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

Annual Business Plan 2013-2014

June 2013

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

Hamilton Niagara Haldimand Brant
Local Health Integration Network

Annual Business Plan
2013-14

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June 3, 2013

Ms. Jane Sager
Manager, West Unit
LHIN Liaison Branch
Health System Accountability and Performance Division
Ministry of Health and Long-Term Care
80 Grosvenor Street, 5th Floor Hepburn Block
Toronto ON M7A 1R3

Dear Ms. Sager:

Re: Hamilton Niagara Haldimand Brant Local Health Integration Network - Annual Business Plan, 2013-14

Our 2013-14 Annual Business Plan (ABP) represents the first year of our new three-year Integrated Health Service Plan (IHSP), based on our Strategic Health System Plan (SHSP), approved by the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) Board of Directors (Board) in December 2012. The draft 2013-14 ABP follows the guidelines provided by the Ministry of Health and Long-Term Care (ministry), focusing on goals and action plans relating to system change and outcomes.

With a view to building on the Minister of Health and Long-Term Care (Minister's) Action Plan, and the LHIN's collective provincial priorities, the overall aim of the HNHB LHIN, over the course of the next three year period, will be to dramatically improve the patient experience through quality, integration and value. Our three key strategic directions, flowing from this aim, are:

1. Dramatically improving patient experience by embedding a culture of quality throughout the system.
2. Dramatically improving the patient experience by integrating service delivery.
3. Dramatically improving the patient experience by evolving the role of the LHIN by becoming Health System Commissioners.

In setting our aim to "dramatically" improve the patient experience, the HNHB LHIN Board is signalling its desire to see bold and urgent action on the transformation agenda.

These strategic directions are defined in terms of specific goals and action steps, with a particular focus on 2013-14, being the first operating year of our new IHSP. Action plans for each of the priorities identified in the IHSP are presented, following the template provided by the ministry. The ABP also outlines proposed HNHB LHIN staffing and operations, following the templates provided by the ministry.

Ms. Jane Sager

We are excited about the potential we see represented by these strategic directions and action plans, and look forward to ministry approval before posting our ABP.

Sincerely,

Donna Cripps
Chief Executive Officer

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 (2013-14) represents the first year of the LHIN's third IHSP.

This year, in preparation for the IHSP, the Hamilton Niagara Haldimand Brant (HNHB) LHIN undertook a strategic planning process to identify those key directions which, implemented together, will transform the system.

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 the Strategic Health System Plan (SHSP).

2a. Mandate and Strategic Directions

The provinces 14 LHINs have a mandate to plan, fund and integrate the local health care system.

The HNHB LHINs SHSP, approved by the Board of Directors (Board) in December 2012, recognizes the need for health system transformation to achieve its 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 vision from the Minister of Health and Long-Term Care (Minister's) Action Plan: ***"To make Ontario the healthiest place in North America to grown up and grow old"***, has strengthened the commitment to transformation.

With a view to building on the Minister's directions, momentum from Don Drummond's "The Commission on the Reform of Ontario's Public Services", and the LHIN's provincial priorities, the HNHB LHIN engaged PricewaterhouseCoopers (PwC) to support them in the development of a strategic plan. To emphasize that the SHSP was not a plan to plan, but a plan for action, the project was titled: **ACTION – A Call To IntegratiON Now**. The intent of the SHSP is to build an evidence-based, integrated, and person-centred health care system.

The overall aim of the HNHB LHIN, over the course of the next three year period, will be to dramatically improve the patient experience through quality, integration and value.

Our three key strategic directions, flowing from this aim, are:

1. Dramatically improving patient experience by embedding a culture of quality throughout the system.
2. Dramatically improving the patient experience by integrating service delivery.
3. Dramatically improving the patient experience by evolving the role of the LHIN to become Health System Commissioners.

These strategic directions are further defined in terms of specific goals and action steps, which will form the basis of the implementation plan over the coming three years. The implementation plan will be further detailed through the LHIN's ABP process.

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

The HNHB LHIN allocates approximately $2.6 billion to programs and services offered through more than 200 Health Service Providers (HSPs). These include ten hospitals, 86 Long-Term Care Homes (LTCHs), 61 Community Support Service agencies (CSS), 35 Mental Health and Addiction providers (MH and A), seven Community Health Centres (CHCs), and one Community Care Access Centre (CCAC). 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. Over the past three years, HSPs have been working with the LHIN to improve patient flow, integrate service delivery, reduce the prevalence of chronic disease, and focus on the health of the priority populations such as Seniors, Francophones and Aboriginals.

The new IHSP focuses our collective attention on improving the experience and outcomes for individuals as they go through the system, through quality improvement, system redesign, and funding/accountability reform. This ABP will outline the detailed goals and actions which will build on the successes of the past three years, and move us toward a transformed system.

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:

Demographics:

- The HNHB LHIN is home to over 1.4 million people - about 11% of the population of Ontario and the third-largest LHIN in Ontario. The LHIN population is projected to grow 4.1% over the next five years, and 8.8% over the next ten years.[1]
- The HNHB LHIN's population is aging. The total number of people ages 65-74 years old is growing the fastest. The largest changes will be among people ages 65-74 (45.2%) and 85 or older (33.4%) over the next ten years.
- As of 2011, more than 230,000 people age 65 or older live in this LHIN, which is the largest number of seniors of all Ontario LHINs.[2]

[1] Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO
[2] Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO

Socio-Demographic Characteristics:

- The LHIN has a very diverse population. For 18% of residents, neither English nor French is their first language. Francophones, First Nations, and urban and rural Aboriginal people are recognized populations in the HNHB LHIN. Compared to Ontario, the LHIN has a lower percent of immigrants and visible minorities.
- There are two First Nation reserves in the HNHB LHIN – Six Nations of the Grand River Territory, which has the largest population of all First Nation communities in Canada, and Mississaugas of the New Credit First Nation. The total registered Aboriginal population in the LHIN is approximately 24,000 people (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.[3]
- The HNHB LHIN has a higher percent of lone parent families, and a lower percent of adults with post-secondary education than the Ontario average. The unemployment rate is slightly lower than the Ontario average, fluctuating over time. The share of economic families below the Low Income Cut-Off (LICO) in the HNHB LHIN is slightly lower at 13.8% than the Ontario average. There are also slightly lower than average education levels (both high school and university), particularly in rural areas of the LHIN.

Health Status:

- Self-reported health can show aspects of health not captured in other measures. Similar to Ontario's rates, more than 61.5% of LHIN residents rate their health as 'excellent' or 'very good'.[4] However, significantly more LHIN residents say they are limited in activities because of a physical or mental condition, or health problem, and have pain or discomfort that prevents activities.
- The HNHB LHIN's residents have significantly more arthritis/rheumatism compared to the province as a whole. Rates of asthma and high blood pressure are slightly, but not significantly higher than Ontario rates. Diabetes rates, on the other hand, are comparable to the province.[5] Other findings include a higher proportion of overweight/obese residents than the Ontario average, a higher incidence of arthritis, heavy drinking and injury hospitalizations (e.g. falls, motor vehicle accident), and the life expectancy is lower in the LHIN.
- Death rates reflect the overall health of the population. Lower death rates show success in preventing, detecting, treating disease, and reducing suicide. The age standardized mortality rate for the HNHB LHIN is significantly higher than the Ontario average (572 per 100,000 vs. 522 per 100,000). Heart disease, lung cancer, and stroke were the top three leading causes of death.
- Potential years of "life lost" rates are useful for measuring the number of years of 'life lost' from deaths that occur "prematurely" (i.e., before age 75). Deaths, potential years of 'life lost' and hospitalization rates in the HNHB LHIN are higher than provincial rates.[6]

[3] First Nations Peoples in Ontario: A Demographic Portrait. Ministry of Health and Long-Term Care, Health System Information Management and Investment Division. Health Analytics Branch, January 2009
[4] Statistics Canada, Canadian Community Health Survey, 2009-10
[5] Statistics Canada, Canadian Community Health Survey, 2009-10
[6] Death, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO

Health Practices and Preventive Care

- Poor health practices increase the risk of chronic disease, disability, and death. Relative to the province, more people in the HNHB LHIN smoke daily or occasionally, drink heavily, and are obese.[7]
- Preventive health care services can help detect disease early, and over the long-term can reduce illness and death. Of the selected preventive health indicators, none are significantly different from Ontario as a whole.
- Among women in the HNHB LHIN, 71.7% had a Pap smear (for cervical cancer screening) within the previous three years, 73.1% received a routine mammogram in the previous two years, and 31.7% had a flu shot in the past year.[8]
- Most people get their care through their family doctors. Physicians play a key role in coordinating care and managing chronic conditions. Most people (81.3%) in the LHIN talked, either in person or by phone, with a physician in the last year. This is similar to the Ontario rate of 82.2%.[9]

3. IHSP 2013-16 Priorities:

1. **Dramatically improving the patient experience by embedding a culture of quality throughout the system**
2. **Dramatically improving the patient experience by integrating service delivery**
3. **Dramatically improving the patient experience by evolving the role of the LHIN to become health system commissioners**

3.1. Dramatically improving the patient experience by embedding a culture of quality throughout the system

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by embedding a culture of quality throughout the system
IHSP Priority Description:
The HNHB LHIN will provide system-level leadership in relation to quality, and hold providers accountable for local implementation. This will be guided by a common LHIN-wide philosophy and approach to quality, targeting the reduction of variation and increasing standardization within the health system. The LHIN's theory of quality improvement is influenced by the work of Dr. Ross Baker and his research into high-performing health systems. To advance change at scale, there must be strategy to set directions and priorities, an alignment of incentives and levers, and the capacity to build and sustain improvement.

[7] Statistics Canada, Canadian Community Health Survey, 2009-10
[8] Statistics Canada, Canadian Community Health Survey, 2005, 2008 and 2009-10
[9] Statistics Canada, Canadian Community Health Survey, 2009-10

Two key strategies will advance this goal:

1. Leveraging Service Accountability Agreements for quality improvement and stakeholder engagement (Quality Guidance Council).
2. Providing advanced analytical support for LHIN initiatives such as Health Links, clinical program integration and population based strategies to ensure connection with Ministry-LHIN Performance Accountability (MLPA) indicators.

Current Status:

Over the last year, the LHIN has engaged HSPs across the continuum on improving our focus and efforts on system-wide quality improvement. Our LHIN is committed to advancing the quality of care of all patients across the spectrum of HSPs.

Delivering quality of care is a foundational core principle to every health care provider. This is supported by the legislative requirements set out in the *Excellent Care for All Act, 2010* (ECFAA).

With the introduction of Quality Improvement Plans (QIPs), hospitals, and the CCAC have been able to showcase their successes, and publically measure progress in reaching their goals. As of April 1, 2013, CHC's will also provide QIPs to demonstrate a measurable commitment to quality improvement. However, numerous reports have demonstrated that providers need to work even more collaboratively to achieve optimum care.[10]

The LHIN's strategic goals for quality improvement will focus on advancing and supporting best-practices and building on areas requiring further development.
The LHIN will utilize its Service Accountability Agreements (SAAs) to solidify and advance quality goals and processes.

A stakeholder engagement plan will be led by the Quality Guidance Council (QGC) which will have a membership from HSPs. It will provide expert advice on the implementation imperatives of the HNHB LHIN's Quality Strategy. The committee will provide advice at a minimum on the following areas:

- Governance policy and engagement
- Balanced scorecard measures and roll-out
- QIP development, testing and implementation
- Sustainability of quality improvement

Key Issues:

- There will be new SAA agreements in place for hospitals, LTCHs and the community sector refresh for April 1, 2013.
- New MLPA performance measures could be added to the existing agreement as of April 1, 2013.
- New QIPs are required for CHC and Family Health Teams (FHTs) as of April 1, 2013.

Successes of Past Year:

- Orthopaedics:
    - The HNHB LHIN Board selected improving Orthopaedic services as one of its key quality priorities. The HNHB LHIN's strategy was centered on working with hospitals and the CCAC on meeting and exceeding the targets provided in the Orthopaedic Scorecard. This required a shift in emphasis from allocating hip and knee volumes, based on demand, to a distribution process focused on quality outcomes and efficient and cost effective service delivery. Through working with the hospitals and the CCAC, the HNHB LHIN has demonstrated success in achieving targets for efficiency, effectiveness and safety.

