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

Annual Business Plan 2015-2016

June 2015



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

Hamilton Niagara Haldimand Brant Local Health Integration Network
Annual Business Plan 2015-16

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July 6, 2015

Ms. Nancy Naylor
Assistant Deputy Minister
Health System Accountability and Performance Division
Hepburn Block, 5th Floor
80 Grosvenor St
Toronto ON M7A1R3

Dear Ms. Naylor:

Re: Hamilton Niagara Haldimand Brant Local Health Integration Network - Annual Business Plan, 2015-16

Our 2015-16 Annual Business Plan (ABP) represents the third year of our 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 final 2015-16 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. It also incorporates the comments provided by the ministry on the draft ABP, received on May 28, 2015.

This final 2015-16 Annual Business Plan was approved by the Hamilton Niagara Haldimand Brant Local Health Integration Network Board of Directors at their meeting on June 24, 2015.

In the fall of 2014, the HNHB LHIN undertook a review and refresh of the SHSP and IHSP overall aim and strategy directions. This review confirmed the current strategic directions, and led to the addition of other priority areas to be focused on. As such, the overall aim of the HNHB LHIN, over the course of the next several years is to continue 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 addition, the following focus areas have been added to the 2015-16 ABP:

- Primary Care
- Home and Community Care
- Health and Wellness of our Population
- Engaged Communities
- Future Ready Thinking

These strategic directions are defined in terms of specific goals and action steps, with a particular focus on 2015-16, being the third operating year of our current 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.

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,



Michael P. Shea
Board Chair

c. Donna Cripps, Chief Executive Officer, HNHB LHIN

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 (2015-16) represents the third year of the LHIN's third IHSP.

In 2012, in preparation for the current IHSP, the Hamilton Niagara Haldimand Brant (HNHB) LHIN undertook a strategic planning process to identify those key directions which, implemented together, will transform the health care system. The strategic directions, goals and deliverables stemming from the plan have guided the work of the HNHB LHIN over the past two years. In preparation for this ABP, the LHIN undertook a 'refresh' of the Strategic Health System Plan (SHSP), as outlined below.

In February 2015 Minister Hoskins announced *Patients First: Action Plan for Health Care*. This is the next phase of Ontario's plan for changing and improving Ontario's health system and it builds on the progress that's been made since 2012 under the original *Action Plan for Health Care*. It exemplifies the commitment to put people and patients at the center of the system by focusing on putting patients' needs first. The spirit of the four key objectives – improve access; connect services; support people and patients; and, protect our universal public health care system – are woven throughout the ABP.

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 SHSP.

2a. Mandate and Strategic Directions

Ontario's 14 LHINs have a mandate to plan, fund and integrate the local health care system.

The HNHB LHIN's SHSP, approved by the Board of Directors (Board) in December 2012, recognized 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*".

With a view to building on provincial directions and local imperatives, 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 was to build an evidence-based, integrated, and person-centred health care system.

The SHSP set out the overall aim of the HNHB LHIN to **dramatically improve the patient experience through quality, integration and value.**

The three key strategic directions flowing from this aim are as follows:

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 were further defined in terms of specific goals and action steps, which formed the basis of the 2013-16 IHSP, and were further detailed through the LHIN's ABP process.

In the fall of 2014, the HNHB LHIN leadership team undertook a review and refresh of the SHSP's aim and strategic directions to identify any mid-course corrections after two years of implementation. The review process included the following four steps:

1. Review accomplishments to date from the first two years of SHSP implementation.
2. Seek input and feedback from stakeholders, including Health Service Providers (HSPs) and the Citizens' Reference Panel (CRP).
3. Review the new government mandate and priorities of the ministry.
4. Align inputs to ensure appropriate direction for the 2015-16 ABP, and advance preparation for the next IHSP (2016-19).

On September 29, 2014, the HNHB LHIN held an engagement session with a cross-section of LHIN-funded HSPs and other stakeholders, most of whom had been involved in the preparation of the SHSP. Key messages received in that engagement session included:

- Continued relevance of quality, integration, and value as key strategic directions.
- Importance of a strong, engaged primary care sector.
- More emphasis must be placed on the continuum of care, as opposed to provider sectors/silos, in order to be patient-centered.
- System transformation requires radical change, not incremental change.
- Support for the LHIN taking a stronger role in leading the way to transformative change through commissioning, funding and accountability.

On November 15, 2014, members of HNHB LHIN's CRP were invited to participate in a similar engagement session. Ten individuals, who participated in the CRP process in preparation for the SHSP, attended to reflect on the HNHB LHIN's progress towards achieving the strategic directions. The key messages received in that Stakeholder session include:

- The current strategic directions seem to be the right focus.
- An increased focus on primary care and the important role that it plays in the health system is critical.
- Continued focus on identifying what people need rather than focus on providers.

The Minister has outlined the priorities of the ministry in the document *"Patient's First: Action Plan for Health Care"* (February 2015), and ministry staff have been reviewing and refreshing the priorities of the ministry for the next four year period, categorized into four broad areas:

1. Improve system integration and accessibility.
2. Ensure sustainability and quality.
3. Increase the health and wellness of Ontarians.
4. Modernize home and community care.

Based on the SHSP and CRP engagement sessions, there is continued support for the overall strategic aim of the LHIN, **"to dramatically improve the patient experience through quality, integration and value"**. There is also continued support for the three strategic directions following from that aim:

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

Additionally, the importance of a strong, engaged primary care sector, integrated into the continuum of services focused on meeting the needs of the person, was also identified at both the HSP and CRP sessions. The ministry priorities include the concepts of quality, integration and value. The health and wellness of the population, and a specific focus on the home and community care sector are also included in ministry priorities.

Accordingly, the HNHB LHIN Board has agreed that the LHIN will maintain its strategic focus on dramatically improving the patient experience through quality, integration and value. In addition to these key directions, the HNHB LHIN will also focus on primary care, home and community care, health and wellness of the population, engaged communities and future ready thinking.

2b. Overview of HNHB LHIN's Current and Forthcoming Programs/Activities

The HNHB LHIN allocates approximately $2.8 billion to programs and services offered through HSPs. The LHIN holds 189 accountability agreements with these providers (95 Multi-Sector Service Accountability Agreements (MSAA), 85 Long-Term Care Service Accountability Agreements (LSAA), and nine Hospital Service Accountability Agreements (HSAA). 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 several 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 Indigenous.

The current 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 several years, and move us toward a transformed system.

2c. Assessment of Issues Facing the HNHB LHIN (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 about 11% of the population of Ontario and is the third-largest LHIN in Ontario. The LHIN population is projected to grow 7.4% over the next ten years.[1]
- The HNHB LHIN's population is aging. The total number of people aged 65-74 years is growing the fastest. The largest changes will be among people aged 65-74 (45.2%) and 85 or older (33.4%) over the next ten years.
- The HNHB LHIN is projected to have amongst the highest number of seniors of all LHINs in Ontario from 2011 to 2017. The number of seniors 65 plus in the HNHB LHIN is projected to grow every year over the next six years from more than 230,000 to over 275,000 in 2017. Over this time, the HNHB LHIN will have a higher proportion of seniors than the Ontario average, and by 2017, nearly one in five residents in the HNHB LHIN will be 65 years of age or older.[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 Indigenous people are recognized populations in the HNHB LHIN. Compared to Ontario, the LHIN has a lower percent of immigrants and visible minorities.
- Over 35,000 Francophones make their home in the HNHB LHIN, representing the largest French speaking population in Southern Ontario. Within the HNHB LHIN, the largest concentrations of French speaking population are in Hamilton and Welland/Port Colborne, both of which are designated municipalities under the *French Language Services Act (FLSA).*
- 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 Indigenous 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.
- HNHB LHIN 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]
- Recent data from the ministry indicates that, while Ontario has one of the lowest rates of smoking compared to other Provinces, HNHB LHIN has one of the highest rates of smoking within Ontario.[8]
- 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.[9]
- 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%.[10]

[7] Statistics Canada, Canadian Community Health Survey, 2009-10
[8] MOHLTC, Health Promotion Division, December 2014
[9] Statistics Canada, Canadian Community Health Survey, 2005, 2008 and 2009-10
[10] Statistics Canada, Canadian Community Health Survey, 2009-10

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.
4. Primary Care.
5. Home and Community Care.
6. Health and Wellness of our Population.
7. Engaged Communities.
8. Future Ready Thinking.

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 provides system level leadership in relation to quality, and holds providers accountable for local implementation. This is underpinned by a LHIN-wide commitment to quality and creating an excellent patient experience.
Current Status:
In 2012, through collaboration and engagement with community members, HSPs and other stakeholders, the HNHB LHIN declared quality to be a priority of its strategic plan. This focus on quality was reconfirmed in the fall of 2014, when the strategic plan was refreshed. Quality remains one of three pillars within the HNHB LHIN strategy. Key elements of the HNHB LHIN quality plan are now in place. The Quality Guidance Council (QGC) is central to ensuring that the quality agenda remains relevant, on track, and is endorsed by leaders representing HSPs from across all sectors. QGC members have informed the development of frameworks and processes, such as the newly drafted patient experience framework and the initial quality plan review process. QGC members also regularly support communication with their colleagues and advise the LHIN regarding important issues or concerns within and across sectors of the health system. In 2014, the HNHB LHIN requested that HSPs (hospitals, community, and long-term care) submit evidence of a Board-approved policy on quality, a balanced scorecard or quality indicators, and a quality plan. The review of these plans and feedback to HSPs provided the LHIN with valuable information about the current state of quality programs in our region, and stimulated supportive discussions with HSPs about the importance of developing or maintaining such a program. Future quality plan review processes will focus on identification of common themes, strengths, and challenges that can be used to identify excellence, build capacity, and improve quality across the continuum of care. We believe that this local review in conjunction with the summary review by Health Quality Ontario (HQO) will provide a fulsome picture of quality at an HSP, organizational, sectoral, and provincial level. This year, there will be an increased focus on advancing performance management and analysis. With foundational processes and practices in place, the HNHB LHIN will initiate identification, validation, and reintroduction of metrics and indicators that better support utilization-focused or purpose-driven evaluation of funded programs. In 2015, there will also be continued and enhanced support of the quality agenda within all health care sectors at a local level. These efforts will be aligned with provincial bodies and strategies (e.g. HQO) as appropriate.

PART 2: GOALS and ACTION PLANS

Goal(s):

1. QGC will advise the LHIN on key quality issues and assist in advancing the quality agenda within all health care sectors.
2. Service Accountability Agreements (SAAs) will be refreshed and/or renegotiated as required.
3. Performance management processes will be enhanced within the LHIN.
4. Focus on and improvement of the patient experience will continue to advance within the LHIN.
5. Revised Execution Framework be used at the LHIN to guide implementation of strategic and risk/performance related initiatives.

Consistency with Government Priorities:

The HNHB LHIN focus on quality is very much aligned with *Patients First: Action Plan for Health Care*. Most notably, the work to ensure decision making is based on solid outcomes and output data and the efforts to better understand the patient experience within and across all health service providers in the HNHB LHIN.

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					
	2015-16		**2016-17**		**2017-18**	
Examples:	Status	%	Status	%	Status	%
• QGC will develop and execute an annual work plan to address its mandate within the LHIN.	Not yet started	100	Not yet started	100	Not yet started	100
• An annual review of HSP quality plans to identify themes, challenges, successes, and opportunities to conduct ongoing improvements. The local process will reflect and augment the quality improvement reviews conducted by HQO.	In progress	100	Not yet started	100	Not yet started	100
• Signed agreements (MSAA, HSAA, and LSAA) with refreshed schedules will be in place by April 1, 2015 for all funded HSPs. Any new agreements and/or reporting requirements will be introduced and negotiated with a focus on supportive accountability.	In progress	100				
• Monitoring and tracking HSP supplemental report submissions will be facilitated and improved through the implementation of a revised reporting process.	In progress	75	Not yet started	25		
• Initiate a review of existing metrics by functional centre, program and/or sector.	Not yet started	40	Not yet started	40	Not yet started	20
• A patient experience framework will be introduced for use within the LHIN and by HSPs including primary care.	In progress	50	Not yet started	50		
• An indicator focusing on patient experience will be identified and implemented for all HSPs as appropriate.	Not yet started	50	Not yet started	50		

• HNHB LHIN will participate in a Pan-LHIN patient experience health system survey.	In progress	50	Not yet started	50		
• Develop and implement a revised Execution Framework within the LHIN. The framework will build upon and align with other tools and frameworks (e.g. HQO Quality Improvement Framework, Performance Accountability policy, Enterprise Risk Management (ERM)).	In progress	75	Not yet started	25		

How will we measure success?

- Achievement of QGC annual work plan (% of initiatives/activities completed).
- 100% review of quality plans received by the HNHB LHIN.
- 100% of accountability agreements are signed and in place.
- Supplemental reports are consistently received and standardized processes applied. Data will be used to inform discourse with HSPs and future funding allocations.
- Program or functional centre based metrics are reviewed. Improvements in indicators are initiated as required.
- Patient experience framework has been rolled out and HSPs are actively measuring the patient experience.
- Execution framework has been implemented within the HNHN LHIN.

What are the risks/barriers to successful implementation?

- Low level of engagement by HSPs (including hospital, community, long term care, and primary care providers) in LHIN quality activities.
- Capacity of LHIN staff to implement multiple frameworks successfully within required time-frame.
- Limited data availability or data collection resources within some HSPs could hamper opportunities for supplemental reporting and/or program focused evaluation.
- Significant variation and diversity among HSPs related to strategies to enhance patient experience.

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

- QGC will develop and endorse an annual work plan that reflects and supports active engagement of HSPs from various sectors.
- Introduction of multiple frameworks will be sequenced and paced to respect capacity of LHIN staff and variation among HSPs.
- Existing and proposed indicators should be subjected to a validation process that considers criteria including data availability and/or feasibility of data collection.
- Quality Risk Management (QRM) team actively building relationships with HSPs within their portfolio.

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

- Establishing and communicating expectations for HSPs regarding quality and patient experience.
- Develop clear processes for submission, monitoring, and utilization of quality data submitted by HSPs.
- Consistent QRM advisor assigned to all HSPs and shared knowledge for all sectors within QRM team.

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

n/a

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:

The government's plan for *Patients First: Action Plan for Health Care* strengthens the commitment to put people and patients first by improving the health care experience. Integrated service delivery means the system will focus on patient-centered care. This includes supporting a new model of care to improve care for high-needs patients, with an initial focus on seniors and patients with chronic conditions. Health Links is to be a catalyst for better quality of care and represents a cornerstone in primary care system by connecting patients to community-based care, as well as using resources more efficiently and effectively. The model respects local variations and needs, but abides by a core set of principles including:

- Patient-centered care.
- Patient engagement – patients, families and caregivers must be involved.
- Broad provider participation – all those who support complex patients.
- Alignment and integration – focusing on care transition points.
- Planning across the continuum – plans of care that incorporates all aspects of a patient's needs and objectives.

Initiatives planned and implemented to support the new model of care will include collaboration with the LHIN's Indigenous and Francophone populations.

Current Status:

In December 2012, the ministry announced Health Links. Hamilton Central and Niagara North West Health Links were announced as "early adopters" and are nearing the end of their first year. In October 2014, eight additional Health Links were approved in the HNHB LHIN, with one approval pending for Niagara South East. These eight additional Health Links are in the early stages of implementing the deliverables outlined in each of their respective Business Plans. Health Links will be accountable to the LHIN based on 11 system-level metrics established by the ministry.

The LHIN has established a governance structure to support the implementation of Health Links that includes the following:

- Steering Committee:
  - A multi-sector group primarily made up of the Health Links leads.
  - The purpose is to oversee and provide guidance and recommendations in the implementation of Health Links.
- Operations Committee:
  - Supports effective implementation of Health Links across the HNHB LHIN by sharing lessons learned and best practices, developing guidelines, tools and templates for universal use based on best practice, and promoting knowledge transfer and capacity building.
- Working Groups:
  - Technology Enabled Practice Collaborative (TEC) Working Group:
    - Establishment of a LHIN-wide information plan that proposes to bring the patient into communication with their providers and others involved in their health care, with the aim to add in the ministry's Coordinated Care Tool (CCT) once available.
  - Care Planning Working Group:
    - Establishment of LHIN-wide Working Group that looks at developing common approaches to support patient-centered care planning.

PART 2: GOALS and ACTION PLANS

Goal(s)

Enhance the health care experience for patients with greatest needs through the continued implementation of Health Links:

1. Fully operationalize all 11 Health Links.
2. Develop a sustainability plan for Health Links to address:
   - Coordinated care planning.
   - Other Health Links initiatives.
3. Develop and disseminate tools and guidelines across the LHIN based on best practice and lessons learned to support integrated coordinated patient-centred care.
4. Implement, monitor and review performance indicators for Health Links.

Consistency with Government Priorities:

Health Links was announced by the ministry in December 2012 and continues to be consistent with the government's plan for *Patients First: Action Plan for Health Care*.

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.					
	2015-16		**2016-17**		**2017-18**	
Examples:	Status	%	Status	%	Status	%
• Provide leadership, coordination and support in fully operationalizing the nine new Health Links Business Plans (one pending approval).	In progress	100				
• Work with the Health Links in developing a sustainability plan to address the ongoing needs identified in the Business Plans.	Not yet started	100				
• Provide leadership, coordination and support for the Health Links governance model.	In progress	100				
• Care Planning Working Group to develop tools and guidelines based on best practice to support a common approach to care planning.	Not yet started	100				
• Monitoring and tracking of all Terms and Conditions of funding for Health Links (annual).	In progress	100	Not yet started	100	Not yet started	100
• Monitoring and tracking of all 11 and related Health Links indicators (annual).	In progress	100	Not yet started	100	Not yet started	100
• HNHB LHIN will continue to support the Health Links initiative at the provincial level by collaborating with other LHINs and the ministry (annual).	In progress	100	Not yet started	100	Not yet started	

How will we measure success?

