes at the LHIN (i.e. Aging at Home program review, communications, IHSP development, local SAA indicators for FLS-identified agencies).

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 <i>FLSA</i> and <i>Local Health Systems Integration Act (LHSIA)</i>, 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: "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.					
	2012-13		2013-14		2014-15	
<i>Examples:</i>	Status	%	Status	%	Status	%
Increase awareness and knowledge of FLS in all LHIN HSPs.	in progress	25		25		25
Assess capacity to provide services in French in health service organizations:						
FLS-identified and designated agencies.	In progress	100	Yearly Review		Yearly review	
All HSPs in Hamilton and Niagara regions.	Not yet started			50		50
All HSPs in Brant, Burlington, Haldimand-Norfolk.	Not yet started					50
Engage and work with the Waterloo Wellington Hamilton Niagara (WWHN) FLS Planning Entity (PE) to meet objectives set out in the 2012-13 JAAP	On-going	100				

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).	On-going					
Contribute to the development of tools and templates to evaluate/measure FLS capacity and performance.	In progress	50		25		25
Describe how you measure success:						
• Number of agencies who completed and submitted French Language Implementation Plan (FLIP). • Progress report on implementation of plan: ○ Number of FL-identified agencies who put a mechanism in place to identify Francophone client. ○ Number of FL-identified agencies who have FL speaking staff/health professionals. ○ Steady increase in these numbers from year to year; agencies indicate progress in implementing their plan. ○ Improved health status of Francophones. ○ Increased satisfaction of Francophone clients. ○ Increased number of FL-identified agencies using translation services. ○ Francophone clients have increased access to health information in French. ○ Number of FL-identified staff taking FL training.						
What are the risks/barriers to successful implementation?						
• Lack of FL health professionals able to provide services in French. • Variable commitment among stakeholders to meeting the needs of FL speaking people. Mitigation: • Assess capacity of providers. • Increase awareness and knowledge of providers with issues. • Work with FLPE.						
What are some of the key enablers that would allow us to achieve our goal?						
• The FLPE is operational and can assist the LHIN in engaging community, identifying gaps, bringing solutions through participation at LHIN planning tables. • More research on health status of individuals living in a minority situation. • Training of French-speaking health care professionals. • Access to translation services.						

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.⁴⁷ 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.⁴⁸ Successes in the Past Year: • Foot care programs for people with diabetes at a high risk for complications continue to operate. The community based program <i>Feet First</i>, led by North Hamilton (NH) CHC is now operational in six communities over nine sites throughout Niagara, Hamilton and Burlington, exceeding original plans. In 2010-11 the program benefited 1,831 people with diabetes at a high risk for foot complications. The program has been successful in decreasing the rate of new ulcers among their clients – from 12% in the first year to 4% currently. The evidence shows that early identification and management of independent risk factors for ulcers and amputations can prevent or heal diabetic foot ulcers significantly reducing the amputation rate. • The hospital-based foot care program, <i>Best Foot Forward</i>, for dialysis patients with diabetes operates at all dialysis sites in the LHIN. As a result of this program, standardized foot care assessments are occurring at all the dialysis centres in the LHIN. In 2010-11, 305 clients were served by the program, during this time the number of new foot ulcers reported was less than 20. • Three working groups in Fort Erie are addressing three distinct priority areas related to CDPM that were identified by community stakeholders. The three priority areas are: increasing access to community services, increasing access to chronic disease self-management (CDSM) programs in the community and decreasing the obesity rate. ○ The Self-Management Working Group led by Bridges CHC has successfully hosted two CDSM programs for individuals with chronic conditions. ○ The Access Working Group has reviewed data specific to Fort Erie and is focusing on interventions that will address the community support needs of individuals who use ED five or more times a year. ○ The Obesity Working Group has identified a need for healthy lifestyle management programs that are available at no cost to residents. Bridges CHC has filled this gap and service and delivered the “Healthier You” lifestyle management program to residents of Fort Erie.

⁴⁷ Chronic Conditions in the Hamilton Niagara Haldimand Brant LHIN. Health System Intelligence Project October 2007

⁴⁸ HNHB LHIN Chronic Disease Prevention and Management Diabetes Action Group Report, December 2008

- Strengthened relationship with Diabetes Regional Coordinating Centre (DRCC) to leverage resources and to work collaboratively to achieve goals of Ontario Diabetes Strategy (ODS) within our LHIN.
- Supported the roll out of the LHIN-wide Self-Management in collaboration with the lead agency, Hamilton Health Sciences Corporation (HHSC). This included aligning the Fort Erie Self-Management Working Group with the LHIN-wide strategy and fostering relationships with health service providers to encourage the uptake of self-management practices and programs.
- CDPM Advisory Committee re-confirmed LHIN's CDPM priorities and added decreasing 30 day readmits to the priorities.
- CDPM Advisory Group agreed to strike a Working Group to address 30 day readmits. The Working Group will focus on the Congestive Heart Failure (CHF) Case Mix Group and standardize the uptake of best practice and improve transitions of care related to CHF.
- Continued development of the LHIN-wide Primary Care Network to facilitate linkages with CDPM priorities and other ministry/LHIN priorities.
- Specific Diabetes Education Programs expanded to focus on the mental health and addictions and homeless populations as they are at a significantly higher risk for complications from diabetes than the rest of the population.