[10] Walker, Baker, and Drummond

- Diagnostic Imaging:
    - Longer than average wait times for Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) were also identified by the Board as key quality priorities. Based on evidence from Health Quality Ontario (HQO's) Quality Monitor 2011, hospitals in our LHIN had opportunities to improve the access and efficiency of MRI and CT services for residents. The LHIN engaged hospitals and medical leaders to develop a balanced scorecard to set targets for improved efficiency and measure progress in achieving goals. This quality improvement project focused on process improvements, system access, supply and demand, and wait time performance. As of the second quarter of 2012-13, wait times for MRI and CT are below the LHIN target, and patients are receiving needed diagnostic procedures sooner.
- Quality Engagement:
    - The LHIN has engaged its HSPs and partners, on advancing system-wide quality improvement. At the governance level, the LHIN held two sessions with the Boards, senior staff of hospitals and the CCAC to discuss the progress and future of providing quality care for patients and their families. At these meetings, Boards provided the LHIN with guidance and ideas for embedding a culture of quality in their organizations as well as in the HNHB LHIN. The LHIN also worked with all providers across the continuum of care through a variety of networks, including: Clinical Vice Presidents (VPs), members of the LTCHs, and Executive Directors of CHC and MH and A agencies.
- Advanced Analytics
    - The LHIN has developed simple, easy to use monitoring tools for HSPs to facilitate greater efficiency in monitoring indicators and goal-setting. Performance targets for a number of indicators are now at the fingertips of HSPs to allow for easy measurement and discussion. By using data more effectively, the LHIN and HSPs can make more informed decisions about care delivery, resulting in improved health care experiences for residents.
    - In addition to engaging providers, the LHIN also launched a new user-friendly report card on its website to facilitate transparency and public education on provider performance.
    - Designed to reflect provider and LHIN comparisons, posting this information on the HNHB LHIN website is an effective tool to support the vision of greater transparency in public policy.

PART 2: GOALS and ACTION PLANS

Goal(s):

Quality Metrics or Improvement Obligations have been included in all SAA's (minimum of one).

Consistency with Government Priorities:

Delivering quality of care is a foundational core principle to every health care provider. This is supported by the legislative requirements set out in the ECFAA. This is also consistent with the Ontario Action Plan for Health Care. LHIN's have worked in conjunction with the ministry to integrate elements of quality improvement into SAAs.

This is consistent with the Pan-LHIN strategic imperatives, including:

- Leading with Quality and Safety by Implementing Evidence Based Practice
- Strengthening and Enhancing Access to Primary Care
- Enhancing Coordination and Transitions of Care for Targeted Populations
- Holding the Gains for Alternate Level of Care (ALC) and Wait times

Recently negotiated SAAs include additional indicators designed to enhance both system-wide and organizational level improvement activities. The ministry also announced in January 2013, that CHCs would be required to complete QIPs for the first time as of April 1, 2013.

Action Plans/Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % 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					
	2013-14		**2014-15**		**2015-16**	
Examples:	Status	%	Status	%	Status	%
Quality obligation added to each SAA	Complete	100				
Quality policy endorsement by all HSP Boards	In progress	50	Complete	50		
Publicly accessible Balance Scorecard for each HSP to include at least one measure for the following: • Patient Satisfaction • Finance and service activity volumes • Staff satisfaction • Standardization/Best practices	In progress	50	Complete	50		
QIP that assessing gaps, engages staff, improves efficiency and involves service recipients and stakeholders	In progress	50	Complete	50		

How will we measure success?

The HNHB LHIN will include a common quality obligation into each SAA agreement to establish a clear benchmark for improvement activities across providers. This will be complete in the fiscal year 2013-2014.

In 2013-2014, the HNHB LHIN will work with providers to determine which organizations meet the SAA expectations through their quality programs already in place. The remainder of 2013-14 and 2014-2015 will focus on facilitating the adoption of the SAA obligations for providers not meeting the requirement.

Providers with well developed QIPs will serve as models, and their work will be used as guidance to assist other providers along the journey of improvement.

What are the risks/barriers to successful implementation?

- Administrative burden
- Resistance to standardization
- Resistance to change
- Information technology (IT) challenges
- Understanding of the tools, techniques and methods for quality improvement
- Physician engagement

For each risk/barrier, describe the plan to mitigate the risk?

The HNHB LHIN will work directly with providers and HQO to leverage common tools and templates to assist HSPs in focusing on their quality work rather than research best practice methodologies.

Through the QGC and peer groups, the HNHB LHIN will facilitate a dialogue on the imperative for standardization for enhancing both the patient experience and value.

The HNHB LHIN will utilize the ministry Change Management model to facilitate provider buy-in and translate strategy into execution.

The HNHB LHIN will also assist providers through leveraging LHIN-wide information systems, such as Integrated Decision Support (IDS), wherever possible to reduce the burden of reporting and increase its efficiency.

The HNHB LHIN will ensure physician engagement at all stages of developing the quality improvement strategy.

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

- Change management methods and techniques
- Effective technology and information systems
- Staff and physician engagement
- Patient engagement
- Sharing of data, best practices, and experiences
- Effective physician engagement committees and depth of staff experience

Additional Comments (i.e. additional information that supports the implementation/success of the goal).

PART 2: GOALS and ACTION PLANS

Goal(s):

Metrics will be aligned to measure improvements in Ministry-LHIN Performance Accountability Agreement (MLPAA) indicators.

Consistency with Government Priorities:

- The MLPA is the HNHB LHIN's key commitment and accountability to the ministry, and is reflected in the structure, implementation, and monitoring of all SAAs.
- There is consistency between the MLPA obligations and requirements of the ECAA.
- The Ontario Action Plan for Health Care sets out clear direction for ensuring the right care, right time, in the right place and is supported through the HNHB LHIN in meeting its MLPA obligations.

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % 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.					
	2013-14		**2014-15**		**2015-16**	
Examples:	Status	%	Status	%	Status	%
Quarterly reporting on key variances and possible statistical causes of data fluctuations.	Complete	100	On-going		On-going	

Quarterly "In Focus" on a relevant MLPA indicator.	Complete	100	On-going		On-going		
Quality Based Procedures (QBP) scorecard in conjunction with Health Analytics Branch.	Complete	100	On-going		On-going		
Health Links indicators monitored with quarterly reporting as data becomes available.	Complete	100	On-going		On-going		
Data quality and accuracy – Dates Affecting Readiness to Treat (DART) obligation.	Complete	100	On-going		On-going		

How will we measure success?

Quarterly reporting on MLPA indicators will be focused on statistical rigor to establish common and special cause variation. In depth reports on key MLPA indicators, such as 30 Day Readmissions, will deconstruct measures to provide meaningful insights to support Board and executive decision making.

In partnership with the Health Analytics Branch (ministry), monitoring QBP will assist in assessing the imperatives of implementation as Health System Funding Reform (HSFR) is implemented over the next few years.

The success of Health Links will be supported by advanced analytical analysis of high user populations and eventually individuals with complex needs. The HNHB LHIN will monitor and assess health link indicators to support alignment of metrics to the MLPA indicators.

The HNHB LHIN will support providers to ensure data quality and accuracy. In 2013-2014, the LHIN will require hospitals, through their Hospital Service Accountability Agreement (H-SAA), to implement and monitor best practices for DART procedures. Success will be reflected through adoption of the procedure and will include metrics such as:

- Number of hospitals approving policy at the Medical Advisory Committee (MAC)
- Number of hospitals including DART procedures in credentialing process
- Number of surgeon's offices adopting DART procedures
- Number of DART days per physician
- Number of closed cases less than the provincial target
- Number of open cases less than the provincial target

What are the risks/barriers to successful implementation?

- Frequency of reporting is dictated by data availability and may not always be available upon request.
- Ensuring the timely release of data from other agencies such as the ministry, Canadian Institute for Health Information (CIHI), Institute for Clinical Evaluative Sciences (ICES), and HQO may delay the availability of key information.
- Privacy concerns and risks could become salient as more providers work together on targeted populations in Health Links.
- Physician engagement on wait list management.

For each risk/barrier, describe the plan to mitigate the risk?

- The HNHB LHIN will advance its internal analytical capacity by investing in software to more efficiently provide data as required.
- The HNHB LHIN continuously works with partner organizations to appropriately share data.

• The HNHB LHIN is working with Privacy Officers in the LHIN to ensure that data provision is consistent with the Personal Health Information Privacy Act (PHIPA) and other regulatory requirements. • LHIN will utilize existing staff expertise on physician engagement.
What are some of the key enablers that would allow us to achieve our goal?
• IT • Decision support partnerships • Staff training and awareness of data sources and limitations • Physician engagement
Additional Comments (i.e. additional information that supports the implementation/success of the goal).

3.2. Dramatically improving the patient experience by integrating service delivery

i. Health Links

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improve the patient experience by integrating service delivery: Health Links
IHSP Priority Description:
Integrated service delivery means the system will be redesigned to ensure the person is at the centre of care. This will include: • Health Links - appropriate services are 'wrapped around' the person through the creation of Health Links. Closest to the person will be their primary care provider who will be supported by a diverse and capable network of community services, including CSS, MH and A, local hospital services and LTC. • Health Links represent a new model of care delivery, where all providers in a geographic area are charged with coordinating plans at the patient/client level.
Current Status:
Health Links were announced by the Minister in December 2012, with the Hamilton Central Health Link announced as an 'early adopter'. Health Links will be accountable to LHINs to put collaborative initiatives in place that will allow for a measurable, positive impact on the care of individuals in the Health Link geography. Health Links will focus initially on the 'high user' population cohort in their geographic area. This cohort is defined as individuals who have had at least three unplanned acute care admission and at least five unscheduled Emergency Department (ED) visits within the last year. While the number of individuals in this cohort varies across Health Links (from under 100 to over 300), their characteristics are remarkably similar – median age in the mid-60's, with multiple chronic conditions (including Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and diabetes, among the most common diagnoses) and underlying MH and A issues. Each Health Link will be able to look at the specific individuals in their area, and develop coordinated plans that will improve their outcomes and reduce unnecessary use of the system.

Key issues:

- Health Links must include:
  - a minimum population of 50,000
  - a minimum of 65% of primary care providers in the area
  - a critical mass of providers who are willing to sign a partnership agreement

Successes of the Past Year:

- Since the announcement of Health Links in December 2012:
  - Hamilton Central Health Link established, with Business Plan complete
  - Health Link geographies mapped out resulting in 12 Health Link areas
  - introductory communications/meetings with providers in most of the Health Link geographies
  - several additional Health Links working on their Readiness Assessment

PART 2: GOALS and ACTION PLANS

Goal(s):

By December 2013, 12 Health Links will be operational across the HNHB LHIN, targeting the High User population.

Consistency with Government Priorities:

- HLs were announced by the Minister in December 2012. The LHIN's SHSP anticipated HLs and, as a result, our strategic directions are in alignment with the ministry.
- HLs represent a new model of care delivery, where all providers in a geographic area are charged with coordinating plans at the patient/client level.

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % 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.					
	2013-14		**2014-15**		**2015-16**	
	Status	%	Status	%	Status	%
Health Link geographies mapped out across the LHIN.	Complete	100				
Introductory communication to providers across the LHIN about Health Links and the plan for their implementation.	In progress	100				
Groups of providers in Health Link geographies mobilized, with cooperation agreements signed.	In progress	100				
Health Link partner groups complete and submit Readiness Assessment for LHIN review/approval and ministry review/approval.	In progress	100				
Approved Health Link groups complete and submit Business Plan for LHIN review/approval and ministry review/approval.	In progress	100				

High User cohort identified.	In progress	100				
Interventions to improve care delivery for High Users designed and implemented.	In progress	50		50		
Performance metrics in place and outcomes actively monitored.	In progress	50		25		25

How will we measure success?

- The ministry has identified 11 indicators which all Health Links will measure:
    1. Ensure the development of coordinated care plans for all complex patients
    2. Increase the number of complex patients and seniors with regular and timely access to a primary care provider
    3. Reduce the time from primary care referral to specialist consultation
    4. Reduce the number of 30 day readmissions to hospital
    5. Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere
    6. Reduce time from referral to home care visits
    7. reduce unnecessary admissions to hospitals
    8. Ensure primary care follow-up within seven days of discharge from an acute care setting
    9. Enhance the health system experience for patients with the greatest health care needs
    10. Achieve an ALC rate of nine per cent or less
    11. Reduce the average cost of delivering health services to patients without compromising the quality of care
- Initially, Health Links will likely focus on the following four indicators, in relation to the High User cohort:
    1. Ensure the development of coordinated care plans for all complex patients
    2. Reduce the number of 30 day readmissions to hospital
    3. Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere
    4. Reduce unnecessary admissions to hospitals
- These indicators will measure improvement at the individual, population, and system levels.

What are the risks/barriers to successful implementation?

- Multi-sectoral participants (primary and specialty care, hospitals, CCAC, community partners) are challenged in understanding (and consequently embracing) the vision of the initiative.
- Existing demands upon time and resources (related to fiscal pressures or case/patient volumes) translate into concerns regarding the participants' ability/willingness to become involved with the necessary collaboration and coordination aspects.
- The reluctance of a mandate partner may impact the ability of the Health Link to develop (regardless if majority acceptance is in place).
- The medical component of the Health Link is not accountable to the LHINs (thus potentially affecting the ability of the LHIN to support the development and implementation of the Health Link).
- The willingness/ability of physicians to support Health Links may be impacted should involvement not be considered revenue neutral.

- Participants doubt their ability to successfully support the Health Links vision given that both patients and services cross different Health Links geographic areas.
- The absence of a common and unified technology framework supporting necessary connectivity is perceived as a threat to a major tenet of Health Links (coordination).

For each risk/barrier, describe the plan to mitigate the risk?