The HNHB LHIN will monitor the implementation of Health Links by utilizing the ministry's 11 indicators including:

1. All complex patients will have a coordinated care plan.
2. Complex patients and seniors will have regular and timely access to a primary care provider.
3. Reduce the time from primary care referral to specialist.
4. Reduce the number of 30 day readmissions to hospital.
5. Reduce the number of avoidable Emergency Department (ED) visits for patients with conditions best managed elsewhere.
6. Reduce the time from referral to home care visit.
7. Reduce unnecessary admissions to hospitals.
8. Faster primary care follow-up after discharge from an acute care setting.
9. Enhance the health system experience for patients with the greatest health care needs.
10. Reduce the Alternate Level of Care (ALC) rate.
11. Reduce the average cost of delivering health services to patients without compromising the quality of care.

In addition, the LHIN has developed in cooperation with its Health Link partners, additional sub indicators that align with the ministry's indicators. These will also be reported and tracked.

What are the risks/barriers to successful implementation?

- Identifying the patients that make up the current five percent utilization cohort.
- Primary Care physician engagement varies within the 11 Health Links.
- Capacity of the providers to universally change to a more patient-centered integrated model of care.
- Information Technology (IT) solutions are required to address the sharing of health information across health service providers.
- Inability to integrate funding across health service providers

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

- Health Links will build sustainable partnerships and processes within hospitals, and with Primary Care physicians, to identify patients with complex medical needs, high utilization or trending toward high utilization of health care resources, and those that would benefit from a coordinated approach to care planning.
- Health Links will work directly with Health Link physician Leads and the primary care physicians on communicating the benefits of Health Links for their patients, and building sustainable relationships. The LHIN will work directly with the Primary Care Network (PCN) on raising the profile of Health Links and the performance results.
- Through various planning and operational mechanisms (e.g. committees), performance plans, and new business plans, identify the need to transform the system to create a new way of working together that is patient-centered.
- Work with Health Link partners to implement an IT Plan within the ministry's IT principles and framework.
- Work within the funding mechanisms and parameters.

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

- More current and easily accessible information.
- More integrated IT and funding resources.
- Primary Care Reform.

Additional Comments (i.e. additional information that supports the implementation/success of the goal).
Coordinated patient-centered care is supported by a number of elements including: • Care coordination at the patient level. • Coordination of the providers to focus on team work. • Coordination of services across providers both vertically and horizontally. Major transformation of the health care system needs to more easily link, if not incorporate, several domains including management, service delivery (health and social) and funding. The LHIN will continue to work with the ministry to work together to ensure the necessary reform in in place.

ii. System Integration

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by integrating service delivery: System integration framework, processes and tools
IHSP Priority Description:
System Integration means that all residents of the HNHB LHIN will experience care and service delivery that is connected and coordinated, in a way that best meets patient and population needs, and optimizes use of available resources. It is about achieving connectivity, alignment and collaboration to optimize system performance and attain quality patient outcomes. System integration means that: • Patients experience easy links and seamless transitions at various points along the continuum of care. • HSPs participate in interprofessional teamwork; coordination of tasks services and care. • Participate in inter-agency relationships to provide seamless service delivery and integrated LHIN-wide clinical programs. System Integration is a key enabler of Health Links implementation and is based on HQOs nine Attributes of a High-Quality System: 1. Person-Centered: System Integration will enhance a timely, person-centered and coordinated approach to care including providing culturally and linguistically appropriate services to the diverse populations we serve 2. Equitable: System Integration addresses the systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, culturally, linguistically or geographically. Achieving equitable services means improving the health status and/or access to service of recognized sub-populations, particularly where there is a known health status gap. 3. Accessible: System Integration provides improved timely access to the appropriate level of health services for defined population(s) in the local health system. 4. Safe: System Integration improves patient safety throughout the continuum of their experience. 5. Focused on Population Health: System Integration requires a LHIN-wide systems perspective through a collective contribution to improve the overall health status of the population. 6. Integrated: System Integration means that the system should be organized, connected and work together to provide high quality seamless care. 7. Efficient: System Integration means efficient utilization of health services, financial services and human resources (HR) capacity within the system.

8. Transformation of Existing Resources: System Integration increases the value of services and the seamless delivery of health care from the perspective of the patient. It minimizes duplication, increases coordination, and optimizes resource use to improve comprehensiveness of services and optimize system interactions across the system.
9. Effective System Performance: System Integration implements models of best practice for evidence-based decision making by embracing innovation and supporting knowledge translation to enable organizations to act on performance results. Initiatives planned and implemented within these strategies will include and collaborate with the LHIN's Indigenous and Francophone population.

Current Status:

The HNHB LHIN has completed the following activities to promote the application of consistent frameworks, processes and tools for System Integration:

- The development of a System Integration Framework and Toolkit to assist health planners and HSPs in the exploration, planning and implementation of integration opportunities.
- A LHIN-wide education session for family physicians was completed in November, 2014 in conjunction with Choosing Wisely Canada, the Ontario Medical Association, the Waterloo Wellington LHIN, as well as Radiologists and Surgical Specialists within the HNHB LHIN, to enhance the appropriateness of Magnetic Resonance Imaging (MRI) and CT scan ordering. An ultimate goal of reducing unnecessary risks of imaging for patients was targeted with this education session.
- Collaborative development of a model for Centralized Intake and Wait List Management in order to envision a future state where patients experience timely access to services.

PART 2: GOALS and ACTION PLANS

Goal(s):

System integration will be continuously improved through the development and application of consistent frameworks, processes, tools and the delivery of appropriate, high-quality care through:

- Promotion and knowledge exchange of the System Integration Framework and Toolkit.
- Application of the Centralized Intake and Wait List Management model.
- Leveraging opportunities to improve patient access and deliver patient care through Ontario Telemedicine Network (OTN).
- Continued support and promotion of the Choosing Wisely Canada campaign.

Consistency with Government Priorities:

A strong focus on meeting people's needs through better access, better quality and better value for money within existing resources drives our work. Ensuring the care that is delivered to people is medically necessary and appropriate is essential as this ensures the sustainability of our health system for future generations. These priorities align with the *Patients First: Action Plan for Health Care* announced in February, 2015.

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.					
	2015-16		**2016-17**		**2017-18**	
	Status	%	Status	%	Status	%
Promotion and knowledge exchange of the System Integration Framework and Toolkit: • Policy and process development. • Development of a web-based resource for planners and HSPs. • Engagement and knowledge exchange with HSPs.	In Progress	60	In Progress	20	In Progress	20
Application of the Centralized Intake and Wait List Management model: • Engage HSPs and eHealth Office to perform readiness assessments to understand opportunities to implement Centralized Intake and Wait List Management to improve patient access. • Develop necessary governance structures, partnerships, and high-level planning to proceed with implementation. • Analysis of resourcing required to procure and implement technology enablers.	In progress	40	In Progress	30	In Progress	30
Leveraging opportunities to improve patient access and deliver patient care through OTN: • Develop necessary LHIN-wide advisory structures and planning partnerships, including eHealth Office, to promote a systems-wide and integrated approach. • Collaborate with HSPs and OTN to identify opportunities to improve OTN utilization and adoption for clinical programs. • Identify opportunities to participate in novel and innovative uses of telemedicine (e.g. telehomecare; telewound care). • Provide leadership, coordination, and support in the development and implementation of a LHIN-wide integrated strategy for the use of telemedicine.	In progress	20	In Progress	40	In Progress	40
Working together with HSPs, physicians and patients to advance Choosing Wisely Canada across the HNHB LHIN: • Creating a guiding coalition to lead the vision for change. • Identify LHIN-wide opportunities for improvement.	In Progress	40	In Progress	30	In Progress	30

• Align and accelerate LHIN-wide implementation and integration. • Reduce the number of unnecessary tests and procedures patients experience to increase the value of the health care system.						

How will we measure success?

- Development of LHIN-wide advisory and planning structures with clear roles, responsibilities and accountabilities for System Integration planning and implementation.
- Consistent application of System Integration framework, processes, and tools to identify and implement integration opportunities.
- Identification of clinical program readiness, scope, and opportunities for Central Intake and Wait List Management, with defined implementation plan.
- Integration of telemedicine strategies into all appropriate areas of LHIN-wide clinical service planning.
- Integration of Centralized Intake and Wait List Management planning into all appropriate areas of LHIN-wide clinical service planning.
- Evaluation of success of Choosing Wisely Campaign initiatives through physician participation, physician experience/satisfaction measures, and metrics demonstrating change in physician practice.
- Identification and endorsement of future Choosing Wisely Canada initiatives.

What are the risks/barriers to successful implementation?

- 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.
- In-year priorities from the ministry may delay or defer goals/activities as outlined.
- Alignment with eHealth strategies and goals is required to ensure cohesive planning.
- Successful implementation and sustaining of Choosing Wisely Canada initiatives will require ongoing engagement of HSPs and physicians.

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

- Ensuring integrated planning is cost neutral.
- Follow local eHealth plan and capitalize on external opportunities.
- Build principles, processes and sustainability into application of System Integration tools.
- Engage physician, senior administrative leadership, and HR leadership in processes.
- Goals/activities will be prioritized if new in-year priorities are added.

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

- Physician and senior administrative leadership engagement.
- Partnership with eHealth colleagues.
- 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).
n/a

iii. 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:

- LHIN-wide integrated clinical programs means that systems are designed/redesigned to ensure the person is at the center of care. This will include:
  - LHIN-wide integrated clinical programs providing specialized services to LHIN residents. 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. LHIN-wide integrated clinical programs will coordinate and standardize clinical service delivery across the LHIN, including:
    - Common definitions and patient flow processes.
    - Common care model and quality improvement approaches, based on leading practices.
    - Projected need and distribution of services (population-based).
    - Common outcomes, goals, and deliverables.
    - Increased standardization and the reduction of clinical variation across HNHB LHIN providers.
    - Transparent sharing of information with key stakeholders, physicians and patients.
  - Initiatives planned and implemented within these strategies will include and collaborate with the LHIN's Indigenous and Francophone population.
  - Integrated clinical programs can help to improve patient access and support seamless quality care as envisioned through Health Links.
  - Integrated care/integrated funding models utilize integrated teams to provide coordinated care across the continuum (transitioning care from hospital to the community) for a defined patient population.

Current Status:

Many hospital-based clinical programs are delivered on an organizational basis, with varying degrees of integration 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 evidence-based practice guidelines. Integrating and coordinating a standardized approach to service delivery in selected clinical program areas is a key goal for this IHSP priority to improve patient care and outcomes.

Key issues:

- Variations in timely access to specialist services (Wait 1 times).
- Variations in timely access to surgical services (Wait 2 times).
- Variation in the standardized use of evidence-informed practices and priority coding across hospital sites.

Successes of the past year:

Following the HNHB LHIN 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:

- Laboratory Services: In June 2012, HNHB LHIN hospitals established a LHIN Laboratory Council, initiating central leadership for the administration of laboratory medicine services offered at each participating hospital laboratory site.

  In 2014, all HNHB LHIN hospital corporations providing laboratory medicine services, signed a Memorandum of Understanding (MOU) to participate in an integrated LHIN-wide Laboratory Council:
  - Standardized processing of microbiology samples to dramatically improve test turnaround times for patients and physicians through automation technology was achieved in 2014.
  - LHIN-wide critical value test results and standardized reporting for common tests was established, and testing restrictions and discontinuation recommendations were made to reduce unnecessary testing for patients (aligned with Choosing Wisely Canada).
  - Guidelines for developing quality management programs for Laboratory with the Standards 2Quality program across the LHIN were reviewed, and quality indicators were implemented across all laboratory medicine sites of the HNHB LHIN.
- Diagnostic Imaging (DI): All HNHB LHIN hospitals have been engaged in planning to target improved wait times and efficiencies, with a focus on metrics identified in the Access to Care Performance Improvement Program 3 (PIP) dashboard and the Ministry-LHIN Performance Agreement (MLPA) target. This work is facilitated through a LHIN-Wide DI Steering committee, to align and integrate administrative and clinical practices for DI across all HNHB LHIN HSPs:
  - Education with HSPs regarding the international best-practice of wait time reporting using Decisions Affecting Readiness to Treat (DARTs) and Wait Two System Delays (W2SDs) was completed across specific surgery and DI clinical service programs.
  - To understand the challenges in young people (pediatrics up to the age of 18) receiving timely access to pediatric MRI scans within the HNHB LHIN, a pediatric MRI working group was formed to attempt to identify strategies to improve timely access to MRI scans.
  - Development and implementation of a LHIN-Wide DI communication plan targeting recommendations from Choosing Wisely Canada related to MRI and Computed Tomography (CT) imaging appropriateness was completed and shared nationally through the Early Adopter Network of Choosing Wisely Canada.
- Ophthalmology: All HNHB LHIN hospitals completing cataract surgery have been engaged in planning to target improved wait time performance with regards to the MLPA target:
  - Successful establishment of an HNHB LHIN Ophthalmology Leadership Committee to support the implementation of the LHIN-wide five year CSP for vision.
  - Development and transparent sharing of a LHIN-wide Vision Plan to improve patients' access to high quality, efficient and appropriate specialized eye care.
  - Transparent sharing of cataract surgeon wait times through hospital websites, and the through the HNHB LHIN website, occurred to improve the ability of all physicians to refer to the ophthalmologist with the lowest wait time, and for patients to be fully aware of where timely access to cataract surgeons can be achieved.
  - A mobile tele-ophthalmology screening program for patients with diabetes was initiated.
- Orthopedics and Total Hip and Total Knee Replacements: The Integrated Orthopedic Capacity Plan (IOCP) is complete, and LHIN-wide improvement strategies are being developed and implemented as a result. These strategies consist of the following LHIN-wide initiatives:
  - Successful establishment of the HNHB LHIN Orthopedic Leadership Steering Committee to support the implementation of the Integrated Orthopedic Capacity Plan.
  - Implementation of standardized pre and postoperative physician order sets, patient care pathways and patient educational material for total joint replacements (TJR).

- Development of a LHIN-wide Wait List Management Policy and sharing of surgeon wait time data within the Regional Joint Assessment Program (RJAP) to allow patients' access to first available surgeon and thus improve access to surgery.
- Formation of a LHIN-Wide Hip Fracture Working Group to implement the Hip Fracture Quality Based Procedure (QBP) Clinical Handbook and develop standardized processes across all hospitals.
- St. Joseph's Healthcare Hamilton (SJHH) completed an evaluation of the Integrated Comprehensive Care-Bundled Care program, demonstrating significant reduction in lengths of stay and improvements in patient experience.

- Cardiac: Catheterization and Percutaneous Coronary Intervention (PCI) services: In April 2014, the Integrated Heart Investigation Unit (IHIU) at Niagara Health System (NHS) St. Catharines site expanded services to provide PCI services in addition to diagnostic cardiac catheterization. The IHIU at NHS is an integrated partnership between Hamilton Health Sciences Corporation (HHSC) and NHS. As of December 2014, the program had performed 1,142 cardiac catheterizations, 276 PCI procedures at the NHS site. The IHIU program operates as a one program – multiple site models. Successes include:
  - Centralized referral and triage at HHSC.
  - Standardized policies, procedures, protocols, patient education, staff education and documentation across the program.
  - One Medical Director and Clinical Manager for the two sites (NHS and HHSC).
  - Improved quality by reducing variation and standardizing care delivery models.
  - Improved transitions through common patient flow processes.
  - Support right care, right time, right place.

PART 2: GOALS and ACTION PLANS

Goal(s):

- Care for patients will be improved through the planning, implementation and evaluation of LHIN-wide integrated clinical programs:
  - Cancer
  - Lab
  - DI
  - Thoracic
  - Vascular
  - Orthopedics
  - Ophthalmology
  - Gastroenterology (GI)
  - PCI
- Enhance the health care experience for an identified group of patients through the planning, implementation and evaluation of a LHIN-wide integrated care/integrated funding model proof-of-concept demonstration project, following ministry guidelines.
- Incorporate Independent Health Facility (IHF) services into program planning processes as appropriate.

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.

A strong focus on meeting people's needs through better access, better quality and better value for money within existing resources drives our work in clinical programs. Ensuring the care that is delivered to people is medically necessary and appropriate is essential as this ensures the sustainability of our health system for future generations. In conjunction with our HSPs and physicians, we drive accountability, transparency and quality for patients across clinical programs. These priorities align with the *Patients First: Action Plan for Health Care* announced by Minister Hoskins in February, 2015.

