



Annual Business Plan 2016-17

**Hamilton Niagara Haldimand Brant Local Health Integration Network
Annual Business Plan 2016-17**

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March 31, 2016

Jane Sager
Director (Acting) - LHIN LIAISON BRANCH
Hepburn Block
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Toronto ON M7A1R3

Dear Ms. Sager:

**Re: Hamilton Niagara Haldimand Brant Local Health Integration Network -
Annual Business Plan, 2016-17**

Our 2016-17 Annual Business Plan (ABP) represents the first year of our three-year Integrated Health Service Plan (IHSP), approved by the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) Board of Directors (Board) in January 2016. The 2016-17 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.

In keeping with the Strategic Health System Plan (SHSP) refresh, undertaken in advance of the 2016-19 IHSP, and with the Minister's Patient's First: Action Plan for Health Care (February 2015), the ABP encompasses the three strategic directions of Quality, Integration and Value, and includes the following key priority areas:

- Primary Care
- Home and Community Care
- Health Links
- Health and Wellness of our Population
- LHIN-wide Integrated Clinical Programs
- LHIN-wide Population-based Strategies
- Indigenous Health and Wellness
- Francophone Health

Ms. Jane Sager

These strategic directions are defined in terms of specific goals and action steps, with a particular focus on 2016-17, being the first operating year of our new IHSP. Action plans for each of the priorities identified in the IHSP are presented, following the template provided by the ministry. The ABP also outlines proposed HNHB LHIN staffing and operations, following the templates provided by the ministry.

We are excited about the potential we see represented by these strategic directions and action plans.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael P. Shea". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

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 draft ABP (2016-17) represents the first year of the LHIN's new 2016-19 IHSP.

The HNHB LHIN has aligned its strategic priorities outlined in the 2016-19 IHSP, and in this draft ABP, with *Patients First: Ontario's Action Plan for Health Care*. Released by the Minister of Health and Long-Term Care (Minister) in February 2015, this document builds on a strong foundation set by Ontario's original Action Plan for Health Care in 2012, and strengthens the government's commitment to put patients first by improving their health care experience. *Patients First: Ontario's Action Plan for Health Care* focuses on four key objectives:

- Access: Improve access – providing faster access to the right care.
- Connect: Connect services – delivering better coordinated and integrated care in the community, closer to home.
- Inform: Support people and patients – providing the education, information and transparency they need to make the right decisions about their health.
- Protect: Protect our universal public health care system – making decisions based on value and quality, to sustain the system for generations to come.

In December 2015, the Minister released *Patients First: A Proposal to Strengthen Patient-Centered Health Care in Ontario*. This discussion paper, which is currently in an active consultation phase, is prefaced by the Minister in this way:

“The next phase of our plan to put patients first is to address structural issues that create inequities. We propose to truly integrate the health care system so that it provides the care patients need no matter where they live. Our proposal is focused on population health and integration at the local level. It would improve access to primary care, standardize and strengthen home and community care, and strengthen population and public health. It would also ensure that services are distributed equitably across the province and are appropriate for patients”.

The 2016-19 IHSP, and this draft ABP, aligns with these proposed directions, identifying that over the next three years, the LHIN will work with providers to develop population-based, geographically integrated LHIN sub-regions. LHIN sub-regions refer to geographically defined areas where providers from primary care, home and community care, long-term care and acute care, work collaboratively to ensure that every person has access to necessary health services. At the same time, a focus on population health and wellness enables a partnership with public health in order to complete the continuum of service provision on a local geographic basis.

In order to achieve this, the HNHB LHIN will focus on several key priority areas, and align them with the vision of LHIN sub-regions. These key priority areas include:

- Primary Care
- Home and Community Care
- Health Links
- Population Health and Wellness
- LHIN-wide Clinical Programs
- LHIN-wide Population Strategies, including the Indigenous/First Nations, and Francophone priority populations.

Accordingly, the 2016-17 draft ABP outlines the goals and action plans to be undertaken in the coming fiscal year, in relation to the priorities outlined in the IHSP. Ministry directions proposed in the December 2015 discussion document, however, are not finalized at this point. As a result, through careful monitoring of and alignment with the ministry process, the goals and action plans outlined in this draft ABP may be adjusted, phased or prioritized before the document is finalized in June of 2016.