- Every opportunity of engagement with participants is utilized as a way to explore the challenges, barriers and gaps that they experience with regards to supporting patient care. Care is taken in highlighting how the vision of Health Links has evolved as a direct response to many of these challenges. The value proposition is established in showcasing how Health Links has the potential to tangibly address these identified challenges.
- Health Links represents not just a dramatic reaffirmation of a commitment to patient care, but also a significant opportunity to redefine how participants collaborate and communicate with one another. Emerging technology enablers (i.e. the increasing scope/prevalence of Ontario Telemedicine Network (OTN)) as well as an interest in non-conventional interaction (e.g., 'huddles') are showcased as indicative of how Health Links will actually evolve to reduce the demand historically associated with the logistics behind collaboration and coordination.
- The LHIN continues to develop compelling value propositions and embrace early champions in an effort to highlight the relevance and importance of Health Links. The LHIN is visiting communities large and small in an effort to understand and address any doubts, concerns or uncertainty regarding how Health Links may positively impact patient care.
  Respecting existing accountability mechanisms with other organizations, the LHIN is focusing on the very unique challenges and uncertainties that may surface from the medical component of the model. An emerging appreciation of greater system involvement and partner participation is encouraging moving forward. The LHIN identifies and partners with physician champions whenever possible in engaging the wider provider community.
- In meeting with primary care providers across many communities large and small, the LHIN is demonstrating its understanding and appreciation of the physician's commitment to practice and care obligations. As such, the LHIN is visiting providers where they work and where they live and at hours more conducive to their scheduling preferences. In addition to redefining how collaboration and coordination actually occurs, Health Links will work to bring together partners in a way that is convenient, relevant and valuable.
- The LHIN has emphasized that providers' ability to refer patients across Health Links will not be affected. Also, the LHIN has acknowledged that supporting patients across different areas and providers is certainly a challenge. The LHIN continues to highlight the importance of connectivity and the various enablers associated with such communication emerging through the Health Links initiative.
- Health Links will offer participants to become engaged in developing solutions to the ongoing challenge of technology as it relates to connectivity across the continuum of care.
- Local experts and ministry resources alike will be called upon to explore the specific issues and challenges put forth and, consequently, work in capitalizing upon local and emerging assets in developing a solution.
- The focus is on early traction with regards to addressing such challenges. It is understood, however, that the road towards comprehensive system connectivity is a longer-term objective.

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

- Clear and consistent messaging regarding what Health Links offers with regards to supporting patients and families across the continuum of care.
- Positioning the LHIN as an enabler and facilitator of the work of partners and providers who are intimately aware of the successes, challenges, opportunities and barriers within their unique geographic areas.
- Engaging champions across various sectors in supporting the Health Links initiative.
- Emphasizing the focus of action over planning; that real change – driven from locally-driven solutions – is not just a possibility but an inevitability.

Additional Comments (i.e. additional information that supports the implementation/success of the goal).
• Focus remains on building a system that is sustainable and responsive over time (as opposed to crafting together short-term solutions for a distinct cohort). • Supporting both patients and their families through providing services at a local level with objective of improving population health and patient/family satisfaction. • Educate and build awareness of such services to empower patients/families to make informed health care choices. • Pursuing a system that is simplified, relevant and powerfully coordinated in the interest of the patient.

ii. LHIN-wide Integrated Clinical Programs

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by integrating service delivery: LHIN-wide Integrated Clinical Programs.
IHSP Priority Description:
Integrated service delivery means the system will be redesigned to ensure the person is at the centre of care. This will include: • LHIN-wide integrated clinical programs providing specialized services to LHIN residents. LHIN-wide integrated clinical programs will coordinate and standardize clinical service delivery across the LHIN, including: o Common definitions and patient flow processes. o Common care model and quality improvement approaches, based on leading practices. o Projected need and distribution of services (population based). o Common outcomes, goals, and deliverables. o Increase standardization and the reduction of clinical variation across LHIN providers. o The key concept behind LHIN-wide integrated clinical programs is 'one clinical program – multiple sites', ensuring that all residents across the LHIN have access to a coordinated program, following the same care delivery and quality standards.
Current Status:
Currently, most 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 SHSP 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 a key goal for this IHSP priority. **Key issues:** • 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 the HNHB LHIN is high compared to the province, and projected utilization is not sustainable.
- **Successes of the past year** – following the LHINs Clinical Services Plan (CSP) in 2009, work proceeded on the development of a number of LHIN-wide programs. The following highlights some of the recent successes:
    - Oncology: The Integrated Cancer Screening Plan (ICSP) has organized cancer services in the LHIN by developing a standardized approach across the LHIN for disease specific treatments and patient care plans. These include radiation and systemic therapy, psychosocial oncology, IT including health records and health human resource planning. Led by the Juravinski Cancer Centre (JCC), this LHIN-wide programming includes the two radiation therapy sites (JCC and Niagara Health System (NHS)), as well as the systemic therapy sites (Hamilton Health Sciences Corporation (HHSC), St. Joseph's Healthcare Hamilton (SJHH), NHS, Brant Community Healthcare System (BCHS) and Joseph Brant Hospital (JBH)). A single intake process is being developed to support standardization and the delivery of a single program across multiple sites.
    - In addition, the program has improved the regional organization of surgical oncology by disease, and implemented a single radiation program/team/leadership for the LHIN with cross credentialing with HHSC and NHS being a key integration mechanism. The establishment of satellite cancer services operating across the LHIN for system therapy has occurred as well as the deployment of a common oncology information system (MOSAIQ) across the LHIN.
    - Laboratory services: in June 2012, the LHIN hospitals established a LHIN Laboratory Council, implementing central leadership for the administration of laboratory services offered at each participating hospital laboratory site. Six of ten hospital corporations are participating, representing approximately 90% of the total annual LHIN hospital laboratory test volume of 12.7 million tests. Centralized administrative leadership will enable the implementation of the integrated program framework, resulting in improved turn-around times, reduced variation and improved quality.
    - Vascular services: To support implementation of an Integrated Vascular Service, a Memorandum of Understanding (MOU) is being signed across all HNHB LHIN hospitals. As a result, the HNHB LHIN Vascular Services Plan has successfully implemented a Regional Vascular physician call schedule. The targeted number of Endovascular Aneurysm Repair (EVAR) procedures being performed is on target and the no refusal policy has been implemented LHIN-wide and is very effective.
    - The Provincial Vascular Planning Group is developing a provincial vascular plan and is using the HNHB LHIN Integrated Vascular Clinical Services Plan as a model to be included in a provincial plan.
    - Thoracic services: Standardized definitions of non-malignant thoracic surgery and an urgent care algorithm have been developed and are in place at all HNHB LHIN hospitals. As a result of this standardization and coordinated community support, a decreased length of stay for specific case mix group (CMG) of typical thoracic cases has been seen. As the lead for this plan, SJHH has partnered with CritiCall to facilitate patient flow across the LHIN, worked to increase the use of telemedicine for thoracic rounds and case conferencing and created a website for both patients and health care professionals that provides information specific to thoracic surgery.
    - Mental Health and Addictions: discussions have been initiated with SJHH to work towards a LHIN-wide program for adult inpatient MH and A services. With the completion of the new West 5th campus of SJHH (March 2014) and the new St Catharines site of the NHS (March 2013), the LHIN will have significantly expanded inpatient schedule 1 and tertiary psychiatry capacity. Other schedule 1 capacity exists at BCHS and JBH.
    - Orthopaedics and Total Hip and Total Knee Replacements: with the announcement of QBP funding for TJRs, all LHINs are in the process of compiling an Integrated Orthopaedic Capacity Plan. The 'current state' portion of the plan has been completed and the future state framework, including common service delivery model, and projected needs-based distribution of services. In 2011-12, over 4100 TJR surgeries were performed in our LHIN, involving 45 surgeons at seven different hospital sites.
    - Cardiac: Catheterization and Percutaneous Coronary Intervention (PCI) services: HHSC and NHS have been working collaboratively to develop an integrated cardiac catheterization and PCI program.

In May 2012, these hospitals submitted a proposal for an Integrated Stand-alone PCI program to be operated by HHSC and located at two sites NHS' new St. Catharine hospital and HHSC.

- The HNHB Board supported the submission of the proposal to the ministry. An MOU for the integrated PCI program has been signed by HHSC and NHS. A final proposal was submitted to the ministry in November 2012, and approved by the ministry in April, 2013. The Cardiac Care Network (CCN) of Ontario has reviewed the proposed program model and submitted a report to the ministry stating the NHS - HHSC proposal aligns with the CCN PCI planning criteria.

PART 2: GOALS and ACTION PLANS

Goal(s):

LHIN-wide clinical programs are in place in the LHIN.

Consistency with Government Priorities:

LHIN-wide integrated clinical programs will:

- Promote equitable access to health and health care for all residents
- Improve quality by reducing variation and standardizing care delivery models
- Improve transitions through common patient flow processes
- Support right care, right time, right place

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % 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.					
	2013-14		**2014-15**		**2015-16**	
	Status	%	Status	%	Status	%
Oncology: Implement the ICSP through the: • development of a decision support network across the LHIN to review Program data • development of a Regional Scorecard • development of a Cancer Council through collaboration between JCC and JBH Develop the Walker Family Cancer Center (WFCC) through the: • implementation of a Regional Informatics Strategy (RIS) • establishment of an Integrated Radiation Treatment Program (IRTP) with a signed partnership agreement between JCC and WFCC	Initiated Initiated	75 100		25		

Strengthen and Integrate the Regional Cancer Program (RCP) through the: • implementation of the ICSP • implementation of the Regional Systemic Therapy Plan	In progress	75		25		
Laboratory Services: • integrate Lab Information System • coordinate LHIN-wide specimen transportation • consolidate specialized testing, where possible, within existing space • continue to plan for a centralized Lab facility (following ministry capital submission and review process) • add remaining hospitals to Integrated Laboratory Services Program	In progress	25		25		25
Vascular Services: • establish outpatient clinics, to be located at HNHB LHIN hospitals. These resources will be standardized and modeled after the Hamilton General Hospital Vascular Clinic	In progress	75		25		
Thoracic Services: • education and implementation of a no refusal policy which is a component of the LHIN–wide critical care strategy • the development of a pleural effusino clinic in Brantford in conjunction with HNHB CCAC and SJHH to enable outpatient care to be provided closer to home and continue to support the decrease in inpatient length of stay	In progress In progress	100 100				
Mental Health and Addictions (adult inpatient): • establish integrated program working group; develop current state assessment; complete framework for integrated program and service delivery	In progress	75		25		
Orthopaedics (TJR): • complete integrated capacity plan for submission to ministry (March 31, 2013); implement common service delivery plan and measure outcomes against MLPA indicator targets	In progress	75		25		
Cardiac (catheterization and PCI services): • following ministry approval of LHIN's proposal for Integrated PCI program,implementation will start in April, 2013, with projected completion in January 2014.	In progress	25		75		

Diagnostic imaging – (interventional): • establish integrated program working group; develop current state assessment; complete framework for integrated program and service delivery	Not Yet Started	25		75		
Obstetrics – (c-section): • establish integrated program working group; develop current state assessment; complete framework for integrated program and service delivery	Not Yet Started	25		75		
Ophthalmology – (cataracts): • establish integrated program working group; develop current state assessment; complete framework for integrated program and service delivery	Not Yet Started	25		75		

How will we 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, including the following MLPA indicators:
  - increase percentage of surgeries completed by priority wait time targets (cancer, cardiac bypass, cataract, hip and knee)
  - increase percentage of diagnostic scans (MRI and CT) completed by priority wait times targets
  - reduce repeat unplanned ED visits within 30 days for MH and A
- 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
- All hospital Laboratory services part of integrated program
- Received ministry approval for an LHIN integrated PCI program to be operated at two sites
- PCI services are provided at the NHS (St. Catharines) through the integrated model – one program, two sites

What are the risks/barriers to successful implementation?