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.					
	2015-16		**2016-17**		**2017-18**	
	Status	%	Status	%	Status	%
Laboratory Medicine Program:						
• Continue to plan for a centralized Laboratory Medicine facility (following ministry capital submission and review process) and consolidate specialized testing, where possible, within existing space.	In progress	25	In progress	25	In progress	50
• Develop implementation plans for transfusion medicine and hematology to facilitate future LHIN-wide services.	Not yet started	25	In progress	25	In progress	50
• Implementation of quality improvement performance measures across the LHIN.	In progress	75	In progress	25		
Diagnostic Imaging:						
• Through the DI Steering committee, oversee strategies to maximize and align performance for LHIN-wide wait time targets for MRI and CT within existing resources and implement quality improvement plans.	In progress	50	In progress	50		
• Identify LHIN-wide opportunities for improvement through current state assessments within DI services, such as rapid assessment benchmark times.	Not yet started	25	In progress	75		
• Complete a review of opportunities for improvements for pediatric MRI access for Priority 4 (non-urgent) cases.	In progress	75	In progress	25		
• Review the opportunity for centralized access to DI services.	In progress	50	In progress	25	In progress	25
Ophthalmology – (cataracts):						
• Through the LHIN-wide Ophthalmology Steering committee, oversee strategies to maximize and align performance for LHIN-wide wait time targets for cataract surgery within existing resources.	In progress	50	In progress	50		
• Improve patient access to timely cataract surgery with	In progress	100				

maintenance of improved transparency of physician wait times to referring physicians and the public through hospital and LHIN websites and through direct, transparent communication to referring optometrists. • Improve Ophthalmic Surgeon's awareness of their Wait 1 and Wait 2 times to enhance patient's timely access to care.	In progress	50	In progress	50		
• Review surgical booking management optimization and intake processes to improve timely access to surgical care for cataracts.	In progress	25	In progress	50	In progress	25
Orthopedics and Total Hip & Total Knee Replacements						
• Oversee strategies to achieve LHIN-wide wait time targets for TJR surgery and maximize performance with existing volumes, including exploration of telemedicine opportunities	In progress	25	In progress	50		
• Improve patient access to timely joint replacement surgery by promoting improved transparency of physician wait times to referring physicians and the public, and increasing surgeon participation in the RJAP.	In progress	10	In progress	50	In progress	40
• Review opportunities for partnerships between small and large hospitals for the management of hip fractures across the HNHB LHIN.	In progress	25	In progress	75		
• Review surgical booking management optimization to improve timely access to surgical care for joint replacement.	In progress	25	In progress	50	In progress	25
Gastroenterology						
• Explore opportunities to develop LHIN-wide partnerships to create an integrated LHIN-wide clinical program.	Not yet started	25	In progress	50	In progress	25
• Develop governance structure to lead the development of LHIN-wide program deliverables.	Not yet started	10	In progress	25	In progress	65
Integrated care/integrated funding project						
• Submit a LHIN-wide expression of interest for an integrated care/integrated funding demonstration project for hospital patients with Chronic Obstructive Pulmonary Disease (COPD)/Congestive Heart Failure (CHF).	In progress	100				
• Implement and evaluate the project.	Not yet started	30	In progress	40	In progress	30

How will we measure success?

• Adoption of common assessment, referral, placement/admission, priority coding and discharge criteria for LHIN-wide integrated programs, starting with those identified above.
• Implementation of evidence-based clinical practice standards and guidelines aligned with QBP clinical handbooks across the LHIN.
• Implementation and ongoing monitoring of evaluation and performance metrics, including the following MLPA indicators:
  ○ Increase percentage of surgeries completed by priority within wait time targets (cancer, cardiac bypass, cataract, hip and knee).
  ○ Increase percentage of diagnostic scans (MRI and CT) completed by priority within wait times targets.
• Identification of program size, scope and distribution for clinical services, with creation of defined implementation plans as needed.
• Improved access to timely specialist care (Wait 1) and treatment (Wait 2) with necessary care provided closer to home.
• Maintenance of LHIN-wide hospital participation in Clinical Service Planning tables with standardized quality measures.

What are the risks/barriers to successful implementation?
• Practice and cultural barriers – different styles of practice, organizational culture and administration may lead to challenges in aligning practices. • 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. • In-year priorities from the ministry may delay or defer goals/activities as outlined.
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 and eHealth engagement. • Build principles, processes and sustainability into transition plans. • Engage physician and HR leadership in processes. • Goals/activities will be prioritized if new in-year priorities are added.
What are some of the key enablers that would allow us to achieve our goal?
• Physician engagement and alignment. • Consistent use of integration planning tools, templates and processes utilized throughout clinical services and integration planning to ensure success of our goals. • Reallocation of volumes for wait times and QBPs to those providers delivering the highest quality services with best patient outcomes
Additional Comments (i.e. additional information that supports the implementation/success of the goal).
n/a

iv. 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:

- The Minister of Health's *"Patients First: Ontario's Action Plan for Health Care" (February 2015),* speaks to four key objectives; two of which are *Connecting Services* through delivering bettering coordinated care in the community and improving *Access* by providing faster care and coordinated care for people with dementia and complex medical condition[11]. The HNHB LHIN-wide population-based strategies refers to initiatives (service delivery models/programs) that support the health care needs and/or optimize the health status (wellness) of 'specific populations', by providing a coordinated and integrated approach to service delivery which aligns with, and supports the Minister's 2015 Action Plan. This will include:
  - Equitable access to population-based strategies.
  - Standardized models of care that are based on evidence best practice or expert recommendations that will decrease variability improve client outcomes and create system efficiencies.
  - Opportunities to provide care in the community setting are optimized (right care in the right place).
  - Provide a resource for primary care, hospitals and other HSPs.
  - Complement or coordinate with other initiatives.
  - Demonstrate common outcomes.
  - Provide effective and seamless care transitions.
- Specific populations include:
  - Older Adults (including caregivers and families):
    - Interventions to prevent or reduce functional and/or cognitive decline.
    - Expansion of wellness programs within congregate community settings.
    - Improve caregiver's access to programs that provide respite care.
    - Improve effective, timely and seamless transitions.
  - Persons requiring flow through the system (Patient Flow) from community to acute hospital services and back to the community.
  - Complex or chronic conditions with a focus on Stroke care, Diabetes, COPD, CHF and Acquired Brain Injury (ABI).
  - Hospice palliative care.
  - Mental Health & Addictions.
  - Maternal/Child and Youth, including Maternal and Newborn Health, and Child and Youth Health.
- Initiatives planned and implemented within these strategies will include and collaborate with the LHIN's Indigenous and Francophone populations.

[11] MOHLTC Patients First Action Plan for Health Care. February 2015.

Current Status:

Older Adults (including caregivers and families):

- Recognizing the LHIN's current and projected growth of individuals over the age of 65 years and current hospital patient flow pressures a key focus of LHIN initiatives has been to:
  - Improve access to resources that maintain or improve functional and cognitive status.
  - Expand access to restorative programs.
  - Increase resources in the community to support people to remain in their homes and return home from hospital.
  - Adopt best practices and innovative solutions.
- The Home First Philosophy adopted by LHIN providers is based on the premise that home is the best place for people to wait for a care setting, provides a place to receive in home post-acute care and is less stressful to make decisions regarding longer term care needs. As of September 2014, the HNHB Community Care Access Centre (CCAC) reported supporting 2,249 individuals with service maximums; of these, 591 were discharged from hospital[12].
- In September 2014, the LHIN's Patient Flow Steering Committee recommended that the HNHB LHIN adopt the standardized discharge procedures and policies utilized in Waterloo Wellington (WW) LHIN. Following this decision, a committee was established chaired by the Executive Vice Presidents of NHS and HNHB CCAC to develop standardized materials. Implementation across LHIN hospitals was scheduled to be completed by March 31, 2015.
- In 2014-15, LHIN hospitals continued to see a high number of individuals waiting in hospital for an ALC impacting patient flow. During 2014-15, from April 6, 2014 to January 5, 2015, the number of individuals waiting in hospital for an ALC ranged from 474 (December 29, 2014) to 604 (July 20, 2014)[13]. As of January 5, 2015, 503 individuals were waiting in hospital for an ALC, the top three discharge destinations were:
  - Long-Term Care (LTC) – 165
  - Home with CCAC – 85
  - Supportive Assisted Living/Group Home -76
- In October 2014, the LHIN provided the HNHB CCAC with $8.5 million in new recurring one-time funding to support increased home services.
- The LHIN has 85 Long-Term Care Homes (LTCHs) with over 10,300 beds. The LHIN's LTCH occupancy rate for May 2014 was 98.5% and the average Length of Stay (LOS) was three years, the same as reported by the province[14]. HNHB LHIN LTCHs report minimal idle beds on a weekly basis in the range of 15-40[15].
- The LHIN supports restorative programs that include; Assess Restore (AR), Slow Stream rehab and Convalescent Care. These programs, which total 187 beds are located across the LHIN, support individuals who need access to restorative care to regain their optimal functional status following an acute illness. As of December 2014, the programs report that 79-85% of individuals admitted were discharged home[16].
- In 2014-15, the LHIN, in collaboration with LHIN providers, developed a Transitional Congregate Model. This program model provided individuals who no longer required hospital care with a supportive environment where they can recover their strength and develop (in collaboration with family and care coordinators) a longer-term care plan. As of January 2014, 92 transitional beds were operational (70 in Hamilton and 22 in Burlington).

[12] HNHB LHIN CCAC Q2 Service Max Report #53.

[13] HNHB CCAC ALC Count as of January 5, 2015 Email January 8, 2015.

[14] MOHLTC LTCH System Report May 2014.

[15] HNHB CCAC Idle Bed Reports 2014-15

[16] HNHB CCAC Transitional Care Program Report 2014-15 Q3 Report January 2015.

Access to ED Services:

- The HNHB LHIN has 12 hospital EDs across eight hospital corporations. Of these twelve ED sites, eight participate in the ministry's Pay for Results (P4R) initiative. The ED at HHSC-McMaster site is dedicated for children and youth.
- A comparison of fiscal years 2012-13 and 2013-14 for the population admitted through the ED showed that the age distribution was relatively stable; 53% of the population admitted was aged 65 years and older[17]. These patterns have continued upon review of data for the first two quarters of 2014-15.
- Upon review of data from April 2012 to September 2014, the largest number of admissions through the ED was seen among people 80 -86 years of age (representing 15% of all ED admissions).
  The data also revealed an increasing pattern in the percentage of people aged 65 years and older, were receiving services from the CCAC at the time of their ED visit over the period April 2012 to September 2014[18].
- As of September 2014, the ED 90th percentile wait time for the three ED 90th percentile LOS metrics were (compared to the same period in 2013-14):
  - Admitted patient - 30.7 hours (compared to 32.75 hours).
  - Non-admitted high acuity patients - 7.2 hours (compared to 7.4 hours).
  - Non-admitted low acuity patients - 4.4 hours (compared to 4.5 hours)[19].

Complex and/or Chronic Conditions:

- Diabetes:
  - As of June 2014, the HNHB LHIN had 134,106 persons living with Diabetes; this represents 12% of the HNHB LHIN population, and the third highest compared to other LHINs[20].
  - Diabetes Education Programs (DEPs) provide tools and skills needed to support people living with Diabetes, and are located across the HNHB LHIN:
    - The HNHB LHIN funds eight DEPs at the following sites: Bridges Community Health Centre (CHC), North Hamilton CHC, Centre de Santé communautaire Hamilton-Wentworth-Niagara Inc. CHC, Brant Community Healthcare System (BCHS), HHSC, NHS, SJHH, and Norfolk General Hospital (NGH).
    - Pediatric DEPs are located at HHSC, NHS, BCHS, and Joseph Brant Hospital (JBH).
- Stroke:
  - In 2014-15, the HNHB LHIN continued to work with providers to integrate Stroke care. The Ontario Stroke Network (OSN) annual report card demonstrated improvements in 13 out of 19 indicators from the previous report card. For most of the indicators, there was significant improvement across the HNHB LHIN.[21] The report card indicated increased access to Stroke unit care, carotid imaging, clot busting medication (Tissue Plasminogen Activator (TPA)) and inpatient rehabilitation.
- COPD and CHF:
  - COPD and CHF are the two most common reasons for individuals in the HNHB LHIN to be readmitted to the hospital within 30 days of being discharged.
  - The HNHB LHIN has worked with HSPs to improve access to timely and appropriate community supports for those who have been hospitalized with a chronic disease. This includes the development of a new community-based model "Caring for my COPD" that has been implemented in four areas of the LHIN (Niagara Falls, Welland, Hamilton and Brant).

[17] Analysis of Emergency Room Admitted Population in the HNHB LHIN 2011-12- 2013-14. October 2014

[18] HNHB LHIN IDS, January 2015.

[19] ATC CCO ER Public Reporting and P4R Hospital Comparison Report November 2014.

[20] Key Performance Measures for the Ontario Diabetes Strategy. June 2014. Health Analytics Branch, Ministry of Health and Long-Term Care.

[21] Ontario Stroke Network Report Card 2012-13 and 2011-12.

Hospice Palliative Care (HPC):

- Hospice palliative care is provided in community, hospitals, and LTCH settings. Through funding to the CCAC, the HNHB LHIN supports five residential hospices for a total of 42 beds. Between April to December 2014, 569 individuals have received care at these residential hospices[22]. The LHIN also supports Good Shepherd's Emmanuel House, a ten bed assisted living program that provides hospice services.
- Other palliative care assets in HNHB include:
  - Formalized Interdisciplinary expert Palliative Care Shared Care Outreach Teams.
  - Prevalence of Alternate Forms of Physician Payments, which better supports a community model of care (compared to fee for service).
  - Interdisciplinary Community-Based and physician education programs.
  - Palliative Care Volunteer Visiting Program.
  - Links to McMaster – Department of Family Medicine and Division of Palliative Care.
  - Two Cancer Centres.
  - Palliative Pain and Symptom Management Consultant Program.
  - Long-standing tertiary care consults teams.
  - Designated hospital-based complex care – end of life (EOL) beds.
- The HNHB LHIN Hospice Palliative Care Council was established in July 2014. The Council acts in an Advisory capacity to the HNHB LHIN and reports to the LHIN Chief Executive Officer (CEO).

Mental Health and Addictions (MH&A):

- The HNHB LHIN is committed to support the development of a person-centered, integrated and coordinated MH&A system. A challenge facing our LHIN is that MH&A services are fragmented, spread across several ministries and offered in a variety of care settings.
- Over this past year, the LHIN-wide MH&A Advisory Group has provided leadership for our LHIN-wide system redesign and has identified the following goals and actions plans.

Maternal/Child and Youth Health (M/C&Y):

- Since its inception, the Provincial Council for Maternal and Child Health (PCMCH) has led a number of initiatives tackling key issues affecting the delivery of care to mothers, newborns, children and youth in Ontario, resulting in significant improvements in how care is understood, delivered and evaluated by providers. Where appropriate, the LHIN works in partnership with the PCMCH to implement the resulting recommendations (e.g., implementation of standardized definitions of levels maternal-newborn care in 2011). The LHIN has increased its activity in the Maternal Child and Youth program over the past few years.

Key issues:

- The LHIN's review of hospital throughput data revealed an increasing trend of the number of people identified as ALC. Comparing April 2013 to 2014 the number of new ALC designations increased from 611 to 741, increasing to 745 in October 2014. Hospitals were challenged to maintain a throughput ratio >1. In November 2014, LHIN hospitals reported a throughput ratio of 0.9 the lowest since March 2014[23].
- In 2014-15, CCAC advised the LHIN to facilitate their capacity to respond to new clients they would need to achieve flow through their organization by transitioning clients who are stable and have lower to moderate care needs to community

[22] HNHB CCAC Report. HNHB LHIN Hospices Data – April 2013 to December 2014. CHRIS Database.

[23] WTIS- ALC November 2014

support service agencies. This would also improve CCAC performance under the Health Based Allocation Model methodology

- The increase in the monthly volume of newly designated ALC to multiple destinations.
- Limited access to supervised supportive housing and/or group homes for the population with ABI and Developmental Disabilities.
- LTC: access to basic beds and person's choice to wait in hospital for LTCHs that report waits in years.
- A number of LHIN hospitals have a limited number of private rooms and are challenged by the number of individuals admitted through the ED requiring isolation precautions.
- Hospice palliative care is poorly understood by the larger medical community and the general public.

Successes of past year:

- The LHIN halted the sharp increase seen between July and December 2013 in the number of people waiting in hospital for an ALC in January 2014. This number was maintained through December 2014.
- Through Access to Care (ATC), Cancer Care Ontario (CCO) reported that in November 2014 the HNHB LHIN had the second highest number of people (562) waiting in hospital for an ALC, the number of ALC days accumulated by these patients was 44,296 the sixth highest of all LHINs. In comparison, Toronto Central (TC) LHIN reported the highest number (684) of people waiting in hospital for an ALC with accumulated ALC days of 108,909[24].
- The HNHB LHIN has managed to keep the number of individuals experiencing long waits (>100 days) to less than 100 across all LHIN hospital sites (79 as of December 28, 2014)[25].
- The HNHB LHIN has maintained the number of individuals waiting for LTC across all LHIN hospital sites to less than 190 since April 2014.
- Opened 92 transitional care beds in congregate settings in Hamilton (70) and Burlington (22).
- In December 2014, the LHIN, working with four hospital corporations, piloted a mobile AR intervention across five hospital sites, with the goal of preventing functional decline in high risk seniors. Though the pilot was time limited, hospitals demonstrated positive outcomes that included: reducing ALC days (26.5%); reducing referral to bedded AR programs (30-40%) and reduction in acute length of stay. Based on the results of the pilot, the mobile model will be introduced across six hospital sites in 2015-16 pending HNHB LHIN Board approval.
- To determine the capacity of LHIN providers to meet the needs of individuals and their caregivers requiring access to respite care, the LHIN completed a review of Adult Day Programs (ADPs) and respite services (in-home and overnight). The review identified a number of opportunities to streamline and coordinate access and introduce standardized staffing/funding models. This will be a focus in 2015-16.
- Significant improvements in 90th percentile ED LOS for the admitted patient population. Notably, the 90th percentile ED LOS at NHS St. Catharines site decreased from 49.2 hours in Q2 2013-14 to 32.2 hours in Q2 2015-16.
- In 2013-14, 17,520 individuals accessed a DEP in the HNHB LHIN, for a total of 57,358 visits. 2014-15, Q2 data indicates the LHIN will see an increase in the number of individuals assessing DEPs. As of Q2 2014-15, 11,473 individuals have accessed a DEP, for a total of 38,557 visits.
- Successfully mitigated a previous duplication of DEPs in the Port Colborne area by integrating services at Bridges CHC and NHS sites. This new collaboration, called the Niagara Diabetes program, was enabled by the development of one standardized referral form and a centralized intake process, which was developed in partnership with the Primary Care Network.