PART 2: GOALS and ACTION PLANS

Goal (s):

- Reduce the prevalence of chronic conditions.
- Provide a local health care system that meets the needs of people with chronic conditions.
- Align with LHIN municipalities and other ministries to improve the health of the population.
- Align the CDPM Advisory Committee priorities with Provincial priorities, Ontario Diabetes Strategy (ODS), DRCC, Ontario Renal Network (ORN) and other relevant priorities.
- Engage family physicians and primary care nurse practitioners to provide input on LHIN initiatives.

Consistency with Government Priorities:

- The LHIN's focus on CDPM aligns with the ministry's priorities to:
 - o Reduce ED visits and wait times, improve patient flow.
 - o Reduce hospital wait times.
 - o Decrease ALC days and decrease pressures on LTCHs.
- The HNHB LHIN CDPM priorities are determined in alignment with ministry priorities including:
 - o ODS
 - o ORN
 - o Assisted Living Policy.

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.					
	2012-13		2013-14		2014-15	
<i>Examples:</i>	Status	%	Status	%	Status	%
Expand LHIN-wide Self-Management Strategy.	Ongoing					
Expand foot care services for people living with diabetes who are at a high risk of developing foot care complications.	Ongoing					
Implement standardized practice guidelines.	Ongoing					
Maintain change coalitions to achieve Triple Aim outcomes that enhance the prevention and management of chronic conditions until they are fully implemented.		25		25		25
Continue to develop an action oriented Primary Care Network in collaboration with the appointed LHIN Primary Care Lead.		50		50		
Describe how you measure success:						
- Improved client/patient experience. - Avoidable ED visits and hospitalizations for populations with diabetes and congestive heart failure (CHF) are reduced. 30 day readmits for CHF population is 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. - Significant HSP coordination required to address readmission rates. - Practice changes required to improve patient transitions implemented without sustainability or robust change management strategy. Mitigating Strategies: - Collaborating with the LHIN eHealth lead to increase the number of primary care providers with EMRs . - Engaged with Public Health Departments throughout the LHIN to work collaboratively where possible to address risk factors for chronic conditions. - Developing an action oriented Primary Care Network. - Developing a subcommittee for readmission rates specifically related to CHF with the intention to apply approach to other diseases.						

- Collaborating with LHIN eHealth lead to increase the number of LHIN primary care providers using ClinicalConnect to improve communications related to the transition from hospital to home (see eHealth section).

What are some of the key enablers that would allow us to achieve our goal?

- Tools/algorithms/pathways/common positive messaging to facilitate system navigation/continuity of care at transition points of care.
- Linking readmission priorities to HQO QIP and accountability agreements.
- A provincially led integrated approach to vascular health.

3.3 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:

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&A services.
- Based on the 2009 “Every Door is the Right Door”, one in five Canadians will be affected by mental illness at some point in their lives (an estimated 280,000 people in the HNHB LHIN). Currently 3% depend on alcohol or illicit drugs in a given year (an estimated 42,000 people in the HNHB LHIN). An estimated 10% to 20% of LHIN residents will have a substance use disorder in their lifetime.

Key Issues:

- 30 individuals with a mental health and/or substance abuse issue accounted for 2,193 visits to LHIN EDs over a one year period.⁴⁹

Successes of the Past Year:

- Implemented a centralized psychiatric sessional fee access model to optimize timely client access, particularly in underserved areas of the HNHB LHIN.
- Implemented enhanced specialized geriatric services in Haldimand-Norfolk and Niagara.

⁴⁹ HNHB LHIN Integrated Decision Support Data Warehouse

PART 2: GOALS and ACTION PLANS							
Goal(s):							
Improving the quality of care for people with MH&A issues and their families by: - Integrating and linking 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:							
- Reduce unplanned repeat visits to the ED by persons with a MH&A. - Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy (plan includes prevention, identification and treatment to support mental health throughout life from childhood to old age).							
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.					
		2012-13		2013-14		2014-15	
		Status	%	Status	%	Status	%
Collaborate with local (sub-LHIN) MH&A networks to implement the recommendations of the ministry's Comprehensive MH&A Strategy.		Initiated	25	Ongoing	25	Ongoing	25
Chart audit of people who are identified as repeat visitors to the ED with a MH&A followed intensive case management/care co-ordination.		Initiated	25	Ongoing	25	Ongoing	25
Design of a <u>Complex Care Resolution Table</u> in Hamilton (to be client specific).		Initiated	50	Ongoing		Ongoing	
Development of a continuum of crisis capacity both within an ED setting and in the community through funding of three crisis worker positions in Niagara, Burlington and Brant.		Initiated	100				
Expansion of early psychosis program in Niagara and implementation of a new program in Brant (inclusive of rapid and specialized assessment, treatment, rehabilitation, early detection and prevention).		Initiated	75		25		