- Cost of restructuring – lack of available one-time funding for restructuring may impede ability to participate
- 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
- Human Resources (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

For each risk/barrier, describe the plan to mitigate the risk?
• 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 HR 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.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).

iii. LHIN-wide Population Based Strategies

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by integrating service delivery: LHIN-wide Population Based Strategies
IHSP Priority Description:

• LHIN-wide population-based strategies will provide a coordinated approach to serve priority populations including:
  ○ Older adults; this priority focuses on:
  ▪ early identification of high risk seniors in hospital and the community
  ▪ prevention of functional and cognitive decline
  ▪ optimizing patient flow by improving:
  ❖ access to restorative programs
  ❖ support individuals as they transition across the continuum
  ❖ facilitate individuals' transition to the right level of care
• Individuals who require timely access to ED services (ED capacity and wait times)
• individuals with complex chronic conditions, this priority will focus on stroke services, diabetes, CHF and COPD
• Individuals that are require palliative/end of life care
• Initiatives planned and implemented within these strategies will include and collaborate with the LHIN's Aboriginal and Francophone populations

Current Status:

LHIN-wide population based strategies:

Older Adults - Patient Flow – Chronic Conditions:

- In 2012-13, the HNHB LHIN continued to implement strategies identified in its 2011 three year Action Plan to improve patient flow across the healthcare continuum. This plan recognized that patient flow must be viewed as a system issue where all components of a strategy are implemented and aligned.
- Literature reports that one-third of frail seniors lose independent function while in hospital – half do not ever regain the function they lost.[11] While the level of risk for functional and cognitive decline for seniors is high, effective interventions can reduce or prevent such outcomes.[12]
- In 2012-13, the LHIN completed a review of hospital data 2011-12, which revealed that 730 patients accounted for the top 10% of the population waiting in LHIN hospitals for an ALC and that together these patients accumulated 51% (55,922 days) of all ALC days. The review further revealed that this population was mainly senior with an average age of 77 years; 68% of the population was 75 years of age or older; had an average length of stay of 77 days; 83% of the population were admitted to the hospital through the ED and 65% were admitted from home without home care.[13]
- HNHB LHIN HSPs from the acute, community and LTC sectors are working together to:
  - facilitate patient's access to the most appropriate level of care, support patients as they transition across care settings and ensure that they have access to care that is patient centered and optimizes their health status. A focus on their work is targeted to the older 'at risk' population.
- Early identification – In 2011-12 an evidence based validated Early Intervention Screening (EIS) tool for seniors 75 or older was developed and piloted in two LHIN hospitals. The pilot found that 58% of those screened were not known to the CCAC. When assessed by the CCAC, 46% (143) were connected to CCAC services.[14] In 2012-13 the EIS tool is being implemented in all ED's across the HNHB LHIN.
- Home First - The HNHB CCAC continues to work with hospitals to support individuals returning home from hospital when their acute phase is over. This Home First approach, practiced through the LHIN since 2009, reinforces the message that home is the best environment for recuperation and is a less stressful place to make life decisions.
- Assess and Restore - For patients who need more time to recover following an acute hospital admission, the LHIN established Assess Restore restorative type programs across the LHIN. In 2012-13, the HNHB LHIN supported 134 Assess Restore type programs across seven sites throughout the LHIN. As of January 2013, 944 individuals were discharged from the program of which 78% were successfully discharged home.[15]
- Transitions in care and patients with chronic conditions - While the acute care model still functions well for younger patients, it often disadvantages older adults with chronic health problems[16]. Providing optimal assessment and discharge planning tends to be more complex for older patients in ED settings, where time pressures and the need to maintain rapid patient throughput are considered essential.[17] These, along with other factors, may account for higher rates of adverse outcomes, such as: ED revisitation, hospitalization, and functional decline.[18]

[11] Sager et al, 1996; Covinsky et al, 2003
[12] Sinha, S. Dr., (2012) Living Longer, Living Well. MOHLTC
[13] Discharge Abstract Database, HNHB LHIN IDS
[14] HNHB CCAC Q3 & Q4 2011-12
[15] HNHB CCAC AR-SSR Report
[16] Sinha, S. Dr., (2012) Living Longer, Living Well. MOHLTC
[17] Hwang, U and Morrison, RS. 2007. The Geriatric Emergency Department: A Systematic Review of Patterns of Use, Adverse Outcomes, and Effectiveness of Interventions. Annals of Emergency Medicine. 39:238-247.
[18] Aminzadeh, F et al. 2002. Older Adults in the Emergency Department: A Systematic Review of Patters of Use, Adverse Outcomes, and Effectiveness of Interventions. Annals of Emergency Medicine. 39:238-247.

- In November 2012, the ministry reported that HNHB LHIN's readmission rate for the first quarter of 2012-13 (April 1, 2012 to June 30, 2012) was 16.48%[19] higher than the LHINs target of 15.95% (includes corridor):
  - In 2012-13, the HNHB LHIN focused on two strategies to improve transitions in care for patients with complex conditions in the HNHB LHIN – the development and implementation of a Rapid Response Transition Team (R2T2) and the development and piloting a Discharge Transition Bundle based on HQO bestPATH.
- Stroke Services Acute – The release of the 2012 Ontario Stroke Report Card identified that for the second year in a row the HNHB LHIN fell below the benchmark on all 20 stroke indicators.
  To address this, the LHIN in consultation with the Central South Regional Stroke Network (CSRSN) identified opportunities to improve stroke care and outcomes in the short and long term. The LHIN in collaboration with the CSRSN Coordinator and Physician Lead is working with specific LHIN hospitals to integrate acute stroke services. The LHIN has also established a working group to develop a Community Stroke Rehab Outpatient Model.
- Diabetes - In the last quarter of 2012-13, the ministry transitioned Diabetes Regional Coordination Centre (DRCC) and select Diabetes Education Programs (DEPs) to LHINs. This transition will be completed by March 31, 2013. A review of LHIN ED data showed an increasing trend in the number of individuals that visited the ED for diabetes related problems from 19,259 in 2009-10 to 23,383 in 2011-12, accounting for 81,740 visits in 2009-10 to 92,289 visits in 2011-12.[20]
- Hospice Palliative Care refers to palliative services provided in the community, in hospitals and in residential hospices. The LHIN supports five residential Hospices through the HNHB CCAC, for a total 42 beds.[21] In 2011-12, 609 individuals received care at these five Hospices. The LHIN also supports the Good Shepherd's Emanuel House, a ten bed unit that provides Hospice services.
- Community palliative care services include: in home care provided by CCAC, the Palliative Pain and Symptom Management Consultants Program, the Interdisciplinary Community Based and Physicians Education Programs, and the Primary Care Volunteer Visiting Program.
- In 2011-12, LHIN hospitals reported 9,926 ALC days associated with patients waiting in hospital to access the preferred palliative care destination, with 6,301 attributed to the two Hamilton hospitals.[22]
- Behavioural Supports Ontario (BSO)– The BSO strategy focuses on improving care and system navigation for individuals/caregivers who have, or are at risk of responsive behaviours. In 2012-13 the LHIN further developed and implemented four of the improvement plans identified in its BSO Action Plan. These included:
  - BSO Connect – a single point of information and referral (clients/caregivers/healthcare providers) providing active referrals, pulling services towards clients
  - BSO Community Outreach Team – five teams located across the LHIN with existing community crisis teams provide 'just in time' (crisis) support to target population linking them to longer term support
  - Integrated Community Lead (ICL) service model – where one community agency is the single point of contact for BSO clients
  - BSO LTC Mobile Team- implemented across the LHIN, serving the LHIN's 86 LTCHs
- Access to ED Services - The HNHB LHIN has 13 hospital EDs across ten hospitals corporations, eight of which participate in the ministry's Pay for Results (P4R) program. In 2011 -12, LHIN ERs saw 462,853 visits, relatively consistent with 2010-11 (462,882). As of December 2012, LHIN EDs reported 361,969 visits.[23] If this trend continues, the number of ED visits for 2012-13 will exceed those seen in the previous two years. In the first six months of 2012, the LHIN reported an increasing trend of unscheduled ED visits of 94 to 97 per 1,000 population but continues to be lower than the provincial average.[24]

[19] Access to Care – Cancer Care Ontario (ATC- CCO) Final Individual LHIN MLPA November 2012
[20] HNHB IDS February 2013
[21] HNHB LHIN confirmation with hospices January 2013
[22] HNHB LHIN IDS DAD Sensitivity Analysis 2011-12. January 2013.
[23] ACT-CCO ER Public Reporting & Pay for Results Hospital Comparison Report December 2012
[24] ATC-CCO Stocktake Report November 2012.

- HNHB LHIN EDs are also reporting a higher volume of high acuity (Canadian Triage Acuity Scale (CTAS) 1-3) visits. From the first quarter of 2008-09 (April 2008 to June 2008) to Q3, 2012-13 (October to December 2012) high acuity visits increased 32% while low acuity visits (CTAS 4, 5) decreased 28%.
- In December 2012, HNHB LHIN hospital EDs reported length of stays (LOS) (from triage to discharge from the ED) for Q3 (October 2012 – December 2012) that were higher than the LHIN's MLPA target and equal or higher than the LHINs 2012-13 fiscal year baseline:
  - admitted patients – 35.4 hours (close to the 2012-13 fiscal year baseline 35.45 hours,)
  - non-admitted high acuity – eight hours (higher than the 2012-13 fiscal year (FY) baseline of 7.75 hours)
  - non-admitted low acuity – five hours (higher than the 2012-13 FY baseline of 4.87 hours)
- Despite the challenges, LHIN EDs are experiencing a reduction in ED LOS, especially for the admitted population. They are making some gains in the face of a five percent increase in the admitted population in the first nine months of 2012 -13, compared to the same interval for 2011-12 (51,956 vs. 49,482).[25]

Key issues:

- Limited access to group home/supportive housing for patients waiting in hospital that have challenging behaviours.
- Individuals waiting in hospital for LTC that have chosen LTCHs with the longest waits (measured in years).
- The time patients wait in a hospital bed, when their acute phase is over, to access complex care, inpatient rehab, restorative type programs and palliative care.
- Access to hospice palliative care services in the community.
- Availability of acute care beds:
  - On December 30, 2012, LHIN hospitals reported 390 patients designated ALC in both acute and other inpatient beds, this number increased to 479 on January 13, 2013. During this time interval the LHIN's internal ALC rate increased from 12.4% on December 30, 2012 to 14.4 on January 13, 2013.[26] Of note the number of patients designated ALC waiting in all hospital beds has improved since January 2010 (656).
- Infection control protocols and facility outbreaks compounded by access to private rooms. In November 2012, some LHIN ERs reported 30% of their admitted patient population through the ED required isolation protocol.[27]
- Availability of health human resources, for example Nurse Practitioners (NPs) (Palliative Care).

Successes of past year:

- A sustained improvement in percent ALC. From April to November 2012, the percent ALC has steadily improved from 14.0% to 12.3%.[28]
- In November 2012, the LHIN reported the lowest number of ALC days in a month (7,676) since reporting started in 2009 – this is a 100% improvement over the 15,428 ALC days reported in June 2009.
- The LHIN exceeded the targets identified in the 2011-12 ABP for the following metrics:
  - Reduced the number of people waiting in hospital for LTC. Since November 2011 the number of people waiting across all LHIN hospitals has ranged from 139 – 16,028 (target 180).
  - LHIN Assess Restore programs reported median length of stay (LOS) ranging from 32 - 62 days (note includes LHIN's new Reactivation Program) and that 76-80% of patients were discharged home[29] (LHIN target median LOS 45 days and 70% discharge rate).
  - As of September 30 2012, 116 patients accessed LHIN slow stream rehabilitation programs, median LOS of 50 days and 78-87%[30] discharged home (LHIN target 18 clients serviced for the year and median LOS 50 days).

[25] ATC-CCO Historical ER Public Reporting & Pay for Results Hospital Comparison Report December 2012, ER Public Reporting & Pay for Results Hospital Comparison Report December 2012,

[26] HNHB CCAC ALC Active Counts and Rates January 27, 2013 and December 31 2012.

[27] Hospital reported isolation data November 2012

[28] HNHB LHIN Weekly Hospital ALC Trigger Report October 2012

[29] HNHB CCAC Transitional Care Bed Report for MOHLTC Q3 2012-13

- 2011-12, 100% of patients identified as requiring ALC for more than 30 days had intensive case management review and discharge plan completed[31] (target 80%).
- Since February 2012, the number of patients waiting in complex care beds for LTC ranged from 17.2% to 19.9% (target 20%).

- The number of people waiting in hospital greater than 30 days for an ALC has decreased from 360 in January 2010 to 157 in January 2013.[32]
- As of September 2012, CCAC reported supporting 1,660 clients on service maximums, of these 523 were from hospital.
- As of September 2012, the R2T2 program was in place across the HNHB LHIN and had reported serving 400 clients, of these, 190 were admitted from hospital and 9.2% of the clients discharged home had been designated ALC. In Hamilton, the R2T2 program is also working with HSPs to support patients with heart failure so they can return and be maintained in their homes.[33]
- As of September 2012, two LHIN General Internal Medicine Rapid Access Clinic's (GIMRAC) reported seeing 1,920 new clients and 895 clients for follow up visits. Of the clients seen, 312 were considered ED divisions and 212 were early hospital discharged. One hospital that is tracking reduction in ED LOS for this population reported a 70% reduction in the LOS patients waited at the Clinic vs. the ED.
- Between October 2012 – December 2012, seven LHIN hospital EDs implemented the Early Intervention Screening (EIS) tool and have referred 154 individuals to CCAC for follow up.
- Completion of a study funded by the LHIN Emergency Services Steering Committee (ESSC) examining ED Quality Indicators for the treatment of: Migraine, Asthma, Sepsis, Stroke, and Acute Myocardial Infarction (AMI). The ESSC is working with the LHIN ED Chief and the Chiefs for the various EDs to implement recommendations; the first set of recommendations to be implemented relate to the management of Migraines in the ED.
- Expansion of the Community Referrals by Emergency Medical Services (CREMS) Program in Niagara, Haldimand, Brant and Burlington. Norfolk County roll-out will be complete in 2013-14. As of August 2012, the CREMs program in Hamilton made 660 referrals to the HNHB CCAC, of these, 92% resulted in new services being initiated.[34]
- Reduced variations in palliative outreach care by developing:
  - host site standardized approach and processes
  - common indicators, metrics and reporting requirements
  - common team care pathways, processes and assessment tools
  - common training and orientation processes
- Implemented through the Hospice Palliative Care Network (HPCN), an Advance Care Planning (ACP) and Health Care Consent (HCC) strategy is in place for the HNHB LHIN, including:
  - providing regulated health professional training sessions for community and LTC sectors training and supporting over 200 organizational champions
  - providing Physician training in conjunction with the Division of Palliative Care, McMaster University
  - developed an HNHB ACP and HCC framework and tool kit for HSPs and patients
- As of December 2012, the following programs reported:
  - BSO Connect served 279 individuals [35]

[30] HNHB LHIN Hospital Q2 2012-13 Reports
[31] HNHB LHIN CCAC and Hospital Reports
[32] HNHB ALC IS January 2013
[33] HNHB CCAC ALC Community Investment Report October 2012
[34] Hamilton Emergency Medical Services
[35] BSO Program reported data December 2012

- BSO Community Outreach Team served 498 clients, linking them with longer-term support as needed
- 41 LHIN funded agencies were operating as Integrated Community Leads (ICLs) for the BSO population across the LHIN
- BSO LTC Mobile Team - 741 unique clients were served and their cases closed and over 6,800 visits.