[24] ATC-CCO Provincial Monthly ALC Performance Summary. Provincial and LHIN Level November 2014.

[25] ALCIS December 2014

- Planning and coordination of both LHIN and non LHIN-funded DEPs continues through the Leaders in Diabetes network, including working with the ministry to implement a new standardized reporting methodology.
- In June 2013, acute and rehabilitative stroke care services were integrated within Brant, Haldimand and Norfolk at BCHS to improve access to best practice integrated stroke care. In 2013-14, the program reported a 60% increase in the proportion of Stroke/Transient Ischemic Attack (TIA). Patients treated on a Stroke unit, at any time during their inpatient stay, had a reduction in ALC days to total LOS (15.2%) at BCHS compared to previous HNHB LHIN Ontario Stroke Network Report card results (35.9%), and individuals with severe stroke had increased access to inpatient rehabilitation with 49.2% of individuals with severe stroke admitted to rehabilitation.
- Implemented a community-based program for patients with COPD ("Caring for my COPD") in each of the three LHIN zones of Hamilton/Burlington, Brant/Haldimand/Norfolk, and Niagara. These sites in total have provided services to 229 individuals (as of November 2014). Initial results indicate that patients enrolled in the "Caring for my COPD" program are significantly less likely to be readmitted to hospital within 30 days.
- The establishment of a recognized Advisory Hospice Palliative Care (HPC) Regional Council accountable to the HNHB LHIN met the intent of the LHIN's commitment to implement a regional structure for HPC identified in the Declaration of Partnership[26].
- The LHIN's Behavioural Supports Ontario (BSO) programs report that as of September 2014:
  - BSO Connect linked 686 clients to services.
  - BSO Community Outreach Team (COT) served 601 clients.
  - BSO Connect and BSO COT performed system navigation for 1,357 clients.
  - BSO LTCH Mobile team served 1,231 clients and performed 14,154 client-based services.
  - BSO LTCH Mobile team supported 242 transitions[27].
- Expansion of Midwifery services in Norfolk County through the opening of an additional Midwifery Practice Group (MPG) (via Grand River CHC as a transfer payment agency (TPA) to fund independent MPGs).
- Participating as a core partner in Ontario's Special Needs Strategy, aimed at ensuring children and youth with special needs get the timely and effective services they need, and improving the service experience of families.
- Continued collaboration with Ministry of Child and Youth Services (MCYS) on Ontario's Moving on Mental Health plan to transform the experience of children and youth with mental health problems and their families, including:
  - Participation in the Niagara and Hamilton Service Collaboratives.
  - MH&A nurses in District School Boards (DSBs) to build capacity within DSBs to recognize and respond to mild to complex mental health and/or substance abuse student issues.
  - Expansion of eating disorders programs at McMaster Children's Hospital, NHS and SJHH.

PART 2: GOALS and ACTION PLANS

Goal(s)

In 2015-16 LHIN-wide population based strategies are in place and have the following goals.

Older Adults (including caregivers and families):

- Prevent Functional and Cognitive Decline:
  - Implement a two year Seniors Mobile AR Teams model that is based on the 2014 pilot for its impact on LOS, ALC

[26] Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action. December 2011.

[27] HNHB LHIN BSO Project January 2015

designation/days/need for restorative programs for specific populations.

- Evaluate the LHIN restorative programs against the ministry newly released AR Guideline.
- Pilot one of the strategies identified by the LHIN Expert Work Group for high risk BSO clients in LTCHs to avoid unnecessary transfers to hospital.
- Complete evaluation of the LHINs BSO LTCH Model.
- Review all LHIN-funded Exercise and Falls Prevention Programs to identify the population served against the program's target population to determine if the programs are:
  - Meeting the population needs; providing evidence-based care, and achieving positive client and system outcomes.
- Improve caregivers' access to programs that provide respite care by developing and implementing standardized processes for referral and assessment, wait list management process, standardized staffing/costing models and improved occupancy.
- Optimize LHIN-funded Adult Day Program (ADP) capacity by:
  - Developing a standardized staffing/costing model for LHIN-funded ADPs based on populations served.
  - Developing a process that better aligns the assessment and program suitability process.

Improving System-wide Patient Flow and Timely Access to ED:

- Reduce the number of days individuals wait in hospital for an ALC through:
  - Expansion of transitional bed programs in the community and explore opportunities for spread across the LHIN.
  - Completion of a LOS review in convalescent care programs with goal of aligning LOS to that reported by LHIN AR programs to achieve at a minimum a five day reduction.
  - Decreasing ALC days to Behavioural Health Units through the implementation of BSO Clinical Leads and exploring opportunities to access services remotely.
  - Develop and implement a community program to support a population with specialized needs currently experiencing long waits in hospital and barriers to discharge (through the partnership of Good Shepherd and SJHH).
  - Implement and evaluate an integrated discharge planning role at two LHIN hospitals.
- Improve access to inpatient beds for patients admitted through the ED by identifying and addressing challenges at underperforming hospital sites.
- Implement standard definitions for rehabilitative care developed by the Rehab Care Alliance.
- Explore electronic solutions to support the implementation of the provincial Resource Matching and Referral (RM&R) standards for referrals from Acute Care to Complex Care, Rehab and CCAC.

Complex/Chronic conditions (Cerebrovascular Accident (CVA), Diabetes, COPD, CHF, ABI):

- Stroke:
  - Reengage with NHS to develop and identify a schedule to implement an integrated stroke unit model.
  - Implement the approach HHSC and SJHH developed for provide integrated stroke unit model care to individuals admitted to SJHH.
  - Complete the evaluation of the Community Stroke rehab model to determine applicability to other LHIN areas and populations.
- Diabetes:
  - Increase access to Specialized Services to First Nations DEP clients (Endocrinology, Clinical Nurse Specialist, Advanced Dietitian) in partnership with HHSC through OTN.
  - Improve access to Diabetes Services through the implementation of a coordinated access model.

- Adopt a standardized approach for Diabetes Education for the population at high risk of developing diabetes.

- COPD and CHF:
  - Expand the reach of the "Caring for my COPD" program into Burlington and Haldimand/Norfolk.
  - Improve standardization of CHF management practices and processes across LHIN hospitals.
  - Review LHIN-funded General Internal Medicine Rapid Assessment Clinic (GIMRAC) to identify opportunities to improve access.
- ABI
  - Explore the opportunity to develop a community model of care that is based on a Life Redesign Model for individuals in collaboration with neighbouring LHINs and HNHB LHIN providers and other stakeholders.

Hospice Palliative Care:

- Adopt standard criteria and develop a reliable process of early identification of patients with palliative care needs by testing an early identification guide in a minimum of three sites using a Plan-Do-Study-Act (PDSA) approach.
- Current processes for referral and triage for palliative care services are reviewed, recommendations for improvement and a plan for phased implementation developed and initiated.
- A regional education plan is developed and recommendations regarding funding and accountability are submitted to the LHIN. The education plan is initiated.
- An "Asset Map" of palliative care providers /teams across all sectors is compiled and assessment of their capacity is complete.
- A process for reporting on the provincial indicators is established.
- An initial set of regional indicators is developed and reporting is initiated.

Mental Health and Addictions:

- Establish an integrated network of MH&A services in HNHB LHIN, including:
  - Enhanced Medical Collaboration between Psychiatry and Primary Care.
  - Enhanced System Performance through LHIN-wide scorecards for both hospital and community.
  - Targeted priority populations including Early Intervention and Concurrent Disorders.
  - Enhanced integration and collaboration through Health Links and other specific proof of concept projects.
  - Enhanced services for children and youth through cross-sectoral collaboration with the MCYS.
- Initiate a LHIN-wide review of 'memory clinics'.

Maternal Child and Youth Health:

- To improve the delivery of services along the continuum of maternal, newborn, and child and youth health system in the HNHB LHIN through:
  - The planning, implementation and evaluation of a quality improvement initiative in collaboration with the Southern Ontario Maternal Child Network (SOMCN), a network comprising of clinical leaders from maternal child programs/services from across HNHB, WW and Mississauga Halton (MH) LHINs (LHINs 4, 3, and 6, respectively).
  - Continued support and participation in the work of the Special Needs Strategy, specifically participating in the development and implementation (as applicable) of proposals for Coordinated Service Planning and for Integrated Delivery of Rehabilitation Services.
  - Collaboration with the LHIN's MH&A strategy to enhance services for children and youth, consistent with Ontario's Moving on Mental Health Strategy.

Consistency with Government Priorities:

- The Minister's 2015 Patients First Action Plan provides a roadmap for transformational change in the home and community care sector. The LHIN's goals for population-based strategies align with the Minister's Action Plan, by:
  - Focusing on the client and caregiver
  - Improving access and quality of services by reducing variation and standardizing care models
  - Support clients/families transition across care settings
  - Aligning goals with specific ministry strategies that includes Ontario's Mental Health Strategy for children and youth, and the Diabetes Strategy
- Each of the goals are also aligned with the LHIN's Strategic Health System Plan

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.					
	2015-16		**2016-17**		**2017-18**	
Examples:	Status	%	Status	%	Status	%
Older Adults:						
• Implement a two year Seniors Mobile AR Team model that is based on the 2014 pilot for its impact on LOS, ALC designation/days/need for restorative programs for specific populations.	In progress	50	In progress	50		
• Evaluate the LHIN restorative programs against the ministry AR Guideline.	Completed	100				
• Pilot one of the strategies identified by the expert panel for high risk BSO clients in LTCHs to avoid unnecessary transfers to hospital.	Completed	100				
• Complete evaluation of the LHIN's BSO LTCH Model.	Completed	100				
• Review all LHIN-funded Exercise and Falls Prevention Programs to identify the population served against the program's target population to determine if the programs are: meeting the population needs; providing evidence-based care and achieving positive client and system outcomes.	In progress	50	In progress	50		
• Improve caregiver's access to programs that provide respite care by developing and implementing standardized processes for referral and assessment, wait list management process, standardized staffing/costing models and improved occupancy.	In progress	50	In progress	50		
• Develop a standardized staffing/costing model for LHIN funded ADPs based on populations served, and a process that better aligns the assessment and program suitability.	In progress	50	In progress	50		

Improving System-wide Patient Flow and Timely Access to ED:						
• Expand transitional bed programs in the community and explore opportunities for spread across the LHIN.	In progress	75	In progress	25		
• Complete a review of LOS in convalescent care programs with goal of aligning LOS to that reported by LHIN AR programs to achieve at a minimum a five day reduction.	Completed	100				
• Decrease ALC days to Behavioural Health Units through the implementation of BSO Clinical Leads and exploring opportunities to access services remotely.	In progress	50	In progress	50		
• Develop and implement a community program to support a population with specialized needs currently experiencing long waits in hospital and barriers to discharge through the partnership of Good Shepherd and SJHH.	In progress	50	In progress	50		
• Implement and evaluate an integrated discharge planning role at two LHIN hospitals.	In progress	50	In progress	50		
• Improve access to inpatient beds for patients admitted through the ED by identifying and addressing challenges at underperforming hospital sites.	In progress	75	In progress	25		
• Implement standard definitions for rehabilitative care developed by the Rehab Care Alliance.	In progress	50	In progress	50		
• Explore electronic solutions to support the implementation of the provincial RM&R standards for referrals from Acute care to Complex Care, Rehab and CCAC.	In progress	50	In progress	50		
• Reengage with NHS to develop and implement an integrated stroke unit model.	In progress	30	In progress	30	In progress	40
Complex/Chronic Conditions:						
• Improve access to Diabetes Services through the implementation of a coordinated access model.	In progress	75	In progress	25		
• Adopt a standardized approach for Diabetes Education for the population at high risk of developing diabetes.	Completed	100				
• Expand the reach of the Caring for my COPD program into Burlington and Haldimand Norfolk.	Completed	100				
• Improve standardization of CHF management practices and processes across LHIN hospitals.	Completed	100				
• Review LHIN funded GIMRAC to identify opportunities to improve access.	Completed	100				

• Explore opportunity to develop a community model of care that is based on a Life Redesign Model for individuals in collaboration with neighbouring LHINs and HNHB LHIN providers and other stakeholders.	In progress	20	In progress	30	In progress	50
Hospice Palliative Care:						
• Adopt standard criteria and develop a reliable process of early identification of patient with palliative care needs by testing an early identification guide in a minimum of three sites using a PDSA approach.	In progress	50	In progress	50		
• Current processes for referral and triage for palliative care services are reviewed, recommendations for improvement and a plan for phased implementation is developed and initiated.	In progress	50	In progress	50		
• Develop a regional education plan and submit recommendations regarding funding and accountability to the LHIN.	In progress	50	In progress	50		
• Complete an "Asset Map" of palliative care providers/teams across all sectors and capacity assessment. • Establish a process for reporting on provincial indicators. • Develop and initiate reporting on a set of regional indicators.	Completed	100				
Mental Health and Addictions:						
• Develop and Implement a comprehensive strategy to achieve an integrated network of MH&A services in response to identified need, including leveraging integration opportunities with Health Links initiatives.	In progress	30		40		30
• Identify, plan, implement and evaluate a LHIN-wide Early Intervention strategy to improve access, continuity and coordination of care, including Indigenous and Francophone populations.	In progress	25		50		25
• Identify, plan, implement and evaluate a LHIN-wide concurrent disorders capacity building initiative.	In progress	30		40		30
• Continue to link with the work of the special needs strategy, to leverage integration and collaboration opportunities.	Not yet started	25		50		25
• Initiate a review of memory clinics.	Not yet started	20		30		50
Maternal Child and Youth Health:						
• Identify, plan, implement and evaluate a quality improvement initiative in collaboration with the SOMCN.	In progress	75		25		
• Continue to support and participate in the work of the Special Needs Strategy, specifically participating in the development and implementation (as applicable) of	In progress	25		50		25

proposals for Coordinated Service Planning and for Integrated Delivery of Rehabilitation Services.						
• Collaborate with the LHIN's MH&A strategy to enhance services for children and youth, consistent with Ontario's Moving on Mental Health Strategy (specific ministry initiatives to be determined).	Not yet started	25		50		25

How will we measure success?

- Reduction in ALC days and LOS for patients that received care through the mobile AR model.
- Development of an integrated stroke unit model at NHS with a planned timeframe for implementation.
- Increased number of clients from First Nations DEP who access specialized services (i.e., Endocrinologist, Advanced Dietitian).
- Reduction of LHIN's ALC rate.
- The number of people waiting in hospital for LTCH is maintained at less than 190.
- Reduction of LHIN ED LOS for admitted patient population to meet MLPA target (28 hours).
- Reduction in the LHIN readmission rate for Stroke, COPD and CHF; impacting the LHIN's MLPA target for readmission for select Case Mix Groups (CMGs).
- Additional access to "Caring for my COPD" program for individuals residing in Burlington and Haldimand/Norfolk.
- Reduction of LOS in convalescent care programs.
- Standardized referral, assessment processes and staffing/costing models identified for LHIN funded respite programs.
- Transitional care bed demonstrates flow through.
- Convalescent care programs report a reduced average LOS of a minimum of five days.
- Implementation of standard definitions for LHIN rehabilitative services developed by the Rehab Care Alliance has been initiated.
- An electronic solution to support the provincial RM&R standards for referrals from acute to complex, rehab and CCAC has been identified.
- 100% of newly funded MH&A HSPs are accountable to implement specific measures of success within the following domains including:
  - Population Health - health functional status.
  - Client Experience - patient experience.
  - Quality - safe, efficient, timely, effective, equitable, person-centered.
  - Value - hospital and ED utilization rates.

What are the risks/barriers to successful implementation?

- Identification of new priority projects that require dedicated LHIN staff resources.
- Capacity of community service providers (CCAC and community support services (CSS)) to work within a shared care model for ADPs and community respite services.
- Readiness and capacity of hospitals to implement new processes (i.e. Home First Refresh), NHS to dedicate resources to develop an integrated stroke services.
- Continuing increases in the number of individuals presenting and being admitted through LHIN EDs.
- Increasing trend in the severity of illness (acuity) of individuals who are visiting/admitted to hospital.
- Access to primary care to provide services on evenings and weekends.

- Demand on ED services as a result of infectious disease outbreaks (e.g. influenza).
- Number of individuals admitted to the hospital through the ED who require isolation protocols.
- MH&A system complexity and fragmentation.
- Readiness and capacity of existing mental health service providers to engage in system-improvement activities with cross-sectoral partners.
- Capacity of Maternal/Child and Youth HSPs to participate in and implement recommendations of LHIN-wide quality improvement initiative.
- Capacity of Maternal/Child and Youth HSPs to manage the complexity and scale of the change initiatives within the Special Needs initiative's specified timelines.
- Risk of variation in initiatives between service delivery areas in the LHIN (Brant, Halton, Haldimand-Norfolk, Hamilton, and Niagara) for the Special Needs Strategy.