Continued implementation of the Ontario Common Assessment of Need (OCAN).	In progress	75	Ongoing	25		
Implementation of the IAR with In-patient MH&A, HNHB CCAC and LTC which will enable sharing of client assessments.	Initiate	25	Ongoing	50		25
Identification and solution building of MH&A service gaps and issues, resulting from collaborative system planning underway (working with LHIN and sub LHIN Networks).	Ongoing	25	Ongoing	25	Ongoing	25
Implement a 24/7 crisis call service and mobile MH crisis outreach service in Niagara.	In Progress	100				
Increase psychiatric care to underserved areas of the LHIN using telemedicine (NPs and Nurses introduced in Niagara, Haldimand-Norfolk and Brant to support people with MH, address the lack of primary care and improve access to specialty clinicians).	Initiated	50	Ongoing		Ongoing	
Describe how you measure success:						
- Reduced avoidable ED visits, hospitalizations and readmissions. - Given the target client group of clients who are repeat users of the ED (e.g. severity of mental illness/addiction) it is not anticipated that the results will be immediate but rather it is a longer term strategy to begin to engage people that are challenging to serve/engage. Longer term success would include engagement of the client (who may not self identify they have a MH&A issue or be non-collaborative), relationship building, development of a person driven plan of care/goal setting and a crisis plan (inclusive of alternative options to the ED when a client is in crisis). - Standardized, consumer-led decision making assessment tool that 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. - Alternative crisis services to the ED are available in the community. - Improved access to psychiatrist in underserved areas of the HNHB LHIN. - Improved identification, treatment, education and support for people with early psychosis particularly in Brant and Niagara. - IAR is operational so that HSPs can view timely client assessment information electronically and securely.						
What are the Risks/Barriers to Successful Implementation?						
- Adequate funding from ministry/LTC for the implementation of OCAN. - Level of resources attached to provincial priority directions. - Adherence to treatment plans given the nature of the mental illness/addiction of people who frequently use the ED. Mitigating Strategies: - HNHB LHIN OCAN Advisory Committee in place which identifies implementation issues and suggests resolutions.						

- Implementation of the OCAN is closely being monitored by the HNHB LHIN with assistance from the Project Management office.
- LHIN-wide planning occurring at both sub-LHIN and LHIN-wide level re: MH&A

What are some of the key enablers that would allow us to achieve our goal?

- Training, ongoing monitoring and support provided through Community Care Information Management (CCIM) for OCAN implementation.
- Implementation of new resources: Sessional fees, Telemedicine Nurses Initiative, Early Psychosis Program.

3.4 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) – Data now integrated from 28 hospitals across HNHB LHIN and WWLHIN plus, two CCACs and the Juravinski Cancer Centre (JCC). Over 2,500 physicians are accessing ClinicalConnect. Continuing to further ClinicalConnect adoption, eHealth Ontario CEO, Greg Reid announced approximately \$5 million in funding to expand ClinicalConnect at a Media Event early August 2011 (\$3.6M for HNHB LHIN and \$1.6M allocated to WWLHIN). Received preliminary funding approval of \$1M from Canada Health Infoway's innovation program (formal public announcement pending contract finalization). The funding will be used to rollout ClinicalConnect Mobile. eHealth Ontario also provided over \$40M funding for the connecting South Western Ontario cluster (cSWO) to develop eHealth plans and ultimately eHealth services for the four LHINs of South Western Ontario (LHINs 1,2,3 and 4).
- Integrated Decision Support (IDS) Data Repository and Business Intelligence Solution – fully operational and continuing to expand data sets. All HNHB hospitals, HNHB CCAC, seven HNHB CHC's and WW Cambridge Memorial Hospital are submitting patient specific clinical, financial, and statistical information to IDS, linked by

the health card number behind the scenes to follow the patient's journey across the HNHB LHIN healthcare sectors. Includes acute inpatient discharge abstract database (DAD), acute mental health Ontario Mental Health Reporting System (OMHRS), emergency, same day surgery, and medical day care National Ambulatory Care Reporting System (NACRS), inpatient rehabilitation National Rehabilitation Reporting System (NRS), CCAC client and provider data (CHRISS and RAI), and CHC client and provider data, with complex continuing care to go live in December 2011 Continuing Care Reporting System (CCRS). With over 250 users in the HNHB LHIN, negotiations are underway with remaining Waterloo Wellington LHIN Hospitals and CCAC and South West LHIN Hospitals and CCAC to submit data into the IDS Platform and expand the patient journey reporting.

Added to the IDS Suite is the information from the ALC Information System, hosted by Hamilton Health Sciences on behalf of HNHB LHIN Partners, for improved, real-time ALC reporting and integration with other datasets.

- Implemented a low cost ALC Information System to facilitate reporting of hospital ALC data from LHIN hospital Meditech systems (nine of ten hospitals in the LHIN).
- Implementation of Joint Regional eHealth Steering Committee partnership between HNHB and WW LHINs.
- Creation of an 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.
- Funding is project based and does not address ongoing sustainability.
- Significant administrative overhead to manage reporting.
- Restrictive procurement policies extend timelines.
- 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 the October provincial election on provincial health care policies and priorities is not known.

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. - Alignment with the Ontario Telemedicine Nursing Initiative.						
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.					
	2012-13		2013-14		2014-15	
	Status	%	Status	%	Status	%
Participation in the common clinical viewer ClinicalConnect by all HNHB hospitals, HNHB CCAC, CHCs and FHTs, expansion to WW LHIN: - Roll-out application to additional providers (>1,000). - Roll-out of mobile version of application. - Expand electronic medical record (EMR) download to additional users and vendors integration of numerous other data sources to improve functionality such as Ontario Laboratory Information System (OLIS), Diagnostic Imaging Repository (DI-r). - Migrate HNHB Oncology to new Regional Oncology System (ROS). - Implement new web based Diagnostic imaging viewer in a proof of concept phase prior to broader LHIN roll-out. - Implement capability to launch regional ClinicalConnect viewer from Hospital Information systems. - Implement enhanced version of ClinicalConnect . - Enhance support and project resources to meet new service reality.		50		25		25
Continue to implement IDS Business Intelligence Solution across HNHB LHIN, WW LHIN, and SW LHIN, expand data sets to include additional healthcare sectors such as regional ambulatory cancer centre information, ambulatory mental health, long-term care and family health team (FHT) information: - Expansion of data sets from all sectors and into other LHINs. - Improved user education and training and ongoing user groups. - Tool utilization is being monitored and popular reports are being designed as part of the data cubes on an ongoing basis.		55		25		20