PART 2: GOALS and ACTION PLANS

Goal(s)

2013-14 LHIN-wide population based strategies are in place and have the following goals:

Older Adults – Patient Flow:

- Initiatives implemented under the LHIN's Patient Flow Action Plan will be maintained to sustain and continue to improve patient flow through the Home First philosophy and the LHIN's patient flow bundled strategies.
- Individuals have timely access to the most appropriate restorative type program (Complex Care, Convalescent Care, Assess Restore, Slow Stream Rehab and Complex Care Restorative Stream) as measured by a reduction in ALC days associated with these destinations.
- The LHIN R2T2 will be fully implemented across the LHIN. Patients identified as 'High Risk" for readmission discharged to the R2T2 will have a lower rate of readmission to hospital within 30 days than the LHIN rate.
- The LHIN's Discharge Transition Bundle based on HQO BestPATH will be implemented across all LHIN hospitals.
- Hospitals will have continued to identify and implement Senior Friendly Hospital initiatives.
- Increase access to Assisted Living/Supportive Housing.
- The LHIN's BSO Integrated Community Lead service model will be incorporated as a LHIN specific expectation in the M-SAA for all community agencies that support the BSO population.
- Performance metrics will be identified for the BSO ICL service model .
- The BSO Mobile LTCH model will be fully implemented .

Improved Access to ED Services:

- Seniors 75 years and older presenting to LHIN EDs will be screened using the EIS tool.
- A standard ED treatment protocol will be developed by the LHIN's ESSC and the LHIN ED site Chiefs for Migraines, and piloted across the LHIN in 2013-14. A plan for development of standardized ED treatment protocols through the ESSC for the remaining four conditions (asthma, sepsis, stroke and AMI) will be identified.
- Expand the use of the Community Referral by EMS to Norfolk County.
- Review and report on 2011-12 ESSC funded projects that may potentially have benefit to improving ED access.
- Reduce avoidable hospital admissions through increased referrals to CCAC, Health Care Connect and use of other non-hospital care settings (Assess Restore, convalescent care).

Chronic Conditions:

- Through integrating existing LHIN resources (R2T2, specialty outpatient clinics), knowledge from the HQO Expert Panel reports, and the leadership provided from the LHIN's Health Links, there will be reduced variation in the care provided to individuals with CHF and COPD through implementation of increased standardized care.
- The LHIN will have access to more timely data on admission and readmission rates through the IDS tool.
- Acute stroke services will be provided through an integrated acute care stroke recovery system that:
  - provides standardized evidence based stroke care, improves stroke care demonstrated by improvement in stroke indicators and improves patient outcomes
- A community stroke rehab outpatient model will be developed and piloted.

- The LHIN will identify the status of the existing diabetes resources transferred to the LHIN, and develop and plan for diabetes services across the HNHB LHIN by April 30, 2013.

Palliative:

- Increase access to, and enhance resources to, interdisciplinary expert Palliative Care Shared Care Outreach Teams in the community.
- Improve access to hospice palliative care:
  - services across the HNHB LHIN area
  - by patients with broader chronic diseases
  - earlier in the disease trajectory, targeting the last year of life.
- Improve patient (caregiver) experience at end of life by embedding a culture of quality throughout the system and integrating service delivery where needed (as measured in ALC days). Monitoring individuals experience in hospital for access to palliative care services.
- Advanced Care Planning (ACP)/Healthcare Consent (HCC) training for all Directors of Care using a standardized training module incorporated as a LHIN specific requirement in the 2013-16 L-SAA.

Consistency with Government Priorities:

Each of these goals is consistent with:

- The Minister's Action Plan for Health Care, whose three foci include:
  - keeping Ontario healthy – through early detection and better management of chronic conditions, and ensuring care is patient centered, driven by outcomes and based on evidence
  - faster access and a stronger link to family health care - by improving system navigation (especially for seniors), supporting patients at key transition points, ensuring they are linked with primary care
  - right care, right time, right place – by providing the right care by the most appropriate care provider and in the right place and where 'home' is always considered first
- Senior's Strategy (Dr. Sinha's report -Living Longer, Living Well and Dr. Walker's Report) [36]
- BSO Provincial Strategy

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % 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.					
	2013-14		**2014-15**		**2015-16**	
Examples:	Status	%	Status	%	Status	%
Older adults – Patient Flow: • Implement additional convalescent care beds in LTCHs and review referral processes and length of stay at existing restorative programs to optimize flow and improve access.	Initiated	75		25		

[36]

• Full implementation of the LHIN's R2T2 program and reduction in readmission rate for clients identified as high risk discharged to team.	Initiated	100				
• LHIN discharge bundle will be implemented across LHIN hospitals.	Not yet started	25		75		
• A new Assisted Living Hub will be implemented in Hamilton.	Not yet started	100				
• Senior Friendly Hospital (SFH) – Review LHIN hospitals current SFH initiatives to identify best practices and opportunity to share processes across the LHIN.	Not yet started	100				
• Sustain and continue to improve patient flow through Home First Philosophy and bundled strategies implemented in 2011-12.	Ongoing					
• 81 LHIN funded HSPs participating in the LHIN's BSO ICL service model.	Initiated	100				
EDs: • All LHIN EDs will screen individuals 75 years and older (exception transfers from LTCH and those in acute distress) using the EIS and hospitals specific targets will be developed for inclusion in the H-SAA 2014-15 agreement/refresh.	Initiated	100				
• A standardized treatment protocol will be developed and implemented across LHIN EDs for individuals presenting to the ED for migraines.	Not yet started	100				
• CREMS will be expanded to Norfolk County.	Not yet started	100				
• Complete a review and report on 2011-12 ESSC funding projects to identify those that have demonstrated a benefit to reducing ED demand and could be disseminated to LHIN EDs.	Not yet started	100				
• Review admission data from LHIN EDs that report admission rates higher than their peer hospitals to identify populations that could be redirected.	Initiated	100				
Chronic Conditions: • Identification of discharge standardize instructions and follow up plan for CHF and COPD for implementation across LHIN hospitals	Not yet started	50		50		
• Acute stroke and inpatient rehab services will be integrated in Brantford, Hamilton and Niagara.	Initiated	50		50		

• Community stroke rehab outpatient model will be developed and piloted (pending approval of the model and confirmation of resources).	Initiated	100				
Palliative: • Implement four new palliative shared care outreach teams and enhance the resources at five existing teams.	Initiated	100				
• Development of a LHIN regional plan for palliative care to reduce variation, eliminate duplication, increase best practice standardization, integrate services and identify common metrics.	Initiated	75		25		
• Review existing program mandates and align to support standardized care delivery.	Initiated	100				
• Specialized palliative and advanced chronic disease resources are standardized and coordinated at the regional level	Initiated	50		50		

How will we measure success?

- Sustain or improve the LHIN's ALC rate < 11%.
- The number of individuals waiting across LHIN hospitals for placement to LTC will be less or equal to 160.
- Reduce the ALC days associated with patients waits to access complex care and restorative programs (baseline 15,854 days. Source: Wait Time Information System (WTIS) ALC 2011-12 all bed types).
- Reduction in admission and readmission rates in targeted populations that include:
  - Individuals served by the LHIN R2T2 program (target or baseline to be identified)
  - HNHB LHIN established Health links.
- Reduce the ALC days associated with individuals waiting for palliative care in hospitals (baseline 10,386 days. Source WTIS ALC 201-12 all bed types).
- MLPA-ED performance metrics will be met.
- All LHIN hospital EDs have implemented InterRAI ED screener and CCAC receiving referrals for individuals that need services (target to be identified).
- Standardized treatment plan for migraines implemented in all LHIN ED.
- CREMS implemented by Norfolk Emergency Medical Services (EMS).
- Reduction in the admission rates at those hospitals that reported rates higher than their peer hospitals (target and or base line to be confirmed).
- Reduction in the 30 day readmission rate for COPD and CHF (baseline 2011 –Readmission ratio COPD 20, CHF 21.937).
- 85% of seniors (75 years and older) referred to Health Care Connect are linked to primary care (need to obtain baseline from ministry).
- Evidence that acute stroke services have been integrated (metrics to be confirmed).
- Metrics for the community stroke rehab pilot to be confirmed (pending approval and implementation of the pilot).

[37] MOHLTC Stocktake Report HNHB LHIN November 2012

- Increase in the number of individuals the accessed the interdisciplinary shared care outreach teams (targets to be confirmed following discussion with program).

What are the risks/barriers to successful implementation?

- Increased pressure on CCAC resources to support high risk clients as they age at home.
- Availability of health human resources (HHR)(i.e. access to NPs)
- Access to Primary Care to provide services on evenings and weekends.
- Hospital's capacity to introduce new processes/protocols (i.e. discharge bundles, screening tools).
- Demand on ED services as a result of Influenza like outbreaks.
- Number of individuals admitted through the ED that need isolation protocols.
- Impact of infection control outbreaks on patient flow.
- Clinical Practice resulting in higher than normal admission rates in some hospitals.
- Co-location of ED and Urgent Care Centre (UCC) in St. Catharines may lead to increased wait times, especially in the short term.
- Timing and impact on ministry funding reform (QBP for stroke) on program integrations
- Magnitude of the burden of diabetes across the LHIN

For each risk/barrier, describe the plan to mitigate the risk?

- CCAC and hospitals to work together to maintain a bed management system that supports system flow.
- Enhance the range and scope of alternative settings available in the community.
- Optimize opportunities for ALC settings – including the expansion of assisted living hubs.
- HealthForceOntario and other recruitment strategies.
- Increased public education regarding flu prevention and treatment options.
- Work with the LHIN ED Physician Lead and LHIN hospitals with high ad to identify the specific barriers and methodology for changing the admission rates while still maintaining high clinical standards.
- Availability of ongoing P4R funding.

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

- Continued financial support for the P4R initiatives.
- Increased availability of health care options including Primary Care availability on evenings and weekends.
- Health links implemented and operational across the LHIN.
- Access to acute and timely data.

Additional Comments (i.e. additional information that supports the implementation/success of the goal).

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Dramatically improving the patient experience by integrating service delivery: LHIN-wide Population Based Strategies: Aboriginal Health

IHSP Priority Description:

Healthy Families, Healthy Children, Healthy Communities

Current Status:

Scope of services currently provided/type and number of providers involved:

- The LHIN currently provides funding to two Aboriginal HSPs – 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 HSPs in our LHIN, such as the three Friendship Centres, that are not currently eligible to receive funding from the HNHB LHIN.
- This year additional funding was provided to the Native Horizons Treatment Centre for the development of a Community Wellness Team.

Number and type of clients served:

- 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.

Key Issues:

- 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 (AHN) has identified three strategic priorities for their five year work plan, including: Youth mental health and the high rates of youth suicide; Chronic Disease management and the high rates of diabetes, and finally family violence and strengthening the family unit. The Network is currently focusing on addressing the first issue of youth suicide and is meeting regularly to develop a detailed action plan.
- The AHN received LHIN one-time funding to provide suicide prevention training to Aboriginal organizations across the HNHB LHIN. The initial intent of this funding is to build community capacity through train-the-trainer sessions in both Applied Suicide Intervention Skills Training (ASIST) and safe Tell, Ask, Listen and KeepSafe (TALK).
- The AHN received LHIN one-time funding to provide cultural awareness training to LHIN staff and Board members and health service providers across the HNHB LHIN. This is recognized as the first step towards building cultural sensitivity, competency and safety.
- The AHN utilized its Aboriginal Engagement Funds to advance aboriginal planning within the context of the HNHB LHIN Strategic ACTION and Health Links by consulting with the broader Aboriginal community to collect stories on the value of including appropriate cultural practices to improve Aboriginal health outcomes.

PART 2: GOALS and ACTION PLANS

Goal (s):

- To advance the three strategic priorities identified by the AHN in their five year work plan.
- Developing work plans identifying key priorities for each of the priorities identified:
  - Youth MH and the high rates of youth suicide
  - Chronic disease – focus on diabetes
  - Improve family and child health.
- Expand suicide prevention training optimizing the trainers trained in the initial phase of training.
- Reduce Aboriginal health disparities – identify a plan to improve engagement within the Aboriginal community and with other stakeholders by June 30, 2013.