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

- Identify the benefits to standardizing process for LHIN ADP and CSS Respite services.
- Work with LHIN HSPs to identify challenges and barriers to introduce new processes and model of work that will improve the patient experience and/or will lead to operating efficiencies.
- Work with the LHIN's ED and Primary Care physician leads and the LHIN Chief Medical Leads to identify drivers of admissions at hospitals that report higher admission rates than their peers.
- Work with the LHIN's ED and Primary Care physician leads and the LHIN's Emergency Services Steering Committee (ESSC) to develop a plan to address surges in flu like illnesses.
- Request hospitals that have limited isolation capacity to develop a plan that addresses peaks for isolation resources.
- Several initiatives require the active participation of HSPs on multiple interventions. The HNHB LHIN will need to work with its provider partners to address issues regarding workload and implementation timelines, as they arise.
- Building strong partnerships with Health Links and PCN in order to align direction and resources.
- Take a collaborative and quality improvement approach to initiatives in order to make participation and implementation manageable.
- LHIN-wide monitoring of planning between service delivery areas.

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

- Continued collaboration between HSPs and primary care through the PCN.
- Health Information Systems (HIS), including Electronic Medical Records (EMRs), which allow the sharing of health information within and between health service organizations.
- Health Links implemented and operational across the LHIN.
- Committed partnerships between HSPs.
- Leadership from the MH&A Advisory group will play a critical role in ensuring our success by continuing to identify priority areas specific to MH&A population.
- Collaborative partnerships between hospital and community for MH&A initiatives.
- Quality Improvement activities will support the broader implementation goals of the strategy.
- Support from the partner LHINs within the SOMCHN to allow the network to identify and prioritize a quality improvement initiative.
- Committed partnerships between HSPs.

- Technological solutions to support our objectives including the development of appropriate and supportive information systems, and the connectivity of EMRs.
- Sharing of data amongst partnering HSPs for issue identification and benchmarking purposes.

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

n/a

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: Indigenous Health

IHSP Priority Description:

Healthy Families, Healthy Children, Healthy Communities

Current Status:

According to the 2006 Canadian Census, there are 24,456 people in the HNHB LHIN who identify as Indigenous; 11,947 of whom live on-reserve and 12,509 off-reserve. Data from Indian and Northern Affairs Canada suggests that the age distribution of Indigenous peoples who live on reserve is considerably younger. Approximately 6.1% of the Indigenous population who live on-reserve in the HNHB LHIN are seniors. In contrast, seniors account for approximately 12.7% of the Indigenous population living off-reserve compared to the LHIN average of 15.8%. Overall, the Indigenous population has a younger age demographic as compared to the population of the HNHB LHIN.

The LHIN currently provides funding to two Indigenous HSPs; De dwa da dehs nye>s Aboriginal Health Access Centre and Native Horizons Treatment Centre.

The LHIN also provides funding to two First Nations; Six Nations of the Grand River Territory and Mississaugas of the New Credit.

There are a number of additional Indigenous HSPs who, while not funded by the LHIN, collaborate with the LHIN through the Aboriginal Health Network (AHN). These HSPs include three Friendship Centres, as well as several native housing and women's organizations.

Key issues:

- There are many challenges related to Indigenous-specific population health data collection, management and analysis including undercounting (due to homelessness and high mobility), non-participation, incomplete enumeration of those who live on-reserve, and lack of mechanisms to permit self-identification[28].
- In comparison to the general population, the demographic profile of Indigenous populations shows disparities according to several social determinants of health, including a younger age structure, higher fertility rates, greater mobility, crowded living conditions, and lower reported household incomes[29].

[28] Firestone, M., Smylie, J., Maracle, S., Spiller, M., and O'Campo, P. (2014). Unmasking health determinants and health outcomes for urban First Nations using respondent-driven sampling. BMJ Open. 4:e004978.

[29] MOHLTC Health Analytics Branch report "First Nations Peoples in Ontario: A Demographic Portrait" (January 2009)

- Canadian studies have consistently shown reduced life expectancy and poor health status for Indigenous peoples compared to the general population, including higher rates of chronic conditions such as Arthritis, Hypertension, Diabetes, and COPD [30]. Data from the Institute for Clinical Evaluative Sciences (ICES) indicates a higher prevalence of chronic conditions, such as Diabetes, among Indigenous persons living on-reserve in the HNHB LHIN.
- These disparities in health outcomes lead to higher hospital utilization in some Indigenous populations compared to the Ontario average.

Successes of past year:

The three strategic priorities of the AHN, identified in the 2012-15 Strategic Plan are addressing youth mental health and high rates of suicide, chronic disease management and high rates of Diabetes, and strengthening the family unit and high rates of domestic violence. Achievements related to these priorities include:

- Continued training of 201 and 480 individuals in Applied Suicide Intervention Skills Training (ASIST) Version 10 and 11 and Tell, Ask, Listen and Keep Safe (TALK) Suicide Prevention. As of January 2015, approximately 40% of these training targets have been met. Various challenges, including staff turnover, have made these training targets difficult to achieve. An evaluation of these training programs will be completed in 2015-16.
- Participation in the Walk the Talk Health and Wellness Initiative remains high (88%) amongst member organizations on the AHN. Recently, a cookbook resource was developed using a local vendor and included as part of the toolkit.
- Three full-time Indigenous Patient Navigators are currently operating in the three LHIN zones: Hamilton/Burlington, Niagara, and Brant/Haldimand/Norfolk. From February to December 2014, 1,318 individuals from across the HNHB LHIN have received improved access to culturally appropriate services as a result of this program.
- In December 2014, the AHN hosted a community engagement event related to Traditional Medicine in Today's Health System. Feedback obtained through breakout sessions with community members will be used to inform and develop goals and strategic priorities by the AHN in 2015-16 and onwards. Another community engagement event is scheduled in 2015 and will provide further information on the strategic direction of the AHN for 2015-16.

PART 2: GOALS and ACTION PLANS

Goal (s):

The Minister's Patients First Action Plan defines *putting people first* as supporting people to make healthy choices and prevent disease, engaging Ontarians on health care to fully understand their needs, focusing on people and not their illness and helping them to understand the system so they can access the care and make informed decisions. The HNHB LHIN works with the HNHB Aboriginal Health Network to identity priority areas with the goal of improving health outcomes and the health experience for Indigenous people. In 2015-16 priority areas of focus are:

Mental Health and Addiction:

- Reduce the rate of Indigenous suicide across the HNHB LHIN area by continuing to train 133 Indigenous community members in ASIST, and 273 Indigenous community members in safeTALK, and evaluate outcomes.
- Reduce the rate of Indigenous persons developing a mental health problem or experiencing a mental health crisis across the HNHB LHIN area, utilizing the nine Mental Health First Aid trainers to train 180 Indigenous individuals, and evaluate outcomes.

[30] Health Canada. A Statistical Profile on the Health of First Nations in Canada: Determinants of Health, 1999 to 2003. Minister of Health: Ottawa, 2009. Available at: http://www.hc-sc.gc.ca/fniah-spnia/pubs/aborigautoch/index-eng.php

Chronic Disease Priority:

- Reduce the rate of Indigenous chronic disease by continuing to implement the HNHB Walk the Talk Health Initiative, by supporting 15 Indigenous organizations to implement activities to exemplify leadership in promoting health and wellness to their service recipients across the HNHB LHIN area. This will include a review of the current toolkit and development of aiding resources to support the initiative.

Cultural Sensitivity Training:

- Identify the number of LHIN hospital staff by hospital organization that received LHIN sponsored Cultural Awareness and Sensitivity Training (CA&ST) and identify hospitals that have programs in place to maintain or expand this training. In collaboration with hospitals, identify and initiate a plan for ongoing training opportunities for health care professionals working in the hospital setting.
- Minimum of 12 LHIN staff/Board members to complete the online Indigenous Cultural Competency (ICC) training module.

Patient Navigation:

- Develop and implement a communication strategy to educate Indigenous and non-Indigenous providers as to the role of Indigenous Patient Navigators that incorporates individuals' stories.
- Identify performance measures, monitor the implementation, and conduct an evaluation of the Child and Youth Indigenous Patient Navigators.

Traditional Healing:

- Develop a standardized referral protocol in collaboration with one LHIN hospital for referrals Traditional Healing services or supports for Indigenous patients.
- Explore opportunities to increase access to Traditional Healing.

Consistency with Government Priorities:

Indigenous populations are a priority population.

The goals outlined are consistent with the Minister's 2015 Patient's First Action Plan, focused on the following:

- Keeping Ontario healthy.
- Faster access and a stronger link to family health care.
- 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.					
	2015-16		**2016-17**		**2017-18**	
Examples:	Status	%	Status	%	Status	%
Mental Health and Addiction:						
Reduce the rate of Indigenous suicide across the HNHB LHIN area by continuing to train 133 Indigenous individuals in ASIST, and 273 Indigenous individuals in safeTALK, and evaluate outcomes. Reduce the rate of Indigenous persons developing a mental health problem or experiencing a mental health crisis across	Complete	100				

the HNHB LHIN area, utilizing the nine Mental Health First Aid trainers to train 180 Indigenous individuals, and evaluate outcomes.						
Chronic Disease:						
Reduce the rate of Indigenous chronic disease by continuing to implement the HNHB Walk the Talk Health and Wellness Initiative, by supporting 15 Indigenous organizations to implement activities to exemplify leadership in promoting health and wellness to their service recipients across the HNHB LHIN area. This will include a review of the current toolkit and development of aiding resources to support the initiative.	In progress	50	In progress	25	In progress	25
Cultural Sensitivity Training:						
Identify the number of LHIN hospital staff by hospital organization that received LHIN sponsored CA&ST and identify hospitals that have programs in place to maintain or expand this training. In collaboration with hospitals, identify and initiate a plan for ongoing training opportunities for health care professionals working in the hospital setting.	In progress	50	In progress	50		
Minimum of 12 LHIN staff/board members to complete the online ICC training module.	Completed	100				
Patient Navigation:						
Develop and implement a communication strategy to educate Indigenous and non-Indigenous providers about the role of Indigenous Patient Navigators and share patient success stories.	In progress	50	In progress	50		
Develop performance measures, monitor the implementation, and conduct an evaluation of the Child and Youth Indigenous Patient Navigators.	In progress	25	In progress	75		
Traditional Healing:						
Develop a standardized referral protocol in collaboration with one LHIN hospital for referrals Traditional Healing services or supports for Indigenous patients.	In progress	25	In progress	50	In progress	25
Explore opportunities to increase access to Traditional Healing.	In progress	25	In progress	50	In progress	25

How will we measure success?

- Increased number of individuals in Indigenous communities across the HNHB LHIN who are trained in safeTALK, ASIST, and Mental Health First Aid.
- Number of additional materials/resources added to the HNHB Walk the Talk Health and Wellness Initiative, further enabling AHN member organizations to promote healthy living in their communities.
- A plan for sustainability and expansion of Cultural Sensitivity Training for hospital staff is developed and implemented.
- Number of clients referred by Indigenous Patient Navigators to mainstream and traditional healing resources.
- A standardized referral protocol for Traditional healing service has been developed and piloted at one LHIN hospital.

What are the risks/barriers to successful implementation?
• Ongoing regional coordination of mental health and first aid training resources. • Change management in hospital setting related to increasing access and referrals to traditional healing.
For each risk/barrier, describe the plan to mitigate the risk?
• Working with the AHN, establish a lead organization to coordinate the regional delivery of training programs related to MH & A management. • Improving partnerships between the hospital sector and Indigenous health service providers through the AHN.
What are some of the key enablers that would allow us to achieve our goal?
• Continued engagement of Indigenous health and social service providers on the AHN.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).
n/a

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 the HNHB LHIN, including their access to health care services, continues to represent a priority for the LHIN and its commitment towards equity and community engagement.
Current Status:
The *FLSA* Ontario, 1986*,* guarantees the right of Ontarians to communicate with the government and receive services in French. In its preamble, the *Local Health System Integration Act (LHSIA) Ontario, 2006,* reiterates the commitment to meeting the health needs of all Ontarians, including Francophone. As system planners and managers of the local health system, HNHB LHIN is accountable for ensuring the availability of French Language (FL) health services. According to the new Inclusive Definition of Francophone (IDF), there are over 35,000 Francophone in the HNHB LHIN. The IDF broadens the mother tongue indicator, and adds those persons who speak French, whose mother tongue is neither French nor English and for whom French is one of the languages spoken at home. This inclusive definition better reflects the evolution and diversity of French-speaking communities. 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 ("active offer") and where; FL speaking health professionals are in short supply; and there is variable commitment among stakeholders to meeting the needs of French speaking people. **Key issues:** • The Francophone population is dispersed across the LHIN, with concentrations in Hamilton and Welland/Port Colborne. • 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:

- There is a lack of data related to the Francophone populations and a lack of means to collect data and information.
- Considering the dispersion and the heterogeneity of the population, health and services promotion are challenging.

Successes this past year:

- 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. This has resulted in:
  - An increasing level of engagement of staff and departments as seen by responses in reports and increased request for information on FLS. (97% of FLS identified agencies submitted their FLS report).
  - 94% of FL-identified agencies have a mechanism in place to identify French-speaking clients.
  - An increasing level of engagement to actively offer services in French. 64% of the FL-identified agencies invite their clients to use their preferred language and 61% publicize their services in French.
  - An increasing level of engagement staff and departments amongst non-identified agencies as seen: 91% submitted their FLS reports on time as per their accountability agreement.
  - In collaboration with Erie St Clair, South West and Central West LHINs and Entité 1 and Entité 2, a special dossier in the Francophone publication "Bonjour Ontario" focused on active offer and active demand for the FL services.
  - The LHIN funded a FL MH&A service to provide individual and group counseling services. Public funds resourced an ADP in French for adults affected by progressive memory loss or other long-term health conditions. As part of the community Mental Health funding strategy aligned with government priorities, the LHIN provides funding for LHIN-wide Mental Health promotion trainers to expand training in French for families and caregivers. (e.g. Mental Health First Aid, Applied suicide intervention, Talking about mental illness.)
  - Engaged and worked with the French Language Planning Entité (FLPE) to meet objectives set out in the 2014-15 Joint Annual Action Plan (JAAP), meeting regularly through the Joint Liaison Committee.
  - The LHIN and the FLPE continue to establish positive working relationships which will facilitate reaching a mutual goal of improving access to health services in French for our Francophone communities.
  - Worked with the FLPE to build on the existing FLS toolkit as a resource available to HNHB LHIN HSPs.
  - FLPE made a presentation to Board of Directors of HNHB LHIN about its role and mandate.

PART 2: GOALS and ACTION PLANS

Goal(s):

- Increase knowledge and capacity of HSPs with respect to FLS.
- Continue to work with FLPE to identify strategies to improve access to FLS for people who speak French.
- Develop and implement a strategy to increase access to LTCH beds for French speaking individuals in Hamilton.
- Develop and implement a strategy to increase the availability of FL services provided through OTN.
- Increase knowledge about French-speaking communities in the designated and non-designated areas.
- Work closely with the CCAC to implement their FLS compliance plan, as per the 2012 regulation attached to the *Community Care Access Corporations Act, 2001, 6.1*.
- Review and reinforce the identification status of HNHB LHIN agencies.

Consistency with Government Priorities:

Access:

Ensure that the Francophone population can reasonably access health services in French.

Accessibility:

- Ensure the 'active offer' of health programs in French as well as availability of French-speaking Health Human Resources (HHR).

Community Engagement:

- Support the active participation of Francophones in public consultations and community engagement activities.

Integration/Coordination:

- Address the needs of Francophones, and ensure that programs and HSPs incorporate the principles of the *FLSA* and *LHSIA* in their business processes to address the needs/concerns of Francophone clients.

Evidenced-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.					
	2015-16		**2016-17**		**2017-18**	
Examples:	Status	%	Status	%	Status	%
• Increase knowledge and capacity of HSPs regarding FLS: o Promote use of existing FLS resources. o Specific capacity-building projects. o Monitor HSP progress/performance with respect to FLS implementation. o Build the foundation for an 'active offer" strategy. o Review and reinforce the identification status of HNHB LHIN agencies. o Work closely with the CCAC to implement FLS compliancy with the 2012 regulation attached to the *Community Care Access Corporations Act, 2001, 6.1.*	In progress	30	In progress	40	In progress	30
• Continue to work with the FLPE on an annual basis to identify strategies to improve access to French Language Health Services (FLHS) for people who speak French: o Coordinate "joint liaison" efforts with FLPE to ensure appropriate completion of 2015-16 JAAP. o Review and coordinate response to FLPE required annual submissions.	In progress	100				
• Improve availability and access to MH&A services for French-speaking individuals: o Continue to work with the FLPE to get a better portrait of the French-speaking communities and their specific needs. o Participation to the LHIN MH&A strategic planning.	In progress	30	In progress	40	In progress	30

• Improve availability and access to chronic disease services for French-speaking individuals: o Continue to support education sessions on diabetes.	In progress	30	In progress	30	In progress	40
• Improve availability and access to LTCH beds for French-speaking individuals in Hamilton.	In progress	25	In progress	25	In progress	50
• Explore telemedicine opportunities across LHIN sectors: o Explore with the FLPE existing resources for French-speaking patients.	In progress	20	In progress	30	In progress	50

How will we measure success?

- Progress report on implementation plan:
  - Number of FL-identified agencies who submit their FLS report on time.
  - Number of FL non-identified agencies who submit their FLS report on time.
  - Number of FL-identified agencies who have a mechanism in place to identify French-speaking clients.
  - Number of FL-identified agencies who invite their clients to use their preferred language and/publicize their services in French.
- A strategy is implemented to improve access to LTCH beds in Hamilton for French speaking individuals.

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.

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.
- Work with various stakeholders and partners.