- Currently 250 users, add additional 100 users over next two years. - Portal to Portal link between ClinicalConnect and IDS. - Leverage IDS reporting tools to enhance ClinicalConnect auditing. - Develop guidelines and policies related to the use of IDS for research purposes across the LHIN for evidence based decision making.					
- Participation in the 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 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		
Resource Matching and Referral (Phase I) - HNHB LHIN is one of four LHINs in the connecting South West Ontario (cSWO) Cluster participating in the first phase of development of the ALC Resource Matching and Referral Business Transformation Initiative Project. Funding allocations to four LHINs (\$566,962) have been pooled for action under the leadership of ESC LHIN's Project Management Office (PMO). The goals of the project are to: - Improve the way referrals are made and patient information is shared between hospitals, LTC and the CCAC within the Cluster. - Provide a consistent and reliable electronic referral and resource system that will improve the speed and accuracy of patient referrals. - Streamline the process for timely patient access to the appropriate care. This project is part of the province's commitment to create an electronic health record for all Ontarians by 2015.	80		20		
Continue to implement initiatives outlined in HNHB LHIN eHealth Strategic Plan.	25		25		25
Develop a LHIN-wide strategy for increasing clinical telemedicine consultations to provide care close to home for the residents of the HNHB LHIN.	25		25		50
Describe how you measure success:					

- 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 connecting Greater Toronto Area (cGTA) announcement by eHealth Ontario, i.e. lack of public recognition by eHealth Ontario of significant achievements by the HNHB LHIN PMO.
- Timing of provider access to integrated decision support tool data and reports.
- Availability of funds/lack of sustainability funding, (e.g. changes in ministry process to fund eHealth PMO to a project basis).
- Recruitment challenges (non competitive salaries, location).
- Completing patient care priorities in a time of financial and economic constraint.

Mitigating Strategies:

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

What are some of the key enablers that would allow us to achieve our goal?

- Early announcement of planning allocations for hospitals will facilitate their budgeting process to ensure that adequate resources are available to continue implementation of eHealth activities.
- Availability of funding to hire resources to build eHealth capacity, e.g. eHealth Ontario, ministry, Canada Health Infoway.
- Build expectation of participation into Hospital Service Accountability Agreements.

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. Success in the past year: • The Health Professional Advisory Committee (HPAC) is developing a three year implementation plan for the five key recommendations they established and approved 2010-11. • Ongoing expansion of ClinicalConnect (common clinical information viewer) across the HNHB LHIN hospitals, CCACs, family physician and specialists' offices. Currently, well over 2,500 providers are using ClinicalConnect. (see eHealth section). • The telepsychiatry project serving patients living in Fort Erie by Psychiatrists from St. Joseph's Healthcare Hamilton (SJHH) via the Ontario Telehealth Network, has been implemented. Approximately 50 individuals have benefited from this service since its inception in April 2011. • This is a partnership with Niagara Health System (NHS), SJHH and Fort Erie family physicians. Seven different family practitioners have referred to the service to-date. Individuals experiencing a range of mental health disorders have been served; however, the most predominant diagnoses relate to the Mood and Anxiety Disorder spectrum. Discussions for expansion of this program to other rural locations and to supply other underserved populations (e.g. FLS) in the LHIN are currently underway. • In reviewing the preliminary results from Joseph Brant Memorial Hospital (JBMH) Geriatric Assessment Intervention Team (GAIT), it was decided to focus on other areas of IPC. A Virtual IPC team in Port Colborne has been established in partnership with City of Port Colborne, McMaster University and HNHB LHIN. • To assist with ED avoidance, a pilot project with CCAC and ten Burlington family physicians was established to identify seniors who could benefit from additional CCAC resources allowing them to remain safely in their homes. The LHIN is working with other primary care practices to expand the use of the screening tool, has shared the tool directly with other LHINs and has presented the tool at the Ontario Hospital Association (OHA)/Ontario Association of Community Care Access Centres (OACCAC) Assessment Conference in November 2011. • Continue to work with the Cancer Care Ontario's (CCO) Primary Care Lead in developing and implementing screening targets across this LHIN, focusing on areas of low uptake. • The initiation of CCO's Ontario Breast Screening Program (OBSP) High Risk Screening Program (includes genetic testing and if appropriate, MRI testing for high risk residents) has been very successful. The JCC site began this enhanced screening in spring 2011 and Phase 2 (SJHH and NHS) opened in December 2011.

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 IPC.								
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.					
			2012-13		2013-14		2014-15	
<i>Examples:</i>			Status	%	Status	%	Status	%
Establish LHIN-wide screening targets.				30		30		40
Develop an IPC best practice toolkit for dissemination and uptake.				25		25		50
Advance update of P-Prompt and ClinicalConnect.				30		30		40
Development of an additional virtual IPC.				25		50		25
Describe how you measure success:								
Screening targets for cancer care are still being established by CCO – the focus will be on the LHIN's vulnerable populations: • The number of providers connect to ClinicalConnect. • The number of providers using P-Prompt. • The number of LHIN residents attached to primary care through Health Care Connect.								
What are the risks/barriers to successful implementation?								
Providers' willingness to practice in an IPC setting: • See eHealth section. Mitigating Strategies: • HPAC developing a three year implementation strategy to educate providers about professional (Colleges) scope of practice.								