Consistency with Government Priorities:

Each of these goals is consistent with the Minister's Action Plan for Health Care, whose three focus include:

- Keeping Ontario healthy
- Faster access and a stronger link to family health care
- Right care, right time, right place
- Aboriginal population is a priority population
- Provincial LHIN's project charter (Fall 2010)

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % 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.					
	2013-14		**2014-15**		**2015-16**	
Examples:	Status	%	Status	%	Status	%
Work with the AHN to develop a work plan identifying key priority actions the three priorities: youth MH and the high rates of youth suicide, diabetes, diabetes and improve family and child health	Not yet started	100				
Identify and implement plan to expand suicide prevention training	Not yet started	100				
Work with the AHN to plan for the needs of the Aboriginal population	Ongoing					
Develop plan for increased engagement within the Aboriginal community and with other stakeholders	Not yet started	100				

How will we 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
- 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 aware, sensitive and 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

For each risk/barrier, describe the plan to mitigate the risk?

- 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

Additional Comments (i.e. additional information that supports the implementation/success of the goal).

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Dramatically improving the patient experience by integrating service delivery: LHIN-wide Population Based Strategies: Francophone Health

IHSP Priority Description:

The health of the Francophone population in our LHIN, including their access to health care services, continues to represent a priority for the LHIN.

Current Status:

The *French Language Services Act (FLSA) Ontario, 1986,* guarantees the right of Ontarians to communicate with the government and receive services in French.

There are over 35,000 Francophone residents in the HNHB LHIN. The LHIN has two agencies designated under the *FLSA* and 30 agencies identified to provide over 40 programs/services in French.

Access to services is challenged in the following ways: people are not comfortable asking for services in French; people do not know what services are available in French and where. In addition, French Language (FL) speaking health professionals are in short supply; there is variable commitment among stakeholders to meeting the needs of French speaking people.

Key issues:

- The Francophone population is dispersed across the LHIN.
- The population is not homogeneous (i.e. new Canadians from different francophone countries, 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 *Entité de planification pour les services en français dans les régions de Waterloo, Wellington, Hamilton, Niagara,* the French Language Health Planning Entity (FLPE) for HNHB and Waterloo-Wellington (WW) LHINs is operational:

- The Joint Liaison Committee (JLC), created with a mandate to develop appropriate mechanisms for collaboration and ongoing dialogue, meets at regular intervals throughout the year to discuss planning issues.
- The Joint Annual Action Plan (JAAP) for 2013-14 was developed and sets out, priorities and actions for each LHIN and the FLPE.
- The LHINs and the FLPE continue to establish positive working relationships which will facilitate reaching our mutual goal of improving access to health services in French for our francophone communities.

Presentations and on-going discussions with FLS-identified agencies increased knowledge and awareness of the FLSA, 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 French Language Services (FLS).
- FLS reports from HSPs identified to provide services in French indicate an increasing number of francophone clients being served in 42% of the HSPs and an increasing number of clients being served in French in 31 % of the FLS-identified HSPs.
- FLS perspectives are becoming integrated in processes at the LHIN (i.e. communications, IHSP development, local SAA indicators for FLS-identified agencies).

PART 2: GOALS and ACTION PLANS

Goal(s):

- Improve Francophone health
- Improve Francophone persons' health experience
- Sustained capacity for FL 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 HHR.
- Community Engagement:
  - Support the active participation of Francophones in public consultations and citizen/community engagement activities.
- Integration/Coordination:
  - Address the needs of Francophones, and ensure that programs and HSPs incorporate the principles of the FLSA and *Local Health Systems Integration Act, 2006 (LHSIA*), in their business processes to address the needs/concerns of Francophone clients.
- Evidence-Based Policy/Program Development:
  - Use the best information available about the needs of Francophones, demographic trends and the enhancement of Francophone-specific research to inform policy and program development.

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % 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.					
	2013-14		**2014-15**		**2015-16**	
Examples:	Status	%	Status	%	Status	%
Increase awareness and knowledge of FLS in all LHIN HSPs. Facilitate discussions to integrate FLS into service delivery in following sectors: • MH and A in Hamilton and Niagara • LTC Sector	In Progress	25		25		25
Assess capacity to provide services in French in FLS-identified and designated agencies.	complete	100				
Assess capacity to provide services in French in all other health service organizations.	In progress	50		25		25
Engage and work with the FLPE to meet objectives set out in the 2013-2014 JAAP.	In Progress	100				
Promote and monitor the use of ministry French Language Health Services (FLHS) translation service and opportunities to increase language capacity through FL training.	In Progress and ongoing	100				

How will we measure success?

- 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. • HSPs need to know needs of francophone community to better plan and focus services. • Francophones are not aware of services provided in French.
For each risk/barrier, describe the plan to mitigate the risk?
• Assess capacity of providers. • Increase awareness and knowledge of providers with issues. • Continued 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.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).

iv. Integrated Support Service System

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Integrated Support Service System
IHSP Priority Description:
• Integrated support services system - services that support care delivery will be coordinated to best reduce duplication within the hospital and community sectors. This may include: ○ Operational support (i.e. purchasing, finance, HR functions)

- Integrated information management and decision support will build on LHIN-wide approaches to eHealth, OTN, common assessment (i.e., RAI-CHA), and the related Integrated Assessment Record (IAR).
- Clinical support (e.g. Lab, Diagnostic Imaging)
- Information management and decision support

Current Status:

The HNHB LHIN funds 10 hospital corporations, 86 LTCHs, and 104 community-based HSPs. While there are varying arrangements across parts of the system for shared support services, these arrangements are not comprehensive and, in the community sector, are largely ad hoc.

Mohawk Shared Services Corporation currently provides many hospital-based shared support services, and is exploring further opportunities.

Many localized arrangements for shared services exist in the community sector.

Key Issues:

- In a resource constrained environment, all HSPs need to be able to focus their attention and resources on patient/client care.
- Taking a comprehensive look at integrating support services may be one way to enable that focus, providing cost-effective solutions that allow for improved consistency in decision making and quality improvement.

Successes of the past year:

- Mohawk Hospital Services is currently developing a plan for shared accounts receivable/accounts payable functions across all hospital corporations.
- As an organization owned and operated by the LHIN hospitals, Mohawk is also exploring how other hospital support services might be shared through their structure.

PART 2: GOALS and ACTION PLANS

Goal(s):

A plan has been developed to identify how best to reduce duplication in administrative support services in the hospital and community sectors.

Consistency with Government Priorities:

Consistent with ministry focus on value for money.

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % 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.					
	2013-14		**2014-15**		**2015-16**	
Examples:	Status	%	Status	%	Status	%
Work with Mohawk Shared Services to develop an integrated support services plan for the hospital sector, including: • Assessment of current status and additional need/opportunity.	In progress	50		25		25

• Identification of service delivery model based on leading practice review. • Development of business case and implementation plan.						
Work with CCAC and other community-based health service providers to develop an integrated support services plan for the community sector, including: • Assessment of current status and additional need/opportunity. • Identification of service delivery model based on leading practice review. • Development of business case and implementation plan.	Not yet started	25		25		25

How will we measure success?

Reduced duplication of support services.

What are the risks/barriers to successful implementation?

- Cost of restructuring – lack of available one-time funding for restructuring may impede ability to participate.
- 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.
- Ministry does not approve the proposed Integrated PCI model for the LHIN.

For each risk/barrier, describe the plan to mitigate the risk?

- Ensuring integrated plans are cost neutral.
- Follow local e-Health plan and capitalize on external opportunities.
- Build principles, processes and sustainability into transition plans.
- Engage physician and human resource leadership in processes.
- The LHIN is working closely with ministry staff from the Provincial Services Branch for timely approval of the LHIN's Integrated PCI proposal.

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

- Consistent integration tools, templates and processes utilized throughout each planning and integration process will ensure success of our goals.
- Objective assessment of opportunities and service delivery models.

Additional Comments (i.e. additional information that supports the implementation/success of the goal).

TEMPLATE A:

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Electronic Healthcare (eHealth)

IHSP Priority Description:

Linked information for effective care and health system decision-making.

Current Status:

The HNHB LHIN eHealth Strategic Plan and direction outlines the leveraging of eHealth solutions to improve the way patients receive care. The principles to guide business planning and grow eHealth include:

- 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 which integrates data from 28 hospitals across HNHB LHIN and WW LHIN plus, two CCACs and the JCC.
- Over 4000 physicians and providers now enrolled (an increase of 1500 since previous year).
- eHealth funded project ($3.6M for HNHB LHIN and $1.6M allocated to WW LHIN) continues to further adoption, mature governance, enhance supporting infrastructure and service management
- Established ClinicalConnect champion network of resources at LHIN HSPs to assist adoption.
- Implemented advanced version of ClinicalConnect.
- Received $1M Canada Health Infoway funding to rollout ClinicalConnect Mobile and to evaluate patient care and workflow improvement (over 400 provider's now using Mobile).
- Planning for extension of ClinicalConnect to LHIN (one-half) as part of South Western Ontario cluster (cSWO).
- Improved inter-operation with hospital systems and community emergency medical records (EMR's) with single sign on and contextual launch to ClinicalConnect (live at HHSC and NHS live end by the end of February 2012). Working with other HSP's and EMR's.
- Planning and development to integrate Ontario Laboratory Information System (OLIS) private lab data (target June 2013), Grand River Hospital (GRH) (target March 2013), Health Outcomes for Better Information and Care (HOBIC) Nursing Assessments (target July 2013) and Diagnostic Imaging Repository (DI-r).
- Began planning to support Health Links (enhance connectivity and enable improvements).
- Planning for e-Referral pilot project (Acute to CCAC), leveraging CCAC Client Health and Related Information System (CHRIS) system and ClinicalConnect
- Planning for migration to new provincial Hospital Report Manager standard.
- IDS Data Repository and Business Intelligence Solution – fully operational, expanding data sets. Implementing in Toronto Central (TC) LHIN, Planning SW LHIN.

- ALC WTIS upgrade planned and to be completed in 2013.

Key issues for eHealth implementation:

- Evolving changes (timelines, resources) with funding agencies (e-Health, Canada Health Infoway).
- Local challenges recruiting resources.
- Funding is project based and does not address ongoing sustainability (cSWO initiative to address).
- Significant administrative overhead to manage reporting.
- Restrictive procurement policies extend timelines.
- HSP financial constraints to balance budgets impacting availability of funds to support local eHealth.
- Impact or changes with provincial health care policies and priorities, budgets.

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 / secure exchange of patient information between healthcare organizations and 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 eHealth Ontario directions and standards including 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	%
Expansion of ClinicalConnect across HNHB & WW LHIN CCAC, CHCs and FHTs, LTC: • Roll-out application to additional providers (>1,000), Rollout mobile and evaluate; expand downloading of reports to physician EMR's; migrate to Provincial Hospital Report Manger; integration of more data sources such as OLIS	In progress	50		25		25

• DI-r, Nursing; improve interoperability via single sign on /contextual launch with Hospital and Physician systems; enhance service and support; plan patient access or portal approaches; introduce secure messaging supporting Health Links connectivity, change and transformational management						
Extend and enhance IDS expand data sets to include additional healthcare sectors	In progress	55		25		20
Extend DI-r and increase adoption	In progress	25		25		25
Resource Matching and Referral (RM&R) (Phase I) - HNHB LHIN is one of four LHINs in the cSWO Cluster participating in Referral Transformation: • HNHB eHealth, HHSC, CCAC pilot electronic referral project to inform RM&R	In progress	80		20		
Continue to implement initiatives outlined in HNHB LHIN eHealth Strategic Plan.	In progress	25		25		25

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?

- Timeliness of decisions and /or delays in processes
- Timing of provider access to integrated decision support tool data and reports
- Expansion of eHealth projects may outpace the availability of resources
- Expansion of eHealth projects may outpace the availability of resources.
- Recruitment challenges (non competitive salaries, location).
- Completing patient care priorities in a time of financial and economic constraint

Mitigating Strategies:

- Availability of:
  - implementation plan to ensure key provider data availability
  - implementation plan geared to resource availability.
  - Further partnering

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
- Availability of funding to hire resources to build eHealth capacity

- Build expectation of participation into H-SAAs.

3.3. Dramatically improving the patient experience by evolving the role of the LHIN to become health system commissioners

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Dramatically improving the patient experience by evolving the role of the LHIN to become health system commissioners

IHSP Priority Description:

To evolve its role within their current legislative mandate, the HNHB LHIN will:

- Become health system commissioners focusing on quality, volume, price, and accountability.
- Commissioning is a complex process with responsibilities ranging from assessing population needs and prioritizing health outcomes to procuring products and services and funding bundles of services. As health system commissioners, the HNHB LHIN staff and Board will make health system decisions based on evidence and performance, develop governance and management capacity. The table below outlines they key differences between the LHIN's current role, and its new role as health system commissioners.

Current Status:

Citizens expect value from public services – including efficiency, effectiveness, affordability and quality. Compared with other Organization of Economic Cooperation and Development countries (OECD), the Canadian health care system has does not consistently delivered high quality services at the most reasonable price point. The global economic slowdown has placed greater pressure on government funded services requiring ever more focused efforts at achieving a high value for health services.

A key strategic priority for the HNHB LHIN is to ensure accessible, patient-centred services that also reflect value for money.