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:
  - Training of French-speaking health care professionals.
  - Access to translation services.
  - Work closely with the CCAC.
  - More information exchanged with the Francophone community.

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

- Continue to raise awareness of FLS obligations with the LHIN staff.

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.
- Building capacity in the health care system to advance quality improvement requires continuous engagement and capacity building with HSPs on performance improvement to ensure that outcomes are being met for patients.

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 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-centered services that also reflect value for money.
The HNHB LHIN maintains 189 SAAs with 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 center of decision making.

Along the path toward adopting a commissioning strategy, the HNHB LHIN will continue and enhance its relationship with 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).

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

- Are there some things that other HSPs can do better? (Quality).
- The number and complexity of HSPs in our LHIN requires a prioritization based on the risk of not meeting performance obligations. 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.

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 allocated its portion of the community investment funding through a 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 demands.
- The LHIN worked with hospitals on the distribution of funding for wait time volumes for surgical procedures and DI. This collaborative effort focused on providing funding to more directly impact key objectives such as wait time reductions for patients.

- The Board approved a Performance Accountability Policy designed to articulate principles to guide performance management.

  This policy sets out a clear relationship between the LHIN and providers, the role of governance in performance improvement and articulates the continuum of steps to address performance challenges.
- The LHIN continued to enhance the methodology to rank agency risk in order to more proactively identify and mitigate performance and contractual issues. The framework is built on assessing risks across the following components: Contractual Compliance, Performance Indicators, and Core Financial Indicators.

PART 2: GOALS and ACTION PLANS

Goal(s):

1. Further develop ERM processes within the LHIN.
2. Further spread of the concept of LHIN commissioning within the LHIN office.
3. HSFR will continue to evolve in alignment with the ministry.
4. Administrative costs within the health sector will continually be reduced.

Consistency with Government Priorities:

- HSFR.
- Optimize utilization of resources.
- Optimize value for money.
- Improve cost efficiency for service delivery.

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.					
	2015-16		**2016-17**		**2017-18**	
Examples:	Status	%	Status	%	Status	%
• Review, develop and /or refresh key ERM components, processes, and practices required to fully operationalize the Risk Identification and Management policy	Not yet started	75	In progress	25		
• Conduct a scan and gap analysis of current risk management plans and processes in place at HSPs. Draft recommendations to support HSPs as required	Not yet started	50	In progress	50		
• Further spread of the concept of LHIN commissioning within the LHIN office. • Development of a Return on Investment (ROI) tool to further support Commissioning: o Development of a program/service sustainability plan should the current service/outcomes not be able to be sustained	In Progress	50	In progress	50		

with current resources. o Ensure that all funding decisions are tied to LHIN priorities.						
HSFR will continue to evolve in alignment with the ministry: • Support continual implementation of HSFR. • Local Partnerships. • Development of LHIN staff competency on the utilization of HBAM and QBP as performance improvement strategies	In Progress	50	In Progress	50		
• Administrative costs within the health sector will continually be reduced. o Plan has been developed to identify how best to reduce duplication in administrative support services within hospital and community sectors: ▪ Assess current state. o Findings, conclusions and actionable recommendations.	Complete	100				

How will we measure success?

- Refreshed ERM components reviewed and approved by leadership and the Board.
- Regular education scheduled for current and new HNHB LHIN staff.
- Completion of new ministry reporting for risk.
- Reporting of current risk management plans by sector.
- HNHB LHIN staff and providers are working effectively within the performance management framework.
- Clinicians actively participate in the design and delivery of efficient and effective healthcare.
- Healthcare 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?

- Varied resources for a comprehensive ERM system available in HSPs.
- Creating and imbedding a culture of risk management that supports all operations within the HNHB LHIN.
- Ability to identify the key risks categories important for the HNHB LHIN to review at a system level.
- A lack of natural incentive to foster cooperation.
- Some providers unaware of the processes required to implement effective quality at a reasonable cost.
- Lack of clarity for not meeting SAA requirements.
- Program and organizational objectives lack clarity (not Specific Measurable Attainable Realistic Timely (S.M.A.R.T.) philosophy).
- 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?
• Use evidence based ERM tools that are easy to use and help report risk. • Focus on using ERM for regular review of HSP reports, new funding requests and project proposals. • Leverage an interdisciplinary HNHB LHIN team approach to identify key risk categories for approval by HNHB LHIN. Leadership. • The HNHB LHIN will advance incentive systems for performance through new initiatives such as the Health Links and innovative accountability instruments such as MOUs. • 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 continue to 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?

• Support from CEO and HNHB LHIN Leadership.
• Building a cross functional HNHB LHIN Team who can support staff with ERM in projects and processes.
• Alignment of ERM with Performance and Accountability policies and procedures:
  ○ SAAs.
  ○ Risk ranking and priority setting.
  ○ Data quality.
  ○ HSP 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).
n/a

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: eHealth
IHSP Priority Description:
Electronic Healthcare (eHealth): Linked information for effective care and health system decision-making.
Current Status:
The HNHB LHIN eHealth Strategic Plan and direction outlines how eHealth solutions are being leveraged to improve the way patients receive care. The principles to guide business planning and grow eHealth include:

- Build on existing and scalable solutions.
- Collaborate and plan with Health Links, South West Ontario LHINs, cSWO (connecting South West Ontario) Program, eHealth Ontario, and the ministry.
- Alignment with provincial strategic directions, leveraging emerging solutions and data repositories.
- 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 (regional electronic health record) integrates data from 50 hospitals, four CCACs, Cancer Centres, the Ontario Laboratories Information System (OLIS), the Southwestern Ontario Diagnostic Imaging Network (SWODIN), as well as from the Health Outcomes for Better Information and Care (HOBIC) nursing assessment repository. The amount of patient data available in ClinicalConnect has significantly increased, since at the beginning of 2014, only data from 28 hospitals, Oncology Centres and two CCACs was available.
    - Over 9,000 physicians and providers now enrolled in ClinicalConnect (an increase of 3,000 over the course of the year).
    - The Change Management and Adoption team has been successfully working to further increase adoption in the LHIN. This work includes the signing of data sharing agreements, completion of readiness assessments and workflow analyses for the15 Family Health Teams (FHTs), six CHCs, 246 other primary care, 25 LTCs, 9 CSS, 9 MH&As in the HNHB LHIN. Once approved, user accounts are also provisioned by the eHealth office team. Of note is the plan to roll out ClinicalConnect to Revera LTC, with a view to expanding use across all of its 24 sites in South West Ontario.
    - Planning stages have been completed, and work is now underway to extend ClinicalConnect to 18 additional hospitals in South West (SW) and Erie St. Clair (ESC) LHINs. These integrations are scheduled to be completed by summer 2015, bringing the total number of hospital integrations to 68.
    - Added additional HNHB LHIN Hospitals with Single Sign-On and Contextual Launch capability to ClinicalConnect.
    - ClinicalConnect now displays Health Links flag if a patient is a frequent visitor / cohort; this feature went live early 2014.
    - Launched new and improved ClinicalConnect website, updated marketing and communications materials including refreshed branding to appropriately reflect the ClinicalConnect product, and created new ClinicalConnect online user forum.

      An in-depth social media strategy is nearing completion which is good timing as we move closer to more specific patient-facing communication campaigns.
    - A variety of eLearning tutorials have been completed (average 90 seconds) to help users quickly learn how to optimize their ClinicalConnect user experience. Visit http://info.clinicalconnect.ca/CC/resources/elearning/ to view tutorials.
    - OLIS private and public lab data integration to ClinicalConnect went live spring of 2014.
- Integration with sites contributing diagnostic images to the SWODIN from HNHB LHIN is underway with two sites integrated to date. More to come in early 2015.
- Hospital Report Manager (HRM) – TPA signed with eHealth Ontario to implement HRM infrastructure. Project started in November. HRM will begin with NHS area. Planning underway with Ontario MD (OMD) along with schedule of other HNHB hospitals.

  Anticipating completion of HNHB LHIN Hospital integration by end of calendar 2015, with implementation to follow.

- Explored eConsult solutions (Champlain and OTN). Not included in Provincial pilot, however, continued with negotiation with OTN to leverage their eConsult system (contingent on OMD working out specialist compensation model).
- Began exploration of other OTN solution opportunities such as telemedicine.
- Recipient of multiple Canada Health Infoway eConnect challenge prizes for user adoption and data access increases.
- Integrated Decision Support (IDS) Data Repository and Business Intelligence Solution has grown to 63 databases crossing four LHINs with over 4.3 million unique patients and over 25 million patient unique encounter records.
- Includes expanded data sets. Implementing in TC LHIN; planning SW LHIN. Work in progress to add additional data elements. Supporting Health Links projects. Worked with eHealth Office to integrate Health Links cohort notification in ClinicalConnect as mentioned above.

Key issues for eHealth implementation:

- Increasing complexities, escalating demands, competing priorities, more and diverse stakeholders, evolving changes affecting timelines, required resources, and adapting to provincial specifications and requirements, legal contracts and privacy legislation.
- Challenges recruiting resources.
- Process or policies not always in alignment or support the new landscape.
- In some cases relative to Mobile usage, devices are not provisioned, not allowed, dated or staff are not authorized to use by their managers.
- Wi-Fi or data plan availability (particularly within hospitals).
- Significant administrative overhead to manage reporting requirements.
- Procurement policies extend timelines.
- HSP financial constraints to balance budgets impacts availability of funds to support local eHealth initiatives
- 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:

In February 2015 Minister Hoskins announced *Patients First: Action Plan for Health Care,* reaffirming the importance of using new technologies to improve access for patients and their families. The HNHB eHealth strategy supports this direction and is actively working with our health care providers to improve the patient experience within HNHB LHIN.

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.					
	2015-16		**2016-17**		**2017-18**	
Examples:	Status	%	Status	%	Status	%
• Complete expansion of ClinicalConnect to SW and ESC LHIN hospitals.	In Progress	100				
• Increase ClinicalConnect adoption to more physicians, providers, HSPs in HNHB LHIN through education/training, change/transformational management activities including rollout using mobile devices.	In progress	60	In progress	40		
• Continue to rollout and improve interoperability (Single Sign On and patient contextual launch from a select number of larger health information systems including HIS systems, Mosaiq, EPIC and CCAC's common case management tool (CHRIS) in HNHB LHIN). Preparing proposal to Canada Health Infoway for funding to help accelerate and improve interoperability amongst the systems listed above as well as for contextual launch for community-based EMRs (see below).	In progress	60	In progress	40		
• Continue rollout of Contextual Launch from a select number of primary care EMRs to ClinicalConnect.	In Progress	60	In progress	40		
• Enhance Services and Support – further enhance Access Governance System and support services.	In progress	60	In progress	40		
• Establish an interim Health Links shared care plan for trial, configure as per CCT definitions. Integrate with ClinicalConnect.	In progress	75	In progress	25		
• Integrate and leverage Provincial assets (OneID, Client and Provider Registries). Complete planning, Proof of Concept pilots.	Not yet started	50	In progress	50		
• OLIS Outbound – leverage ClinicalConnect to feed HNHB hospital labs to Provincial OLIS database vs. separate hospital integrations (Hamilton/Brantford on track for Spring/Early Summer 2015; planning for HNHB sites complete). Other sites to be scheduled.	In Progress	75	In progress	25		

• Continue integration of diagnostic images being contributed to SWODIN and make accessible.	In Progress	75	In progress	25		
• Expand downloading of reports to physician EMRs and provide support for HRM.	In Progress	75	In progress	25	In progress	25
• Investigate / explore options for patient portal access.	In progress	50	In progress	25	In progress	25
• User Interface improvements considering input from Mobile Evaluation project.	In progress	50	In progress	50		
• Introduce secure messaging using ClinicalConnect.	In progress	50	In progress	50		
• Link eReferral from ClinicalConnect to CCACs - dependent on CCAC / Ontario Association of Community Care Access Centres (OACCAC) schedule – expected mid-2015.	In Progress	100	In progress			
• Extend and enhance IDS expanded data sets to include additional healthcare sectors.	In progress	75	In progress	25		
• Extend Diagnostic Imaging-repository (DI-r) and increase adoption. Foreign Exam Management (FEM) – Project to start April 2014 and run 18-24 months. Improve performance.	In progress	50	In progress	50		
• RM&R –finalize referral process and determine technical needs.	In progress	75	In progress	25		
• eConsult. - Leverage OTN eConsult. Integrate with ClinicalConnect.	In progress	75		25		
• Upgrade ALC Wait Time Information System (WTIS) - in planning stages.	Not yet started	50	In progress	50		
• eNotification – planning continues with cSWO, eHealth, OMD; select options, arrange funding, implementation.	Not yet started	50	In progress	50		
• Unified View Proof of Concept (using technology such as Thoughtwire) to provide advanced connectivity and access.	In progress	75	In progress	25		
• Other data integration (e.g., Panorama Immunization).	Not yet started	50	In progress	50		
• Telehomecare - Support LHIN, review and planning for Telehomecare alignment to our local IHSP priorities.	Not yet started	50	In progress	25		
• Central Intake/Wait List Management – Support LHIN, review and planning for alignment to our local IHSP priorities.	Not yet started	50	In progress	50		
• Provide eHealth management, consulting, planning, support for HNHB LHIN Strategic directions and initiatives.	In progress	25	In progress	25	In progress	25
• Enhance WW Pharmacy data availability in ClinicalConnect.	In progress	100				

How will we measure success?

- Increased adoption of eHealth solutions across the continuum of care.
- Sustained adoption.
- More comprehensive and complete electronic health record information available in ClinicalConnect.
- Incorporation of eHealth solutions into workflow via interoperability with more HIS and EMR's.
- Improved experience and patient care quality, changes in efficiency, workflow, productivity, speed of information access, positive practice changes as reported by providers/patients.

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 and competing priorities outpacing capacity.
- Recruitment challenges (non-competitive salaries, location).
- Completing patient care priorities in a time of financial and economic constraint.
- Data Sharing Agreements / Privacy Legislative changes / Consent Model processes, management, administration / Reporting complexity and frequency.
- Resource skills and expertise.

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

- Availability of:
  - Lean / effective and efficient management.
  - Implementation plan to ensure key provider data availability.
  - Implementation plan geared to resource availability.
  - Further partnering (e.g., Mohawk College, McMaster University, secondments from partners).
  - Continue to adjust and evolve and mature eHealth program / establish new roles or revise existing roles and responsibilities / update compensation to attract and retain staffing.

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

- Effective and efficient collaboration amongst the growing number of stakeholders in eHealth.
- Early announcement of planning allocations for hospitals will facilitate their budgeting.
- Build expectation of participation into Accountability Agreements.

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

n/a

3.4. Primary Care

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Primary Care
IHSP Priority Description:
Primary Care, in most cases, is the first point of contact a person has with the health care system, and where they receive most of their health care needs. The primary care provider has a variety of roles, including health promotion, chronic disease management, and providing the continuity of care, and facilitating referrals to Specialists when appropriate. On February 11, 2015, Minister Hoskins announced *Patients First: Action Plan for Health Care*, which included four priorities relating to putting patients at the center of the system – improve access; connect services; support people and patients; and, protect our universal public health care system. This includes ensuring every Ontarian who wants one, has a primary care provider, and improving timely access and appropriate care. Primary Care involves a variety of professionals, including physicians, nurse practitioners, and a variety of allied health providers.
Current Status:
The 2012 Ontario Physician Human Resource Data Centre (OPHRDC) noted there were approximately 1,776 family physicians practicing across the HNHB LHIN, of which the largest numbers are in Hamilton and Niagara. Within the HNHB LHIN, the aging demographics of our family physicians is, and will continue to be a concern, with significant retirements over the next five to ten years. The HNHB LHIN has one of the highest proportions of patients enrolled in FHT organizations. The structure of FHTs provides easier access for their patients to access the allied health professionals who can assist with their care. The implementation of the 11 Health Links across our LHIN is helping to bridge the various enrolment models for family physicians, as well as focusing on those patients with complex needs. The ministry is developing an implementation plan for Primary Care Reform across the province, which will guide future planning and Primary Care strategies across our LHIN.

PART 2: GOALS and ACTION PLANS
Goal(s):
1. Support the ongoing development of a comprehensive quality agenda within Primary Care. 2. To enhance access to Primary Care services and enable primary care practitioners to access other specialist expertise.
Consistency with Government Priorities:
The ministry has consistently identified Primary Care and the implementation of Health Links as a priority for the Province. This has been articulated in the February 2015 *Patients First: Action Plan for Health Care*

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.					
	2015-16		**2016-17**		**2017-18**	
Examples:	Status	%	Status	%	Status	%
• Ensure that primary care and best practice are included in all clinical integration planning processes, working with specialists.	In progress	100				
• Host two HNHB LHIN education evenings (similar format to the November 12, 2014 Choosing Wisely event): o Chief of Psychiatry/Youth and Adolescent o Vision strategy/Recognition of ocular emergencies (combined with ED physicians).	Not yet started	100				
• Facilitate the implementation/performance of best practice QBPs for primary care, with specific focus on COPD and CHF.	In progress	25	In progress	50	In progress	25
• Continue to educate and develop mechanisms to review the appropriateness of diagnostic tests, specifically related to MRIs.	In progress	50	In progress	25	In progress	25
• Work with the Primary Care Network to build clinical knowledge and skills to improve care for lower back pain, memory and cognitive impairment, and concussions.	In progress	50	In progress	50		
• Working with the Primary Care Network, develop a clear assessment of current primary care HR, with three, five, and ten year projections, including risk assessment and options for remediation: • Integrate the HNHB LHIN HR assessment and planning with the Provincial work being chaired by TC LHIN and SW LHIN.	In progress	80	In progress	20		
• Continue to work with OTN, the LHIN eHealth Office, and specialist colleagues in the development of an e-consult system based on directions from eHealth Ontario.	In progress	25	In progress	50	In progress	25
• Ensure primary care physicians will be supportive and ready to implement central intake for various clinical programs.	In progress	25	In progress	50	In progress	25

• If HNHB LHIN is successful with the Bundled Funding Project, work with the implementation team to ensure family physicians follow best practice guidelines for community, COPD, and CHF (QBP)	In progress	20	In progress	50	In progress	30

How will we measure success?