What are some of the key enablers that would allow us to achieve our goal?

- eHealth
- EMRs
- ClinicalConnect.

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.

Key Issues:

- There is variation in access to health-related transportation across the LHIN.
- There are a high number of 'unfilled rides' with no way of tracking across agencies to ensure the client receives service.
- Agencies are faced with aging fleets and difficulties in maintaining volunteers.

Successes this past year:

- Stakeholder working group completed its report recommending the development of an integrated service delivery model for health-related transportation.
- The Canadian Red Cross Society (CRCS) was identified as the lead to develop a business case for implementation of the model, and a partnership agreement (voluntary integration) as the mechanism for implementation.
- The LHIN Board approved the business case and the partnership in December 2011, allowing the implementation of the integrated model to proceed.

PART 2: GOALS and ACTION PLANS

Goal (s):

- Advance equitable access to LHIN-funded transportation programs.
- Optimize community-based transportation services.
- Increase the number of health related rides available.
- Decrease the number of unfilled ride requests.

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 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.					
	2012-13		2013-14		2014-15	
<i>Examples:</i>	Status	%	Status	%	Status	%
Implement the initial partnership.		100				
Implement the model within the initial partnership.		50		25		25
Expand the partnership and the model.				50		50

Describe how you measure success:

- Increased number of health-related rides.
- Fewer unmet ride requests (90% target).
- Reduced unit costs.
- Improved client experience.

What are the risks/barriers to successful implementation?

- Significant inter-agency planning required for effective implementation.
- Agency governance may negatively perceive changes to service provision.

Mitigation: • As lead agency, CRCS has the depth of experience and resource to lead the implementation. • Ongoing dialogue and demonstration of the benefits of the coordinated model.
What are some of the key enablers that would allow us to achieve our goal?
• Build expectation of participation into accountability agreements.

4. HNHB LHIN Operations Spending Plan

LHIN Operations Sub-Category	2011-12*	2012-13**	2013-14	2014-15
(\$)	Actuals	Allocation	Planned Expenses	Planned Expenses
Salaries and Wages	3,278,244	3,134,685	3,330,023	3,330,023
Employee Benefits				
Hospitals of Ontario Pension Plan (HOOPP)	293,761	298,009	319,404	319,404
Other Benefits	357,461	366,533	386,770	386,770
Total Employee Benefits	651,222	664,542	706,174	706,174
Transportation and Communication (T & C)				
Staff Travel	35,755	34,550	34,550	34,550
Governance Travel	12,724	13,500	13,500	13,500
Communications	73,273	76,500	76,500	76,500
Other Benefits	4,164	5,000	5,000	5,000
Total Transportation and Communication	125,916	129,550	129,550	129,550
Services				
Accommodation	375,629	348,590	348,590	348,590
Advertising				
Banking				
Community Engagement				
Consulting Fees	186,327	287,000	50,000	50,000
Equipment Rentals				
Governance Per Diems	82,850	77,500	77,500	77,500
LHIN Shared Service Office (LSSO) Shared Costs	501,996	388,510	388,540	388,540
Other Meeting Expenses	11,597	16,000	16,000	16,000
Other Governance Costs	5,270	10,000	10,000	10,000
Printing & Translation	7,414	9,600	9,600	9,600
Staff Development	12,035	17,250	17,250	17,250
Total Services	1,183,118	1,154,450	917,480	917,480
Supplies and Equipment				
IT Equipment	15,390	15,000	15,000	15,000
Office Supplies Purchased Equipment	52,482	61,341	61,341	61,341
Total Supplies and Equipment	67,872	76,341	76,341	76,341
LHIN Operations: Total Planned Expense	5,306,372	5,159,568	5,159,568	5,159,568
Annual Funding Target	5,306,372	5,159,568	5,159,568	5,159,568
Variance	-	-	-	-

* Preliminary unaudited results for 2011-12

**Budget for 2012-13 and future years is a preliminary budget based on information known at the time and is subject to change.

5. HNHB LHIN Staffing and Operations

LHIN Staffing Plan Full-Time Equivalents (FTEs)

Position Title	2011-12 Actual as of March. 31, 2012 FTEs	2012-13 Forecast FTEs	2013-14 Forecast FTEs	2014-15 Forecast FTEs
Chief Executive Officer	1	1	1	1
Physician Lead	1	1	1	1
Senior Director	1			
Director	5	5	5	5
Access to Care Advisor	2	2	2	2
Health System Advisor	5	5	5	5
Performance Advisor	2	2	2	2
Funding Advisor	3	3	3	3
Quality & Risk Advisor	1	1	1	1
Information Controller	2	2	2	2
FLS Advisor	1	1	1	1
Communications Advisor	1	1	1	1
Corp Coordinator	1	1	1	1
Executive Assistant	2	2	2	2
Project Assistant	1	1	1	1
Program Assistant	4	4	4	4
Receptionist	1	1	1	1
Finance Clerk	1	1	1	1
Corporate Services Assistant	1	1	1	1
Total FTEs*	36	35	35	35