The HNHB LHIN maintains SAAs with over 200 providers, and is responsible for monitoring fiscal and operational performance. The HNHB LHIN also has a responsibility to work with individual providers on key system wide priorities, including ED wait lists, ALC, and a shift of services from the acute to community services.

To drive a greater focus on value for money, the HNHB LHIN is adopting the best-practices from the commissioning of health services (a proven international best practice in health care management).

A strategic focus on the tenants of commissioning will result in:

- A focus on population health and gaps in service and not on providers.
- A focus on common solutions that cross silos and traditional working relationships.
- Making health system decisions based on evidence and performance.
- Ensuring that the patient's needs are at the centre of decision making.

Along the path toward adopting a commissioning strategy, the HNHB LHIN will continue and enhance its monitoring of HSPs. The LHIN will work in partnership with HSPs to meet their legal obligations.

This will include a performance management framework that will seek to answer the following key questions:

- Are HSPs delivering what they're supposed to be delivering? (Effectiveness)
- Are HSPs delivering services as efficiently as possible? (Efficiency)
- Are there some things that other HSPs can do better? (Quality)

This work will support and advance the imperatives of implementing the government's HSFR, which is focused on funding providers based on their efficiency and patient activity rather than base budget increases.

The number and complexity of HSPs in our LHIN requires a prioritization based on the risk of not meeting performance obligations. Enterprise Risk Management (ERM) is a strategic approach to identify, assess, mitigate and communicate key risks to the organization. A key strategic risk for the HNHB LHIN is ensuring that HSPs deliver high quality services effectively and efficiently in compliance with accountability agreements. The HNHB LHIN will build on current processes by more rigorously applying the ERM program to SAA management.

Risk Process	SAA Management
Risk Identification (What have we discovered?)	Monthly and quarterly monitoring and assessment of financial, performance and quality data.
Risk Assessment (What does it mean?)	Determination of risk level – Green, Yellow and Red Analysis to focus on: • Performance (targets/volumes) • Surplus from HSP • System level quality outcomes
Risk Mitigation and Control (What can we do about it?)	• Capacity building • Additional performance and financial reporting • Audits • Performance Management Escalation • Operational review and governance review • Additional performance requirements • Reallocation
Risk Measurement and Communication (How do we know it worked? Who needs to know?)	• Assessment of impact • Communication to stakeholders and public

A key strategy for advancing the LHIN role in commissioning will be provider engagement. This will involve the engagement of Boards, executives, and staff to articulate new expectations and ways of providing services.

The HNHB LHIN will develop and implement an engagement plan sequenced with SAA negotiation timelines to ensure that significant performance issues are addressed at the time of agreement negotiations. The engagement plan will involve strategies to focus upon the following:

- Data quality – financial and statistical.
- Governance – ensuring a clear understanding of board's fiduciary responsibility for SAA management.
- Performance – the key organizational elements required to be in place to deliver value for money services
- Communications – clear, consistent messaging on performance improvement, the impact of not meeting SAA obligations and the negotiations involved in transfers and ceasing funding.

Successes from past year:

- The LHIN successfully reviewed its Aging at Home (AAH) programs to determine effectiveness in offering quality services. This comprehensive process provided the LHIN with an opportunity to provide additional funding to programs offering value while also reinvesting public funds for other priority needs.
- The LHIN also allocated its portion of the 4% community funding through a modified Request for Proposal (RFP) process to target key priority populations. This exercise allowed the LHIN to focus funding directly on specific patient needs and link funding to high quality proposals.
- The LHIN worked with hospitals on the distribution of funding for wait time volumes for surgical procedures and diagnostic imaging. This collaborative effort focused on providing funding to more directly impact key objectives such as wait time reductions for patients.

PART 3: GOALS and ACTION PLANS

Goal(s):

- An enterprise risk management system has been fully developed and implemented within the LHIN office.
- An actionable plan has been developed and implemented to link performance with outcomes and funding.

Consistency with Government Priorities:

Action Plans/ Interventions: **"We will deliver the following"**	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % 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.					
	2013-14		**2014-15**		**2015-16**	
Examples:	Status	%	Status	%	Status	%
LHIN internal strategy linking SAA management with commissioning model	Complete	100				
Engagement plan for value for money created	Complete	100				
Engagement plan for value for money rolled out to providers	On-going	50	On-going	50		
ERM program in place to rank providers through objective criteria	Complete	100				
Financial processes in place to more effectively redistribute in year funding based on Q2 results	Complete	100				
Internal balanced scorecard in place for monitoring provider performance	Complete	100				
Internal expertise developed for external audit and engagement on performance improvement		50		50		

External Audit process in place to address performance issues		50		50		

How will we measure success?

- Clear understanding on the part of governors, management and clinicians of the performance framework
- HNHB LHIN staff, and providers are working effectively within the performance model
- Patients demonstrate improved confidence in the system through improved rates of satisfaction
- Patients/clients voice confidence in the health care system through improved rates of satisfaction
- Clinicians actively participate in the design and delivery of efficient and effective healthcare
- Health care funding provides high quality services at the best price
- Services reflect local community needs
- Patient experience improved through enhanced collaboration

What are the risks/barriers to successful implementation?

- A lack of natural incentive to foster cooperation
- Data quality is poor for some providers
- Some providers unaware of the processes required to implement effective quality at a reasonable cost
- Lack of clarity for not meeting SAA requirements
- Funding processes (internal and external) less efficient
- Program and organizational objectives lack clarity (not Specific Measurable Attainable Realistic Timely (S.M.A.R.T.) philosophy)
- Boards unclear as to their fiduciary role in SAA management
- Significant number of providers with limited internal staff for review
- Communications risks with possible reduction of funding or closing poor performing programs
- Significant variation in cost per case

For each risk/barrier, describe the plan to mitigate the risk?

- The HNHB LHIN will advance incentive systems for performance through new initiatives such as the health links and innovative accountability instruments (MOUs).
- Population based strategies will necessity the cooperation of providers for set objectives at a set price.
- The HNHB LHIN engagement plan will focus on key identified gaps including: data quality, performance management, governance and fiduciary responsibility.
- The SAA will be clear instruments for incentive and disincentive in meeting objectives.
- Effective ERM processes will rank providers based on performance allowing staff to focus on areas of highest risk.
- A clearer, more transparent process on funding reductions will assist in communications objectives outlining the importance of patient continuity and safety.
- The HNHB LHIN will leverage HSFR over the next few years to support the goals of reduced variation and cost per case.
- Shifting the focus of funding review for high risk providers will increase the efficiency of in-year allocations and transfers.

What are some of the key enablers that would allow us to achieve our goal?
• SAA agreements • Risk ranking and priority setting • Data quality and engagement • Information scorecards • Staff education and engagement on auditing and value for money processes and thinking
Additional Comments (i.e. additional information that supports the implementation/success of the goal).

4. HNHB LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2012/13 Actuals	2013/14 Allocation	2014/15 Planned Expenses	2015/16 Planned Expenses
Salaries and Wages	$ 3,224,685	$ 3,750,235	$ 3,750,235	$ 3,750,235
Employee Benefits				
HOOPP	$ 328,009	$ 351,316	$ 351,316	$ 351,316
Other Benefits	$ 381,533	$ 430,487	$ 430,487	$ 430,487
Total Employee Benefits	**$ 709,542**	**$ 781,803**	**$ 781,803**	**$ 781,803**
Transportation and Communication				
Staff Travel	$ 39,550	$ 40,550	$ 40,550	$ 40,550
Governance Travel	$ 13,500	$ 13,700	$ 13,700	$ 13,700
Communications	$ 76,500	$ 78,000	$ 78,000	$ 78,000
Other Benefits	$ 7,000	$ 5,000	$ 5,000	$ 5,000
Total Transportation and Communication	**$ 136,550**	**$ 137,250**	**$ 137,250**	**$ 137,250**
Services				
Accommodation	$ 348,590	$ 364,469	$ 364,469	$ 364,469
Advertising	$ 0	$ 0	$ 0	$ 0
Banking	$ 0	$ 0	$ 0	$ 0
Community Engagement	$ 5,000	$ 10,000	$ 10,000	$ 10,000
Consulting Fees	$ 509,941	$ 460,916	$ 460,916	$ 460,916
Equipment Rentals	$ 13,500	$ 15,000	$ 15,000	$ 15,000
Governance Per Diems	$ 77,500	$ 83,200	$ 83,200	$ 83,200
LSSO Shared Costs	$ 398,500	$ 510,000	$ 510,000	$ 510,000
Other Meeting Expenses	$ 16,000	$ 16,000	$ 16,000	$ 16,000
Other Governance Costs	$ 10,600	$ 6,000	$ 6,000	$ 6,000
Printing & Translation	$ 24,600	$ 45,000	$ 45,000	$ 45,000
Staff Development	$ 17,250	$ 23,000	$ 23,000	$ 23,000
Total Services	**$ 1,421,481**	**$ 1,508,585**	**$ 1,508,585**	**$ 1,508,585**
Supplies and Equipment				
IT Equipment	$ 15,000	$ 15,000	$ 15,000	$ 15,000
Office Supplies & Purchased Equipment	$ 35,131	$ 33,100	$ 33,100	$ 33,100
Total Supplies and Equipment	$ 50,131	$ 48,100	$ 48,100	$ 48,100
LHIN Operations: Total Planned Expense	**$ 5,542,389**	**$ 6,225,973**	**$ 6,225,973**	**$ 6,225,973**
Annual Funding Target	$ 5,542,389	$ 6,225,973	$ 6,225,973	$ 6,225,973
Variance	$ 0	$ 0	$ 0	$ 0

1. 2012/13 is an estimate to year end based on January 31, 2013 and forecasted to March 31, 2013

2. Funding is shown as follows:	**2012/13**	**2013/14**
LHIN Operations Base	$4,916,172	$4,916,172
Aboriginal Engagement	$37,500	$37,500
French Language Services	$106,000	$106,000
ED LHIN Lead *	$75,000	$75,000
ER/ALC LHIN Lead *	$100,000	$100,000
Critical Care LHIN Lead *	$75,000	$75,000
Primary Care LHIN Lead **	$75,000	$75,000
Diabetes Regional Coordination	$157,717	$841,301
Total Funding	**$5,542,389**	**$6,225,973**

* The Lead funding is shown as paid out in Consulting Fee's. The lead revenue and expense was not all included in the 2012/13 Annual Business Plan.

3. Salary increases relate to the new positions required for the Diabetes Regional Coordination.

5. HNHB LHIN Staffing and Operations

LHIN Staffing Plan Full-Time Equivalents (FTEs)

Position Title	2012/13 Estimates as of March 31, 2013 FTEs	2013/14 Forecast FTEs	2014/15 Forecast FTEs	2015/16 Forecast FTEs
Chief Executive officer	1	1	1	1
Physician Lead	1	1	1	1
Director	5	5	5	5
Access to Care Advisor	4	4	4	4
Health System Advisor	5	5	5	5
Performance Advisor	4	4	4	4
Funding Advisor	4	4	4	4
Information Controller	3	3	3	3
French Language Services Advisor	1	1	1	1
Communication Advisor	1	1	1	1
Communication Assistant	1	1	1	1
Corp Coordinator	1	1	1	1
Executive Assistant	2	2	2	2
Project Assistant	1	1	1	1
Program Assistant	3	3	3	3
Receptionist	1	1	1	1
Corporate Services Assistant	1	1	1	1
Health Links Advisor	1	1	0	0
Total FTEs	**40**	**40**	**39**	**39**

***Hiring new positions for Diabetes Regional Coordination from February to March 2013.**

6. Integrated Communications Strategy

Objectives

Business Objective:

Implementing the SHSP over the next five years, and executing the ABP over the next year, will take the HNHB LHIN on a journey to a new health care system that will dramatically improve the patient experience through quality, integration and value. This strategic aim will be achieved through the realization of three strategic directions:

1. dramatically improving the patient experience by embedding a culture of quality throughout the system.
2. dramatically improving the patient experience by integrating service delivery.
3. dramatically improving the patient experience by evolving the role of the LHINs to become health system commissioners.

The HNHB LHIN's 2013-16 IHSP five-year SHSP, and the initiatives contained in this ABP, will require a deliberate communications and engagement approach. A strong communications strategy and plan are critical to support the execution of a transformation agenda and will support and enhance the engagement undertaken. The communication strategy and plan will need to:

- Foster an understanding of the need for health system transformation both internally and externally.
- Build support for the health system model by focusing on the benefits of the health system transformation in building an evidence-based, integrated and person-centred health care system.
- Align the health service providers to the shared vision and common direction.
- Demonstrate how organizations and individuals can participate in the success of the health system transformation.
- Mitigate communications risks of negative publicity by proactive planning of risk reduction.
- Provide information on performance and progress on the implementation – document successes and share it.

Communications Objective:

- To lead, coordinate or assist with the communications and engagement activities of the HNHB LHIN (Board and staff) and HSP partners involved in initiatives contained in the 2013-14 ABP.
- To ensure that all stakeholders understand the role of the respective organizations to identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services based on funding available and tracking performance against signed accountability agreements.
- To provide accurate and timely information to all audiences.
- To be transparent and accountable to our shared audiences re: timelines, outcomes and opportunity for participation/feedback.