Using a variety of data sources, including IDS system and the Health Links performance dashboard, we will track access to primary care as well as Wait 1 data for certain specialties.

What are the risks/barriers to successful implementation?

1. More current and easily accessible information to support improved communication between a variety of health care providers.
2. Partnerships with HSPs, primary care and specialists will be essential for the implementation of central intake. Central intake has reduced the waiting time for patients to see specialists.
3. More integrated IT resources including the implementation of a HNHB LHIN e-consult solution.

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

1. As the ministry provides information on the future of Primary Care, the deliverables will be reviewed to ensure appropriate alignment with this direction.
2. The HNHB LHIN will continue to work closely with the ministry and ensure primary care and our specialists are ready to respond to changes to IT programs (e.g., e-consult).

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

Health Links will work directly with Health Link physician leads and primary care physicians on communicating the benefits of Health Links for their patients and building sustainable relationships. The LHIN will work directly with the Primary Care Network on raising the profile of health Links and performance results.

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

n/a

3.5. Home and Community Care

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Home and Community Care

IHSP Priority Description:

Delivering better coordinated and integrated care in the community closer to home is a focus on the Minister's 2015 Patients First Action Plan. To support this direction, populations that require access to home and community care will receive quality care that is timely, seamless, dependable, and efficient. The LHIN's plan to modernize the home and community care sector involves the following:

- CCAC and CCS agencies will collaborate as one care sector to coordinate and optimize home and community care for older adults with frailty or long-term chronic conditions, to support them in living safely and independently in the community.
- Expanding the capacity of home and community care while providing quality outcomes would greatly assist the HNHB LHIN in relieving health system pressures and ensure that patients receive the right care in the right place at the right time.
- This collaboration will enhance the capacity of CSS agencies to support older adults who are relatively independent and have lower care needs, allowing the CCAC to focus resources on clients who require complex care and ongoing case management.
- Models of care that advance integrated and coordinated care through transitioning care to the most appropriate service provider can decrease variability in services, improve client outcomes and increase system efficiencies.

Current Status:

The collaborative home and community-based care coordination initiative will be implemented in two phases.

Phase 1: Working with Assisted Living and Supportive Housing Providers to Increase Community Capacity for Providing Personal Support Services:

- Nine Assisted Living/Supportive Housing (AL/SH) providers in the HNHB LHIN are currently approved to provide personal support services in the community. Each of these organizations is participating on a committee along with the HNHB CCAC and LHIN.
- In collaboration with the CCAC, a model has been developed in alignment with the provincial policy guidelines which detail the process for "Coordinated Access and Intake", "Standardized Assessment", "Care Planning and Ongoing Coordination", "Client and Family Engagement", "Delivery of Home and Community Services", "Supportive Transitions", and "System Integration".
- According to the new model, CSS-AS/SH agencies will assume the lead to provide care for clients who are identified as stable, independent, and have low to moderate care needs. The CCAC will lead care coordination of clients with post-acute or complex care needs. The implementation of this model will begin in February 2015.

Phase 2: Additional Approved Agencies to Provide Personal Support Services in Home:

- The HNHB LHIN has been selected as an "Early Adopter" to implement a new policy amendment to the *Home Care and Community Services Act, 1994*, which allows CSS agencies to be approved to provide personal support services.
- This will result in an expanded mandate for selected CSS agencies to provide in-home personal support.

Key Issues:

- Communication strategy to ensure consistent messaging to clients and communities from CCAC and CSS providers.
- Ongoing monitoring of program implementation to ensure common assessments, screening tools, standards, and service guidelines.
- Development of performance metrics that inform, track and assess the progress of implementation and enable a continuous quality improvement process with minimal administrative costs.

Successes of the past year:

- Established a committee composed of AL/SH CSS agencies, the CCAC, and LHIN to develop a model and implementation process for home and community-based care.
- Successful bid to become an "Early Adopter" LHIN for implementing a new policy amendment which allows CSS agencies to be approved to provide personal support services.

PART 2: GOALS and ACTION PLANS

Goal(s):

- Modernizing community care:
  - Implement a collaborative care model between the CCAC and Community Assisted Living/Supportive Housing providers to deliver personal support services to eligible clients in the home and community.
  - Identify community agencies for approval to provide Personal Support Services (PSS) in alignment with the collaborative care model for home and community based care.
  - Implement PSS stabilization strategy.
  - Review recommendations from Home and Community Care Expert Panel, and develop a plan to address recommendations applicable to the HNHB LHIN.

Consistency with Government Priorities:

- The Minister's 2015 Patients First Action Plan – continues to drive transformation of home and community care to improve the experience of patients and families. The LHIN's goals and activities support the Minister's direction by modernizing home and community care by:
  - Improve quality by reducing variation and standardizing care delivery models.
  - Improve transitions through common patient flow processes.
  - Support right care, right time, right place.
  - This initiative also supports the ministry's transformation agenda, Action Plan and Seniors Strategy by:
    - Improving access to safe and effective home and community care.
  - Enabling person-centered care, suited to the needs of clients and caregivers.
  - Enabling flexibility at the local level to adapt community-based care to the local needs of clients.

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.					
	2015-16		**2016-17**		**2017-18**	
Examples:	Status	%	Status	%	Status	%
• Implement a collaborative care model between the CCAC and Community AL/SH providers to deliver PSS to eligible clients in the home and community.	In progress	75	In progress	25		
• Identify community agencies for approval to provide PSS in alignment with the collaborative care model for home and community-based care.	Complete	100				
• Implement PSS stabilization strategy.	In progress	50	In progress	50		
• Review recommendations from Home and Community Care Expert Panel and develop a plan to address recommendations applicable to the HNHB LHIN.	In progress	25	In progress	75		

How will we measure success?

- Implementation/process evaluation of this collaboration to be completed by April 30, 2015.
- Reduction in ALC rate for hospitals within HNHB LHIN.
- Reduced pressures on HNHB CCAC to provide Personal Support Worker (PSW) services to clients with lighter care needs.
- Reduced impact of HSFR on HNHB CCAC.
- Percentage of clients waiting less than 10 business days from referral to CCAC to initiation of services from CSS agency.

What are the risks/barriers to successful implementation?

- Change management strategy for CCAC, CSS agencies, and individual receiving care in-home.
- Facilitating local implementation of provincial guidelines.

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

- Timely implementation of the Home and Community-Based Care Collaborative to transition clients with low to moderate care needs to CSS agencies should mitigate potential HSFR impacts to CCAC.
- To ensure effective engagement of both patients and caregivers, a communications strategy has been developed in consultation with the HNHB CCAC and CSS agencies. As a result, consistent messaging will be delivered care recipient in the case of a transition of care providers.
- Continuous quality improvement approach to implementation to allow for validation and refinement of procedures, standards, principles, and definitions over time.
- Ongoing consultation with ministry and LHIN colleagues to ensure that elements of the provincial model can be successfully applied in our region.

What are some of the key enablers that would allow us to achieve our goal?
• LHIN Collaborative (LHINC) Implementation Steering Committee, and support of the LHIN CEO Council. • Effective partnerships between CSS agencies and the CCAC. • Leveraging existing networks, such as Health Links, and the Primary Care Network.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).
n/a

3.6. Health and Wellness of our Population

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Health and Wellness of our Population
IHSP Priority Description:
• Health is defined by the World Health Organization (WHO) in its constitution as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1946)[31]. Health is influenced by complex interactions between the social determinants of health, which are the social and economic conditions that influence the health of individuals, communities and countries (i.e., the conditions in which people are born, grow, live, work, and age)[32]. The Public Health Agency of Canada (PHAC) lists the following social determinants of health: o Income and Social Status. o Social support networks. o Education and literacy. o Personal health practices and coping skills. o Employment and working conditions. o Social environments. o Physical environments. o Healthy child development. o Biology and genetic endowment. o Health services. o Gender. o Culture. • There is mounting evidence that the contribution of medicine and health care on health and wellness is quite limited, and that spending more on health care will not result in significant further improvements in population health. Therefore, it is becoming increasingly apparent that the most effective way to address health disparities is to address the systematic and unjust distribution of the social determinants of health between populations or communities. This is achieved by taking a population health approach to and by integrating health equity into planning (i.e., one in which the scale of intensity of

[31] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948

[32] Public Health Agency of Canada, 2011; WHO, 2014

programs, services and policies is proportionate to the level of disadvantage experienced by vulnerable and marginalized populations).

Current Status:

The LHIN has developed and begun to implement a health equity planning framework to guide the LHIN's approach to addressing the social determinants of health and to achieving health equity in its planning activities. In this planning framework, the LHIN has identified two priority populations for focus in the coming year:

- Migrant Agricultural Workers (MAWs).
- Refugees.

Migrant Agricultural Workers:

- Each year, more than 38,000 legal temporary contract positions are available in Canada for migrant workers. Industry within the HNHB LHIN employs the greatest number of those; up to 8,000 workers. While MAWs are covered by Ontario Health Insurance Program (OHIP), the vast majority do not access health care services and those who do need urgent health care typically go to walk-in clinics or EDs. The most common health conditions include: injury / trauma, and gastrointestinal, musculoskeletal, ocular, skin, respiratory, and urinary problems. A number of practical and systemic barriers to MAWs accessing traditional health care/primary care services exist, including:
  - Fear of being sent home or not invited back the following year; workers are reluctant to admit to having health issues.
  - Lack of awareness of available primary care services and how to access them.
  - Inability or reluctance to take time off work.
  - Lack of access to a health card.
  - No transportation into town from the rural and remote areas in which they work.
- In 2014, the LHIN supported the implementation of a MAW health program at Grand River and Quest CHCs in Brantford and St. Catharines, respectively. The primary care-based model is Nurse Practitioner-led and supported by a team of professionals including a Registered Nurse, an outreach worker, a translator, and volunteers. Together, these programs saw 427 clients.

Refugees:

- The Peace Bridge in Fort Erie, Ontario is Canada's highest-volume entry point for refugees seeking asylum in Canada. Since 2000, an average of more than 5,000 refugees per year have entered the country at Fort Erie, and this number has increased significantly in the past 15 years. An estimated 15 to 25% of refugees entering Canada at Fort Erie remain in the Niagara Region. Refugees arriving in Canada experience multiple challenges which negatively affect virtually all social determinants of health, and they are widely recognized as among the most marginalized members of society, with poorer health, greater health needs, and more significant access barriers than immigrants and Canadian-born citizens.

- Short-term essential and urgent health care coverage is provided to eligible refugee claimants who are not eligible for provincial or territorial health insurance plans.
- However, recent immigrants underuse health services and when they are in need of health care, they typically do not seek medical or health services until they are seriously ill, leading to an overuse of costly emergency and acute-care services. Barriers to care such as stigma, awareness of services, language difficulties, transportation costs, socio-economic factors and differences in illness models between services and clients are factors that delay treatment. A number of factors that have been demonstrated to facilitate service use need to be addressed to improve refugee access and health outcomes such as literacy, trust in services, cultural competence, targeted health promotion, an increased diversity of services, and links between different types of services.

PART 2: GOALS and ACTION PLANS

Goal(s):

- A plan will be developed to improve the health and wellness of the population through the application of a framework for health equity and the social determinants of health, collaborating with appropriate organizations, including Public Health
- The health equity planning framework will be applied to planning for priority populations:
  - MAWs
  - Refugees
- In partnership with Public Health, the LHIN will explore opportunities to coordinate smoking cessation activities across the LHIN.

Consistency with Government Priorities:

- These priorities align with the *Patients First: Action Plan for Health Care* announced by Minister Hoskins in February, 2015.
- They also align with the Minister's mandate to work with the Associate Minister (Long-Term Care and Wellness) to a build culture of health and community wellness, including supports and programs, to help people stay healthy.
- Furthermore, these goals support Ontario's Healthy Kids, Poverty Reduction and Smoke-Free Ontario Strategies.

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.					
	2015-16		**2016-17**		**2017-18**	
Examples:	Status	%	Status	%	Status	%
• Develop, implement and evaluate a health equity action plan.	In Progress	50	In progress	50		
• Apply the health equity planning framework to planning for priority populations: MAWs.	In Progress	100				
• Apply the health equity planning framework to planning for priority populations: o Refugees.	In Progress	25	In progress	50	In progress	25
• Meet with Public Health to develop a plan to coordinate smoking cessation activities across the LHIN	In Progress	75	In progress	25		

How will we measure success?

- Increase the capability and confidence of the LHIN and of HSPs to take a population health and health equity approach to planning.
- Increased use of the health equity planning framework in planning activities.
- Improve the health outcomes of priority populations, and decrease the disparities in health outcomes of priority populations compared to the general population, and improve the quality, client/patient experience, and value/financial sustainability of services provided to priority populations.

What are the risks/barriers to successful implementation?
• Engaging HSP leadership into taking an approach that is broader than the health care system alone. • Achieving collaboration across government.
For each risk/barrier, describe the plan to mitigate the risk?
• Articulating and demonstrating the impact of taking a population health and health equity approach to planning. • Leverage the ministry priorities and the objectives of the Ontario's various relevant strategies to build will and engage stakeholders.
What are some of the key enablers that would allow us to achieve our goal?
• Support from, and collaboration and partnership across government to prioritize addressing unequal distribution of the social determinants of health.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).
n/a

3.7. Engaged Communities

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Engaged Communities
IHSP Priority Description:
Enabler to address strategic directions.
Current Status:
Since its inception, community engagement has been an integral way of work for HNHB LHIN staff and Board members. Community engagement permeates the work of the LHIN. This concerted way of work for the HNHB LHIN will continue.

PART 2: GOALS and ACTION PLANS
Goal(s):
Communication and community engagement continues with communities and stakeholders including public, media, elected officials, ministry, municipalities and with providers as it relates to the SHSP ensuring we are reflective of the diverse communities in our LHIN including Indigenous and Francophone.
Consistency with Government Priorities:
The Minister's mandate letter clearly articulated the Premier's direction to the Minister (and indirectly LHINs): *"Our government continues to deliver better access, better quality and better value for money for Ontario's health system. As Minister of Health and Long-Term Care, you will lead the shift toward a sustainable, accountable system that provides coordinated quality care to people, when and where they need it. You will partner with administrators,*

health care providers and patients to achieve our shared commitment for a system that is there for generations.

In pursuit of our commitment, I ask that you keep in mind three key goals: people receiving the right care at the right time and the right place; an accountable, efficient and transparent system; and promoting healthier lifestyles for Ontarians through shared responsibility across government.

Delivering quality health services is a shared responsibility. You will foster collaboration across the system and make the necessary trade-offs to shift spending to where Ontario will get the best value for our health care dollars — which must be shared between our health system partners."

The directions within the Minister's Mandate Letter can more easily be achieved through working with engaged communities.

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.					
	2015-16		**2016-17**		**2017-18**	
Examples:	Status	%	Status	%	Status	%
• Development and execution of effective and appropriate public participation opportunities (as per International Association for Public Participation (IAP2) practice) that will inform the recommendations of LHIN staff and decisions of the LHIN Board in relation to SHSP objectives.	In progress	100				
• Continue the creation and distribution of core HNHB LHIN communication products including HNHB LHIN website, LHINsight (e-newsletter), CEO Blog, Physician newsletter(s) and Annual Report.	In Progress	100				
• Continue to develop the 'Voices in the Community' video series.	In Progress	100				
• Enhance and expand the CRP.	In Progress	100				
• Liaise with the Patient Ombudsman and HQO.	Not yet started	100				
• Issues Management and Complaints Log and Tracking.	Ongoing	100				
• Topic/question/issue specific community engagement opportunities.	Not yet started	100				

How will we measure success?

- Maintain or increase readership, viewership and membership to communication vehicles.
- Reduce patient complaints to the LHIN and/or the Patient Ombudsman.
- Waiting list for participation on the CRP.
- Activities that are reflective of the diverse communities in our LHIN, including Indigenous and Francophone.

What are the risks/barriers to successful implementation?
• Community engagement and therefore engaged communities are a way of work for the LHIN – implementation is constant.
For each risk/barrier, describe the plan to mitigate the risk?
• Work will be reviewed regularly to enhance or change tools and tactics as required by each initiative, priority or focus.
What are some of the key enablers that would allow us to achieve our goal?
• Continued open and timely communication with the ministry to ensure appropriate engagement and strategic communication opportunities to support ministry priorities – new and current – and to ensure appropriate alignment with HNHB LHIN priorities, goals and action plans.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).
n/a

3.8. Future Ready Thinking

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Future Ready Thinking
IHSP Priority Description:
Enabler to address strategic directions.
Current Status:
In order to fully deliver on our strategic direction of dramatically improving the patient experience through quality, integration, and value, the HNHB LHIN needs to effectively manage the current resources, needs and opportunities, while predicting, planning, preparing for the challenges of the future. HNHB LHIN staff are skilled and knowledgeable at balancing these two perspectives; however, additional support and explicit commitment to innovation will enhance our abilities to fulfill this part of our mandate. Availability and analysis of relevant, timely data will also be important to ensure we are always engaging in *future ready thinking*. The current and developing expertise of our staff in extracting, interpreting, and presenting information will also support this goal.
PART 2: GOALS and ACTION PLANS
Goal(s):
Create the organizational culture, processes, and initiatives that inspire world class innovation and transformation.
Consistency with Government Priorities:
Dr. Robert Bell, Deputy Minister of Health and Long-Term Care, has declared that Ontario will create a world class health care system. This vision challenges us to continually strive for excellence, develop system agility, and anticipate both current and future needs.