6. Communications Plan

Part 1 – General Communication Plan
Objectives: What is the purpose of the ABP?
• The ABP is one of the guiding documents critical to the work of the HNHB LHIN. The other document is the Integrated Health Service Plan 2010-13 (IHSP). • The IHSP defines the activities to be undertaken from 2010 to 2013 that will move us closer to an integrated health care system. • The ABP demonstrates progress made toward reaching the IHSP goals and objectives, and also provides the opportunity to fine tune strategies for the upcoming year. It provides a framework for communicating to stakeholders the impact local decision making has on health care delivery in our communities.
Context: Why do we do an ABP?
Under the <i>LHSIA</i> 2006, and the M-LPAA, LHINs are required to publish their ABP to inform stakeholders about the LHINs' strategies and initiatives for addressing IHSP priorities. The HNHB LHIN's ABP communication plan ensures that all stakeholders have full and easy access to our strategic and operational plans. The document also includes an overview of the activities to support key provincial activities and a management plan to identify the future challenges faced by our health care system. LHINs are responsible for engaging health care providers, consumers, and the general public in the work that is required to build an accessible and sustainable quality health care system. The ABP also provides LHIN funding requirements for the next three years with particular focus on the 2012-13 fiscal year.
Target Audience:
The HNHB LHIN deals with many stakeholder audiences, each with its own, and often differing, understanding of the health care system and the role of the LHIN in funding, planning and integrating the system. Stakeholders can be categorized in several categories and sub-categories: • Ministry • Internal to the HNHB LHIN: - o HNHB LHIN Board of Directors (Board) - o HNHB LHIN Leadership Team - o HNHB LHIN Staff. • HNHB LHIN Advisory and Reference Groups: - o HNHB CEOs Leadership Group and sub-groups (including VP Clinical Services Group; Chief medical leaders group) - o FLPE - o HPAC - o AHN - o Emergency Services Steering Committee

- o ALC Steering Committee
- o CDPM Advisory Committee
- o Geriatric Access and Integration Network (GAIN)
- o LTCH
- o MH&A Networks
- o Hospice Palliative Care Network
- o Primary Care Network
- o Community Support Services Network (CSSN)
- o HNHB LHIN eHealth Adoption Steering Committee
- o HNHB LHIN OCAN Advisory Committee
- o HNHB LHIN InterRAI CHA.
- Internal to the Health Care System:
 - o Hospitals
 - o HNHB CCAC
 - o LTCHs
 - o CHCs
 - o Community Service Agencies
 - o MH&A Agencies.
- External Stakeholders:
 - o Members of Provincial Parliaments (MPPs)
 - o General Public
 - o Media.

Strategic Approach and Tactics:

- The ABP describes many key initiatives to advance the priorities of the IHSP and each of these has its own communication strategy. In addition, the HNHB LHIN has an overall strategic communications plan that outlines the various tactics used to communicate with stakeholder groups.
- This section of the ABP therefore will focus on the strategy to build awareness and understanding of the ABP among all stakeholder groups.

Stakeholder	Timing	Tactic	Details
DRAFT ABP			
HNHB LHIN Board of Directors	January 2012	Open Board meeting	A summary presentation and the full text of the draft ABP.
ministry	January 31, 2012	Electronic Submission	Submission of draft ABP to ministry once approved by the Board of Directors.

Final ABP			
HNHB LHIN Board of Directors	May 2012	Open Board meeting	A summary presentation and the full text of the final ABP.
HNHB LHIN Advisory and Reference Groups	Upon ministry approval	Meetings/formal presentations	Summary presentation plus full text of ABP.
Hospitals/CCAC/LTCH/CHCs/Community agencies/ MH&A agencies/MPPs	Upon ministry approval	Email notification	An email, from the LHIN CEO, including attachment of full text ABP, in advance of public posting.
Media/General Public	Upon ministry approval	Localized press release Posting on HNHB LHIN Website with web alert LHINsight and LHINfo Minute Twitter	Simultaneous posting by all LHINs of MLPA and ABP. HNHB LHIN newsletters and social media.

Part 2 – Communication Plan for Specific Initiatives

Specific Initiatives:

While the LHIN system enables health planning to address local issues, there are a number of common initiatives and platforms that can best be addressed in a coordinated and consistent fashion. To support these activities, and to enhance the awareness of the LHIN role with key stakeholders, LHINs, with the support of the ministry, have worked together to ensure a consistent overarching communication plan and branding approach to support the following key provincial priorities:

- Home First** - Home First is a philosophy and common understanding that when a person enters a hospital with an acute episode, every effort is made to ensure adequate resources are in place to support the person to ultimately go home on discharge, if appropriate.
- Senior Friendly Hospitals** - Research shows that seniors are more vulnerable to adverse events and complications the longer they stay in the hospital. They have a two-fold risk of adverse events (e.g. falls, pressure ulcers, surgical complications, and hospital acquired delirium). One-third of frail seniors lose independent function as a result of hospital practices. These risks increase the likelihood that seniors will not be able to be discharged and will become ALC.

The Senior Friendly Hospital strategy strives to foster hospital environments that respond to seniors' physical and mental health needs, promote good health (e.g. nutrition, activation), are safe (e.g., prevent drug interactions, infections, falls), and involve seniors, their families and caregivers fully in the client's care. After their acute care is completed, seniors regain their health so that they can transition to the next level of care – post-acute, home, community or LTC.
- Provincial Falls Prevention Strategy** - In September 2010, falls prevention was identified as a top priority by the ministry. In response, the *Integrated Provincial Falls Prevention Project* was initiated as a LHIN priority project, in partnership with Ontario's Public Health Units.