Context

- Ontario's Action Plan for Health Care, announced by the Minister in January 2012, which is consistent with the principles of the ECFAA, puts LHINs at the centre of health system transformation.
- The HNHB LHIN has a critical role to play in key provincial initiatives recently introduced such as HSFR, Health Links, Seniors Strategy and the expansion of QIPs into the primary and community care sectors.
- The HNHB LHIN's 2013-16 IHSP and SHSP, and the initiatives laid out in this ABP, are strategically aligned with government directions and priorities and recognize the joint accountability of the ministry and LHINs to serve the public interest and effectively oversee the use of public funds.
- The health care system has evolved to the point where LHINs are being recognized as the local system managers who play a central leadership role in driving health system transformation.

Target Audience

Depending on the situation, primary and secondary audiences will include but not be limited to:

- Health Service Providers and Key Stakeholders (LHIN-wide, cross-LHIN and pan-LHIN):
  - HNHB LHIN HSPs – Administrative and Governance
  - Primary Care Providers including physicians
  - Patients, clients, consumers, and residents
  - Professional Associations (such as Ontario Hospital Association (OHA), Ontario Medical Association (OMA) and HAM (Hamilton Academy of Medicine))
  - AHN
  - FLPE
- Government – Administrative Leadership and Elected Officials:
  - municipal
  - regional
  - provincial – including ministry stakeholders:
- General Public
  - Residents
  - CRPs:
    - Broader Public
    - Aboriginal Peoples
    - Francophone
  - Community Organizations
- Media:
  - Print – daily, weekly and community newspapers and publications
  - Electronic – television, radio and online
  - Social Media – Twitter, Facebook
- Other LHINs, especially neighbouring LHINs – Southwest (SW), WW and Mississauga Halton (MH)
- ministry and other ministries (as appropriate and required):
  - LHIN Liaison Branch (LLB)
  - Communications and Information Branch (CIB)
  - Minister's Office (MO)

Strategic Approach

To support the communication strategy for the SHSP and the Annual Report the HNHB LHIN will utilize the communication strategy framework depicted below for each strategic direction.

This framework will enable the LHIN to establish a clear process and will minimize risk by identifying key stakeholders, key messages and communication vehicles up front.

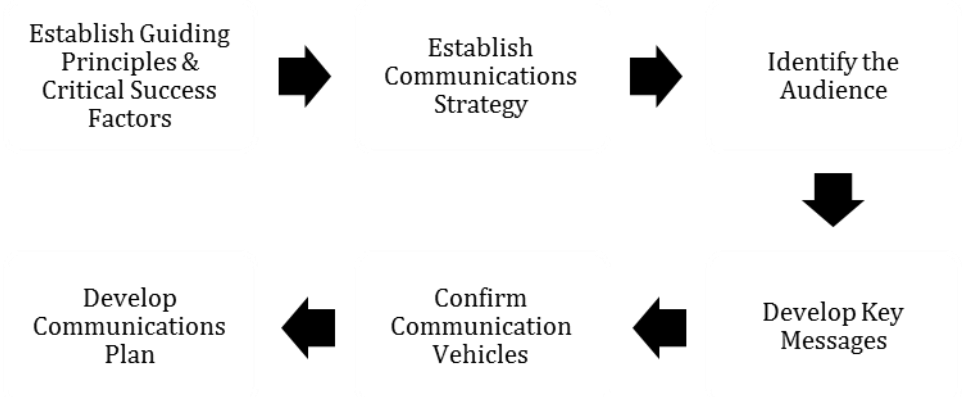
Effective utilization of the communication strategy will support the strategic goals of:

1. Stakeholders understanding the rationale for change, the transformational model and the plans for implementation.
2. Leaders are engaged to champion change throughout the region.

3. The HNHB LHIN is ready and able to take ownership of the changes following implementation on a "business as usual" basis.

The communication strategy and plan is a "living document" that will be revised and updated by the HNHB LHIN to accommodate and address any changes, issues or developments.

Framework: Communications Strategy and Approach



Key Messages

- The HNHB LHIN is a key partner in transforming the health system to provide quality care that meets the needs of Ontarians today and into the future.
- The work of the HNHB LHIN supports the ministry's Action Plan for Health Care which aims to provide the right care, at the right time, in the right place to ensure better patient outcomes.
- We are changing from an old system designed to treat people once they are sick to a more coordinated, value-driven model that promotes wellness.
- The population in the HNHB LHIN is growing and aging. The rates of chronic conditions are rising. The HNHB LHIN is working with our health care partners to address these realities and together we are developing innovative solutions to keep citizens healthy.
- Current fiscal realities have resulted in even more challenges and the HNHB LHIN and its health care partners continue to bring about significant and positive change to ensure better patient outcomes.
- The HNHB LHIN and its providers have already brought about significant and positive change in the way health services are delivered, and we must continue that work. In fact, we must aggressively build upon that work, because the status quo is neither acceptable nor sustainable.
- Transformation requires action now. ACTION – A Call To IntegratiOn Now.
- Everyone has an important role to play in making healthy change happen, including HSPs, the LHINs, community leaders and the public.

Tactics – high level, if available

The communication/engagement tactics will flow out of an overarching communications plan that will guide alignment of all audience- and initiative-specific communications plans. The leadership team and staff will provide input into the communications plan, how it will be implemented, and a plan for decision making.

The following table provides a preliminary set of communications roles and responsibilities. To ensure consistency and to avoid misinformation, all communications need to be approved by the CEO and Communications team.

Target Audience	Lead	Vehicles
Provider Boards	LHIN Board	• Governance to governance sessions (G2G)
Hospital Boards	LHIN Board	• Governance to governance sessions (G2G)
Elected officials	LHIN Chair and LHIN CEO	• All party meetings • Individual party meetings
Citizens' Reference Panel Members	LHIN CEO	• Group sessions • Twitter • Portal or some sort of preferred access
General Public	Communications Lead/LHIN CEO	• Media • LHIN Website • Newsletters • Blog • Twitter
Editorial Board meetings	Communications Lead/LHIN CEO	• Meetings, social media
Health Professions Advisory Committee	LHIN CEO	• Meetings
Physicians	LHIN CEO/LHIN physician lead	• Meetings/blog • Twitter
Francophone Community	LHIN	• Meetings, media
Aboriginal Community	LHIN	• Meetings, media
Neighbouring LHINs	LHIN CEO	• Meetings, media
Ministry, LHIN Liaison Branch	LHIN CEO/Board Chair	• Meetings
Agencies with provincial/national mandate (i.e., CMHA)	LHIN	• Meetings, media

Evaluation

Identifying critical communication success factors will enable the HNHB LHIN to more effectively identify whether stakeholder engagement activities have been successful.

Critical success factors may include:

- Visible senior leadership engagement and support of the project and related communications.
- Senior leadership and LHIN-wide committees take visible, active roles in supporting communications and change with their teams.
- Key stakeholders have a clear understanding of the 'case for change' and how they will be impacted by the implementation of the SHSP.
- Health care providers across the HNHB LHIN are engaged early and frequently and can see how their participation is impacting the implementation of the SHSP.
- HNHB LHIN citizens are engaged by the LHIN and with the LHIN via a variety of tactics including traditional media, online media (e.g., websites, blogs) and LHIN communication vehicles (newsletters and bulletins).
- The Communication program leverages a variety of communication vehicles tailored to various stakeholder groups.
- Feedback mechanisms and ongoing assessment are in place to monitor the effectiveness of communication vehicles and messages, and the LHIN has the ability to make quick modifications based on shifts and lessons learned as the project unfolds. Ongoing issues management, feedback from stakeholders including volume of correspondence, social media responses and traditional media coverage will all be monitored for tone and volume.
- HNHB LHIN stakeholder, resident and health service provider engagement is gauged by monitoring and measuring traditional media, online/social media (including Twitter, blogs and websites) and other LHIN communication vehicles (including LHINsight enewsletter, Donna's CEO blog, Twitter and website visits). Media summary reports are provided and reviewed monthly with LHIN Leadership and quarterly with the Board.

7. APPENDIX

7a. Glossary of Acronyms

AAH	Aging at Home
ABI	Acquired Brain Injury
ABP	Annual Business Plan
ACP	Advanced Care Planning
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
AMI	Acute Myocardial Infarction
AR	Assess Restore
ASIST	Applied Suicide Intervention Skills Training
BCHS	Brant Community Healthcare System
BSO	Behavioral Supports Ontario
BSS	Behavioral Supports Services
CAMH	Centre For Addictions and Mental Health
CBHSC	Community-Based Health Service Capacity
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

CCN	Cardiac Care Network
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
CHF	Congestive Heart Failure
CHRIS	Client Health and Related Information System
CHSEE	Continuing Health Sciences Education Event
CIHI	Canadian Institute for Health Information
CKD	Chronic Kidney Disease
CMG	Case Mix Group
COPD	Chronic Obstructive Pulmonary Disease
CPI	Clinical Program Integration
CRCS	Canadian Red Cross Society
CREMS	Community Referrals by Emergency Medical Services
CSP	Clinical Services Plan
CSCHN	Centre de Santé Communautaire de Hamilton-Niagara
CSRSN	Central South Regional Stroke Network
CSS	Community Support Services
CSSN	Community Support Services of Niagara
CT	Computed Tomography
CTAS	Canadian Triage Acuity Scale
CYMHA	Children and Youth Mental Health and Addictions
DAD	Discharge Abstract Database

DART	Dates Affecting Readiness to Treat
DEP	Diabetes Education Program
DI	Diagnostic Imaging
DI-r	Diagnostic Imaging Repository
DRCC	Diabetes Regional Coordinating Centre
ehealth	Electronic Healthcare
ECFAA	*Excellent Care for All Act*
ED	Emergency Department
EIS	Early Intervention Screening
EMRs	Electronic Medical Records
EMS	Emergency Medical Services
ERM	Enterprise Risk Management
ESC	Erie St. Clair
ESSC	Emergency Services Steering Committee
EVAR	Endovascular Aneurysm Repair
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
GIMRAC	General Internal Medicine Rapid Access Clinic's
GRH	Grand River Hospital
GTA	Greater Toronto Area
HCC	Healthcare Consent
HHR	Health Human Resources
HHSC	Hamilton Health Sciences Corporation
HNHB	Hamilton Niagara Haldimand Brant
HOBIC	Health Outcomes for Better Information and Care
HOOPP	Hospitals of Ontario Pension Plan
HPCN	Hospice Palliative Care Network
HPAC	Health Professionals Advisory Committee
HQO	Health Quality Ontario
HR	Human Resources
H-SAA	Hospital Service Accountability Agreement
HSFR	Health System Funding Reform
HSP	Health Service Provider
IAR	Integrated Assessment Record
ICES	Institute for Clinical Evaluative Sciences – Ontario
ICL	Integrated Community Lead
ICSP	Integrated Cancer Screening Plan
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
IRTP	Integrated Radiation Treatment Program
IT	Information Technology
JAAP	Joint Annual Action Plan
JBH	Joseph Brant Hospital
JCC	Juravinski Cancer Centre
LHIN	Local Health Integration Network
LHSIA	*Local Health System Integration Act*
LICO	Low Income Cut-Off
LOS	Length of Stay
LSSO	LHIN Shared Services Office
LTC	Long-Term Care
LTCH	Long-Term Care Homes
MAC	Medical Advisory Committee
MH	Mental Health
MH and 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
MOU	Memorandum of Understanding
MPCC	Mobile Primary Care Clinic
MPP	Member of Provincial Parliament
MRI	Magnetic Resonance Imaging
M-SAA	Multi-Sector Accountability Agreement
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
OECD	Organization of Economic Cooperation and Development
OHA	Ontario Hospital Association
OLIS	Ontario Laboratory Information System
OMHRS	Ontario Mental Health Reporting System
ORN	Ontario Renal Network
OTN	Ontario Telemedicine Network
P4R	Provincial Pay for Results
PAG	Planning Advisory Group
PCI	Percutaneous Coronary Intervention
PD	Peritoneal Dialysis
PE	Planning Entity
PHIPA	Personal Health Information Privacy Act
PIP	Process Improvement Plan
PMO	Program Management Office

PwC	Pricewaterhouse Coopers
QGC	Quality Guidance Council
QBP	Quality Based Procedures
QIP	Quality Improvement Plan
R2T2	Rapid Response Transition Team
RAZ	Rapid Assessment Zones
RCP	Regional Cancer Program
RFP	Request for Proposal
RIS	Regional Informatics Strategy
RM&R	Resource Matching & Referral
RMON	Regional Municipality of Niagara
ROS	Regional Oncology System
SAAs	Service Accountability Agreements
SFH	Senior Friendly Hospital
SGS	Specialized Geriatric Services
SHSP	Strategic Health System Plan
SSR	Slow Stream Rehab
SJHH	St. Joseph's Healthcare Hamilton
S.M.A.R.T.	Specific Measurable Attainable Realistic Timely
SW	South West
SWO	South West Ontario
TALK	Tell, Ask, Listen and KeepSafe
TJR	Total Joint Replacement
UCC	Urgent Care Centre
VP	Vice President
WFCC	Walker Family Cancer Centre

WTIS	Wait Time Information System
WW	Waterloo Wellington
WWHN	Waterloo Wellington Hamilton Niagara
YTD	Year To Date