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.					
	2015-16		**2016-17**		**2017-18**	
Examples:	Status	%	Status	%	Status	%
• Support staff to regularly engage in generative dialogue, reflection, environmental scans, and innovative thinking.	In progress	100				
• HNHB LHIN staff will actively contribute to the provincial dialogue on key strategic priorities (e.g. patient experience, integration, access, HSFR).	In progress	100				
• Actively build knowledge base of LHIN communities, assets, health-related programs, and HHR. Knowledge base will inform funding decisions based on current and predicted need and trends.	Not yet started	50	Not yet started	50		
• Create a System Strategy Council (SSC) composed of health care and community leaders.	In progress	100				

How will we measure success?

- Staff can describe what this focus area means and report feeling supported to engage in "future ready thinking".
- Percentage of staff actively participating on provincial committees/ working groups, or presenting at a provincial forum.
- Database and processes are developed to compile asset and program information. Approximately 50% of database is populated with information by year-end.
- SSC is established, terms of reference approved, and council is enacting its advisory mandate.

What are the risks/barriers to successful implementation?

- Lack of clarity for staff related to this new component of our LHIN strategy.
- Information required for the "asset and program database" is unavailable or outdated, limiting the ability to create this tool.
- Difficulty balancing the capacity pressures to address both current deliverables and future innovation.

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

- LHIN leadership will engage with staff to describe and define the scope of this strategic area of focus.
- Identify multiple sources of data whenever possible, and advocate for the collection and retention of relevant data by HSPs, government agencies, and private organizations.
- Incorporate this balance into project planning and timelines.

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

- LHIN leadership support for this area of focus will be essential.
- Inclusion of "future ready thinking" into role descriptions, performance assessments, and regular discussions with staff.

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

n/a

4. HNHB LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2014-15 Projected Actuals	2015-16 Allocation	2016-17 Planned Expenses	2017-18 Planned Expenses
Salaries and Wages	**3,677,781**	**3,640,764**	**3,640,764**	**3,640,764**
Employee Benefits				
Hospitals of Ontario Pension Plan (HOOPP)	353,317	361,559	361,559	361,559
Other Benefits	450,438	465,959	465,959	465,959
Total Employee Benefits	**803,755**	**827,518**	**827,518**	**827,518**
Transportation and Communication				
Staff Travel	45,000	44,000	44,000	44,000
Governance Travel	13,700	13,700	13,700	13,700
Communications	58,000	55,750	55,750	55,750
Other Benefits	5,000	5,000	5,000	5,000
Total Transportation and Communication	**121,700**	**118,450**	**118,450**	**118,450**
Services				
Accommodation	347,470	356,157	356,157	356,157
Advertising	0	0	0	0
Banking	12,000	12,000	12,000	12,000
Community Engagement	30,000	30,000	30,000	30,000
Consulting Fees – Leads	200,000	200,000	200,000	200,000
Consulting Fees	236,047	226,360	226,360	226,360
Equipment Rentals	20,000	5,000	5,000	5,000
Insurance	0	6,000	6,000	6,000
Board Chair Per Diems	30,000	30,000	30,000	30,000
Governance Per Diems	53,220	53,220	53,220	53,220
LSSO Shared Costs	460,000	460,000	460,000	460,000
LHIN Collaborative	50,000	50,000	50,000	50,000
Other Meeting Expenses	25,000	24,250	24,250	24,250
Other Governance Costs	6,000	6,000	6,000	6,000
Printing & Translation	45,000	45,000	45,000	45,000
Staff Development	23,000	23,000	23,000	23,000
Total Services	**1,537,737**	**1,526,987**	**1,526,987**	**1,526,987**
Supplies and Equipment				
IT Equipment	35,000	40,000	40,000	40,000
Office Supplies and Purchased Equipment	50,000	55,428	55,428	55,428
Total Supplies and Equipment	**85,000**	**95,428**	**95,428**	**95,428**
LHIN Operations: Total Planned Expense	6,225,973	6,209,147	6,209,147	6,209,147
Annual Funding Target	**6,225,973**	**6,209,147**	**6,209,147**	**6,209,147**
Variance	**0**	**0**	**0**	**0**

Funding Breakdown	2014-15	2015-16
Operations	4,916,172	4,916,172
Indigenous Community Engagement	37,500	37,500
French Language Service	106,000	106,000
Primary Care LHIN Lead	75,000	75,000
Critical Care Lead	75,000	75,000
ED/ALC Lead*	100,000	100,000
ED Lead*	75,000	75,000
Diabetes Regional Coordination Centre (DRCC) - One Time	0	0
DRCC - Base	841,301	824,475
Total	**6,225,973**	**6,209,147**

* Lead funding is shown as paid out in Consulting Fees
Note: the above does not include funding for Entité

5. HNHB LHIN Staffing and Operations: LHIN Staffing Plan Full-Time Equivalents (FTEs)

Position Title	2014-15 Estimates as of March 31, 2015 FTEs	2015-16 Forecast FTEs	2016-17 Forecast FTEs	2017-18 Forecast FTEs
Chief Executive Officer	1	1	1	1
Physician Lead	1	1	1	1
Director	6	6	6	6
Access to Care Advisor	6	6	6	6
Health System Transformation Advisor	5	5	5	5
Quality and Risk Management Advisor	3	3	3	3
Finance Advisor	4	4	4	4
Health Information Advisor	3	3	3	3
Finance Analyst	1	1	1	1
Quality and Risk Management Analyst	1	1	1	1
French Language Services Coordinator	1	1	1	1
Communication Advisor	1	1	1	1
Communication Assistant	1	1	1	1
Corporate Coordinator	0	0	0	0
Executive Assistant	2	2	2	2
Project Assistant	1	1	1	1
Program Assistant	1	1	1	1
Receptionist	1	1	1	1
Corporate Services Assistant	1	1	1	1
Health Links Implementation Lead	0	0	0	0
	40	**40**	**40**	**40**

6. Integrated Communications Strategy

Objectives

Communications Objectives:

Continuing the implementation of the SHSP, and executing the ABP over the next year, will continue to 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 continues to 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-centered health care system.
- Align the HSPs 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.
- To guide the communications and engagement activities of the HNHB LHIN (Board and staff) and HSP partners involved in initiatives contained in the 2015-16 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 in January 2012, which is consistent with the principles of the *Excellent Care for All Act, 2010* (ECFAA), puts LHINs at the center of health system transformation.
- In February, 2015 the *Patients First: Action Plan for Health Care*, the next phase of Ontario's plan for changing and improving Ontario's health system, was launched. It builds on the progress that's been made since the original *Action Plan for Health Care*. It exemplifies the commitment to put people and patients at the center of the system by focusing on putting patients' needs first.
- In May, 2015, the *Patients First: A Roadmap to Strengthen Home and Community Care* - a new plan to improve and expand home and community care over the next three years – was launched.
- The HNHB LHIN has a critical role to play in key provincial initiatives recently introduced such as HSFR, Health Links, health initiatives for seniors, and the expansion of Quality Improvement Plans (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:

- HSPs 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)).
  - Aboriginal Health Network.
  - FLPE
  - SSC
  - QGC
- Government – Administrative Leadership and Elected Officials:
  - Municipal.
  - Regional.
  - Provincial – including ministry stakeholders.
- General Public:
  - Residents.
  - CRPs:
    - Broader Public.
    - Indigenous Peoples.
    - French-speaking persons.
  - 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 – SW, WW and MH.
- Ministry and other ministries (as appropriate and required):
  - Health System Accountability and Performance Division – Relations and Coordination Unit (HSAPD-RCU).
  - Communications and Marketing Division (CMD).
  - Minister's Office (MO).

Strategic Approach

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

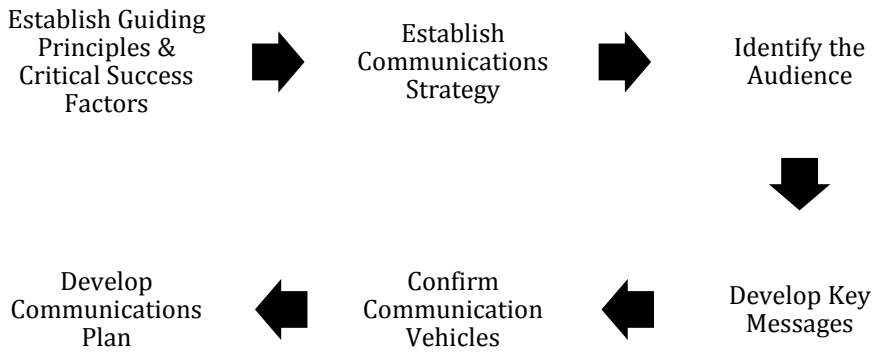
This framework will enable the LHIN to establish a clear process, and will minimize risk by identifying key stakeholders, key messages and communication vehicles up front.

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 a leader, and as such, the 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. It will also target specific populations such as French speaking peoples, Indigenous peoples, and migrant workers and refugees with information/support related to strategic initiatives.

Framework: Communications Strategy and Approach



Key Messages

- Putting people and patients first by improving the health care experience.
- Providing information to make decisions, and tools to live healthy and stay healthy.
- Providing better access to quality health services, and protecting those services for generations to come.
- Patients First:
  - A caring, integrated experience for patients.
  - Faster access to quality health services.
  - For all Ontarians at every life stage.
- Access:
  - Providing faster access to the right care.
- Connect:
  - Providing better home and community care.

- Inform:
  - Providing information to make the right decisions about your health.
- Protect:
  - Ensuring our universal health care system is sustainable for generations to come.
- 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.
- We are changing from an old system designed to treat people once they are sick, to a more coordinated, patient-centred model that promotes wellness.
- The population in the HNHB LHIN is growing and aging. The rates of chronic conditions are rising.
- Current fiscal realities have resulted in even more challenges.
- 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.
- Everyone has an important role to play in making healthy change happen, including HSPs, the LHINs, community leaders and the public.
- The HNHB LHIN and its health care partners continue to bring about significant and positive change to ensure better patient outcomes.

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)
Elected officials – Municipal and Provincial – and their staff	LHIN Chair and LHIN CEO	• All party meetings • Individual Members of Provincial Parliament (MPP) meetings • Constituency Staff meetings
CRP Members	LHIN CEO	• Group sessions • Twitter
General Public (including same audiences listed here)	Communications Lead/LHIN CEO	• Media • LHIN website • Newsletters • Blog • Twitter • Voices in the Community videos
Editorial Board meetings	Communications Lead/LHIN CEO	• Meetings, social media

Health Professions Advisory Committee (HPAC) Physicians Francophone Community	LHIN CEO LHIN CEO/LHIN physician lead LHIN	• Meetings • Meetings/blog • Physician Newsletter • Twitter • Meetings, media
Indigenous Community	LHIN	• Meetings, media
Neighbouring LHINs	LHIN CEO	• Meetings, media
ministry, HSAPD-RCU	LHIN CEO/Board Chair	• Meetings • Teleconferences
Agencies with provincial/national mandate (i.e., Canadian Mental Health Association (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 Future State.
- 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.
- The tone and volume of traditional and social media.

7. Glossary of Acronyms

ABI	Acquired Brain Injury
ABP	Annual Business Plan
AHN	Aboriginal Health Network
AL/SH	Assisted Living/Supportive Housing
ALC	Alternate Level of Care
APP	Alternate Forms of Physician Payments
AR	Assess Restore
ASIST	Applied Suicide Intervention Skills Training
ATC	Access to Care
BCHS	Brant Community Healthcare System
BSO	Behavioral Supports Ontario
CA&ST	Cultural Awareness and Sensitivity Training
CCO	Cancer Care Ontario
CCAC	Community Care Access Centres
CCT	Coordinated Care Tool
CDPM	Chronic Disease Prevention Management
CE	Community Engagement
CEO	Chief Executive Officer
CHC	Community Health Centres
CHF	Congestive Heart Failure
CMD	Communications and Marketing Division
CMG	Case Mix Group
CMHA	Canadian Mental Health Association
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outreach Team
CRP	Citizens Reference Panel
CSP	Clinical Services Plan
CSCHN	Centre de Santé Communautaire de Hamilton-Niagara
CSRSN	Central South Regional Stroke Network
CSS	Community Support Services
CT	Computed Tomography
CVA	Cerebrovascular Accident
DART	Dates Affecting Readiness to Treat

DEP	Diabetes Education Program
DI	Diagnostic Imaging
DI-r	Diagnostic Imaging Repository
DRCC	Diabetes Regional Coordinating Centre
District School Board	DSB
eHealth	Electronic Healthcare
ECFAA	Excellent Care for All Act
ED	Emergency Department
EMRs	Electronic Medical Records
EMS	Emergency Medical Services
EOL	End of Life
ERM	Enterprise Risk Management
ESC	Erie St. Clair
ESSC	Emergency Services Steering Committee
FEM	Foreign Exam Management
FHT	Family Health Team
FL	French Language
FLHS	French Language Health Services
FLPE	French Language Planning Entity
FLS	French Language Services
FLSA	*French Language Services Act*
FTE	Full-Time Equivalent
FY	Fiscal Year
GI	Gastroenterology
GIMRAC	General Internal Medicine Rapid Access Clinic
GTA	Greater Toronto Area
G2G	Governance to Governance
HAM	Hamilton Association of Medicine
HBAM	Health Based Allocation Model
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

HPC	Hospice Palliative Care
HPCN	Hospice Palliative Care Network
HPAC	Health Professionals Advisory Committee
HQO	Health Quality Ontario
HR	Human Resources
HRM	Hospital Report Manager
HSAA	Hospital Service Accountability Agreement
HSAPD-RCU	Health System Accountability and Performance Division – Relations and Coordination Unit
HSFR	Health System Funding Reform
HSP	Health Service Provider
ICC	Indigenous Cultural Competency
ICES	Institute for Clinical Evaluative Sciences
IDF	Inclusive Definition of Francophone
IDS	Integrated Decision Support
IHIU	Integrated Heart Investigation Unit
IHSP	Integrated Health Service Plan
IOCP	Integrated Orthopaedic Capacity Plan
IAP2	International Association for Public Participation
IT	Information Technology
JAAP	Joint Annual Action Plan
JBH	Joseph Brant Hospital
JCC	Juravinski Cancer Centre
LHIN	Local Health Integration Network
LHINC	LHIN Collaborative
LHSIA	*Local Health System Integration Act*
LSAA	Long-Term Homes Service Accountability Agreement
LICO	Low Income Cut-Off
LOS	Length of Stay
LSSO	LHIN Shared Services Office
LTC	Long-Term Care
LTCH	Long-Term Care Home
M/C&Y	Maternal/Child and Youth Health (M/C&Y):
MAW	Migrant Agricultural Worker
MCYS	Ministry of Child and Youth Services
MH	Mental Health

MH & A	Mental Health and Addictions
Minister	Minister of Health and Long-Term Care
ministry	Ministry of Health and Long-Term Care
MLPA	Ministry-LHIN Performance Agreement
MO	Minister's Office
MOU	Memorandum of Understanding
MPG	Midwifery Practice Group
MPP	Member of Provincial Parliament
MRI	Magnetic Resonance Imaging
MSAA	Multi-Sector Accountability Agreement
NH	North Hamilton
NHS	Niagara Health System
OACCAC	Ontario Association of Community Care Access Centres
ODIT	Ontario Diagnostic Imaging Terminology
OECD	Organization of Economic Cooperation and Development
OHA	Ontario Hospital Association
OHIP	Ontario Health Insurance Program
OLIS	Ontario Laboratory Information System
OMA	Ontario Medical Association
OMD	Ontario MD
OPHRDC	Ontario Physician Human Resource Data Centre
OSN	Ontario Stroke Network
OTN	Ontario Telemedicine Network
P4R	Provincial Pay for Results
PCI	Percutaneous Coronary Intervention
PCMCH	Provincial Council for Maternal and Child Health
PCN	Primary Care Network
PDSA	Plan-Do-Study-Act
PHAC	Public Health Agency of Canada
PIP	Process Improvement Plan
PSDA	Plan-Do-Study-Acts
PSS	Personal Support Services
PSW	Personal Support Worker
PwC	Pricewaterhouse Coopers
QBP	Quality Based Procedures

QGC	Quality Guidance Council
QIP	Quality Improvement Plan
QRM	Quality Risk Management
RJAP	Regional Joint Assessment Program
RM&R	Resource Matching & Referral
RMON	Regional Municipality of Niagara
ROI	Return on Investment
SAAs	Service Accountability Agreements
SHSP	Strategic Health System Plan
SJHH	St. Joseph's Healthcare Hamilton
S.M.A.R.T.	Specific Measurable Attainable Realistic Timely
SOMCN	Southern Ontario Maternal Child Network
SSC	System Strategy Council
SW	South West
SWO	South West Ontario
SWODIN	Southwestern Ontario Diagnostic Imaging Network
TALK	Tell, Ask, Listen and Keep Safe
TC	Toronto Central
TEC	Technology Enabled Practice Collaborative
TIA	Transient Ischemic Attack
TJR	Total Joint Replacement
TPA	Tissue Plasminogen Activator
W2SDS	Wait Two System Delays
WHO	World Health Organization
WTIS	Wait Time Information System
WW	Waterloo Wellington