The *Integrated Provincial Falls Prevention Framework & Toolkit* was developed to improve quality of life for Ontario seniors aged 65 years and over, and to lessen the impact of falls on the health care system by reducing the number and impact of falls. In November 2011 a meeting of key stakeholders across

the health care sectors identified opportunities to move forward on the LHIN's Falls prevention Strategy in an integrated way (building on the work to date).

4. **Resource Matching and Referral** - Some of the most significant quality of care issues occur in transition points in the health care system as patients/clients move from one provider to the next. In the absence of an electronic system to support patient referrals, health care providers frequently base referrals on incomplete knowledge of available services and significant time and resources are spent on the administrative burden of completing and faxing multiple forms.

To address this issue, Ontario's LHINs are working together towards an electronic referral information solution based on a system first introduced in the Toronto Central LHIN. A Resource Matching and Referral system expedites referrals and matches individuals to the earliest available services that best meet their needs, improving quality of care and the experience of individuals and families.

5. **Behavioural Supports Ontario (BSO)** - In January 2010, the ministry funded a working group to undertake the first phase of an Ontario Behavioural Support System (BSS) Project and develop a principle-based Framework for Care. The BSS Project was later renamed the Behavioural Supports Ontario by the ministry. The framework would enhance services for elderly Ontarians with complex and 'responsive' behaviours wherever they live – at home, in long-term care homes or elsewhere. Responsive behaviours are aggression, wandering, agitation as well as others and for many people are the trigger for a crisis visit to hospital and transfer to long-term care. The reasons identified to undertake this project were:

- o The numbers of people at risk for responsive behaviours is increasing.
- o Challenges are experienced across all health sectors and services.
- o The person and family required better quality experiences.
- o There are significant costs associated with managing behaviours.
- o There are recognized best practices that could be more systematically adopted.
- o There is an opportunity to leverage existing initiatives in Ontario.
- o There is a stakeholder readiness for change.

6. **CCAC Expanded Role** - In 2010, a LHIN/CCAC working group was established to define a consistent/common approach to ensure legislative changes to enable an expanded role for the CCAC. This group has defined how the expanded role should be implemented, outlined what needed to be done consistently across the LHINs and what flexibility would be required for local implementation.

The working group concluded that a more global review of the CCACs' role was needed and it was agreed the focus of their work would be on:

- o Defining a vision and directional plan for an expanded CCAC role within an integrated system.
- o Developing a practical framework to support the consistent implementation of the CCACs' expanded role in placement.

In 2010, the 14 LHIN and 14 CCAC CEOs agreed upon carrying out the following five *Directions for Action*:

1. To ensure the right care at the right place at the right time, the CCACs and LHINs are working in partnership to optimize CCAC capacity: i) to be the single point of access for defined health services; and ii) to be a connection for Ontarians to the most appropriate health care services.
2. CCACs will be the single point of access for expanded services for placement (i.e., adult day programs, complex continuing care, rehabilitation, and supportive housing/assisted living). Access for placement will incorporate best practices and a standard approach throughout the province. Each LHIN/CCAC will develop an implementation plan for their area by March 31, 2011.
3. CCACs will be the single point of access for assisted living services described in the ALS for High Risk

Seniors Policy.

4. The practical steps and success factors identified through a survey and interviews with LHINs and CCACs will be used as a common, practical framework and provincial directional plan to implement the expanded role of CCACs. Each LHIN/CCAC will develop more detailed directional plans that will include deliverables, responsibilities and timelines.
5. Each LHIN/CCAC will determine whether to implement the opportunities associated with new prescribed services, new care settings, and use of therapy assistants/aides given that these implementations are highly dependent on local needs and circumstances (e.g. availability of health human resources, financial constraints). The CCACs will share best practices information to build on others' successes.

Communicating the Provincial LHIN Priorities:

The overarching communications plan is a shared responsibility between the 14 LHINs, the ministry and the Minister's Office. The plan speaks to both a shared communication strategy and communication and operational activities to be undertaken by all LHINs, specifically related to a number of LHIN priority projects. It is the platform upon which the LHINs reinforce the LHIN brand and value of the organizations in leading the important transformation of Ontario's health system.

It is to be noted that the progress of programs supporting the provincial LHIN priorities varies among the LHINs. For example, one LHIN may be deeply entrenched in one priority while at the planning stage of another. For this reason, the overarching plan provides a commonality from which each LHIN can then develop a local communication plan for specific initiatives. However, the communications objectives, target audiences, and key messages developed in the overarching plan are to be incorporated into every local communications plan.

Strategic Objectives:

- To raise the profile and demonstrate the value of LHINs at a provincial level.
- Create a communications campaign that highlights LHIN initiatives and promotes the value of LHINs across Ontarians.
- Campaign is focused on "Access to Care".

Audiences (in order of importance):

- Public (Taxpayers, patients/clients and family members)
- Health Service Providers (funded and non-funded such as public health)
- Health Service Provider Governance representatives
- Physicians (specialists & general practitioners)
- Local government stakeholders (municipal & provincial)
- Premier
- Minister's Office
- Ministry
- Media.

Communication Boilerplate:

LHINs bring together health care partners from the following sectors – hospitals, community care, community support services, community mental health and addictions, community health centres and long-term care – to develop innovative, collaborative solutions leading to more timely access to high quality services for the residents of Ontario and the HNHB LHIN. By supporting these important partnerships, LHINs are ensuring that Ontarians have access to an effective and efficient health care system that delivers improved health care results and a better patient experience.

Key Messages:

- Because of LHINs, for the first time, providers in the local health care system are working together to improve access to quality care for Ontario residents.
- Because of LHINs, for the first time, the health care needs of people in your community are being identified, coordinated and addressed as a truly integrated system.
- Local residents are receiving the right care at the right time in the right place, at the right cost.
- Hospitals and community partners are working together to reduce ED wait times and deliver greater access to care.
- Because of LHINs, for the first time, local decisions are being made to respond to local health care needs.
- Every corner of this vast province has different health care needs. Those needs are best met through local decision-making.
- By talking and listening to local health care providers and community residents, LHINs identify and bring to life local initiatives.
- Health care decisions are focused on quality and with an understanding of the diverse and unique needs of each community.
- Because of LHINs, for the first time, health service providers, such as hospitals, long-term care homes and community agencies, are being held accountable for the taxpayer dollars they are given.

On-going collaboration among the 14 LHINs will ensure that a consistent message is delivered across the province for provincial priorities; while the development of local communications plans to support specific projects or programs will ensure that local priorities are addressed.

7. APPENDIX

7a. 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
ALSHRS	Assisted Living Services for High Risk Seniors
AR	Assess Restore
BSO	Behavioral Supports Ontario
BSS	Behavioral Supports Services
CAMH	Centre For Addictions and Mental Health
CBHSC	Community-Based Health Service Capacity
c	Connect or Connecting
cGTA	Connecting Greater Toronto Area
cSWO	Connecting South Western Ontario
cWO	Connecting Western Ontario
CC	Complex Care
CCO	Cancer Care Ontario
CCAC	Community Care Access Centres
CCIM	Community Care Information Management
CCRS	Continuing Care Reporting System
CDPM	Chronic Disease Prevention Management
CDSM	Chronic Disease Self-Management

CE	Community Engagement
CEO	Chief Executive Officer
CHC	Community Health Centres
CHSEE	Continuing Health Sciences Education Event
CHF	Congestive Heart Failure
CHI	Canada Health Infoway
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CPI	Clinical Program Integration
CRCS	Canadian Red Cross Society
CREMS	Community Referrals by EMS
CSP	Clinical Services Plan
CSCHN	Centre de Santé Communautaire de Hamilton-Niagara
CSS	Community Support Services
CSSN	Community Support Services of Niagara
CTAS	Canadian Emergency Department Triage and Acuity Scale
CYMHA	Children and Youth Mental Health and Addictions
DAD	Discharge Abstract Database
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
FL	French Language
FLHS	French Language Health Services
FLIP	French Language Implementation Plan
FLPE	French Language Planning Entity
FLS	French Language Services
FLSA	French Language Services Act
FLT	French Language Training
FP	Falls Prevention
FTE	Full-Time Equivalent
FY	Fiscal Year
GAIN	Geriatric Access and Integration Network
GAIT	Geriatric Assessment Intervention Team
GTA	Greater Toronto Area
HHR	Health Human Resources
HHSC	Hamilton Health Sciences Corporation
HNHB	Hamilton Niagara Haldimand Brant
HOOPP	Hospitals of Ontario Pension Plan
HPAC	Health Professionals Advisory Committee
HQO	Health Quality Ontario
HR	Human Resources
HSP	Health Service Provider
IAR	Integrated Assessment Record
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
Inter RAI CHA	interRAI (Resident Assessment Instrument) CHA – Community Health Assessment
IT	Information Technology
JAAP	Joint Annual Action Plan
JBMH	Joseph Brant Memorial Hospital
JCC	Juravinski Cancer Centre
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
Minister	Minister of Health and Long-Term Care
ministry	Ministry of Health and Long-Term Care
MLAA	Ministry-LHIN Accountability Agreement
MLPAA	Ministry-LHIN Performance Accountability Agreement
MPCC	Mobile Primary Care Clinic
MPP	Member of Provincial Parliament
MSSU	Medical Short Stay Units
NACRS	National Ambulatory Care Reporting System
NEO	North East Ontario
NH	North Hamilton
NHS	Niagara Health System
NLOT	Nurse Led Outreach Team

NP	Nurse Practitioner
NRS	National Rehabilitation Reporting System
OACCAC	Ontario Association of Community Care Access Centres
OBSP	Ontario Breast Screening Program
OCAN	Ontario Common Assessment of Need
ODIT	Ontario Diagnostic Imaging Terminology
ODS	Ontario Diabetes Strategy
OHA	Ontario Hospital Association
OLIS	Ontario Laboratory Information System
OMHRS	Ontario Mental Health Reporting System
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
PMO	Program Management Office
PwC	Pricewaterhouse Coopers
QIP	Quality Improvement Plan
RAZ	Rapid Assessment Zones
RM&R	Resource Matching & Referral
RMON	Regional Municipality of Niagara
ROS	Regional Oncology System
SAA	Service Accountability Agreements
SGS	Specialized Geriatric Services
SSR	Slow Stream Rehab

SJHH	St. Joseph's Healthcare Hamilton
SW	South West
SWO	South West Ontario
UCC	Urgent Care Centre
VP	Vice President
WW	Waterloo Wellington
WWHN	Waterloo Wellington Hamilton Niagara
YTD	Year To Date