The ABP is not intended to repeat detailed information provided in other LHIN planning/reporting documents. It identifies actions and intended changes planned for the upcoming fiscal year. The information below summarizes the LHIN mandate and the local health system in which the LHIN operates. A more complete discussion can be found in the IHSP and the Strategic Health System Planning (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, set out the overall aim of the HNHB LHIN as follows:

Dramatically improving the patient experience through:		
Quality	Integration	Value
Dramatically improving the patient experience by embedding a culture of quality throughout the system	Dramatically improving the patient experience by integrating service delivery	Dramatically improving the patient experience by evolving the role of the HNHB 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 advance of the new three-year IHSP, the Hamilton Niagara Haldimand Brant (HNHB) LHIN undertook to ‘refresh’ its SHSP, reconfirming the strategic aim and strategic directions for the LHIN. This review and refresh of the SHSP’s aim and strategic directions was undertaken to identify any mid-course corrections after three years of implementation, and included:

- A review of accomplishments to date from the first years of SHSP implementation.
- Seeking input and feedback from stakeholders, including Health Service Providers (HSPs) and the Citizens’ Reference Panel (CRP).
- Reviewing the priorities and emerging directions of the ministry.

Based on the HSP and CRP input, the LHIN Board concluded that there is continued support for the overall strategic aim and strategic directions. Additionally, the importance of a strong, engaged primary care sector, and Home and Community 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. These priorities align well with the ministry’s directions, and, accordingly, the HNHB LHIN Board 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. There are ninety-five (95) Multi-Sector Service Accountability Agreements (MSAA), eighty five (85) Long-Term Care Service Accountability Agreements (LSAA), and nine (9) 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 and ABP 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 the Indigenous and French speaking populations.

The new three-year 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 Agency (Environmental Scan of Opportunities and Risks)

The HNHB LHIN encompasses Brant, Burlington, Haldimand, Hamilton, Niagara and most of Norfolk County, a geographic expanse of approximately 6,500 km including both urban and rural areas. There are 1.4 million people in the HNHB LHIN, representing about 10.4% of the province's population.¹ The following summarizes some of the key characteristics of the local health system:

Demographics:

- The HNHB LHIN's population is projected to grow by 7.4% over the next ten years¹. Population growth will be highest among the HNHB LHIN's older adults. There are currently more than 260,000 individuals 65 years or older living in the HNHB LHIN. This number is expected to increase by 35% to approximately 360,000 by 2025.
- Francophone, First Nations, Inuit, Métis, and urban Indigenous Peoples are recognized populations within the HNHB LHIN.
- 2.4% of the LHIN population is defined as Francophone, almost 80% of whom live in Niagara and Hamilton.²
- There are two First Nations reserves in the HNHB LHIN- the Six Nations of the Grand River Territory and Mississaugas of the New Credit First Nation. There are 36,700 individuals who identify as Indigenous within the HNHB LHIN.³
- Although the HNHB LHIN population has a lower percentage of immigrants and visible minorities when compared to the provincial average, there are approximately 17% of individuals for whom neither English nor French is their first language.
- Within the HNHB LHIN there is a higher percentage of lone parent families and a lower percentage of adults who have completed high school and/or post-secondary education.
- There is significant diversity within the HNHB LHIN on a number of socio-demographic characteristics. This diversity is sometimes masked as the average across all areas of the LHIN tends to be similar to the province.

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

² 2011 Census of Canada, Statistics Canada

³ 2011 National Household Survey, Statistics Canada

One notable example is the rate of low income families. HNHB LHIN's proportion of low income families is 13.2%, similar to the provincial rate.⁴ However, within Hamilton's urban core, the rates of individuals living in poverty is 37%, 2.5 times the provincial average. The HNHB LHIN is actively working to understand the socio-demographic and social determinants of health and health status differences at regional and community levels.

Health Status and Practices

- Health can be measured using perceived or self-reported indicators as well as the presence or absence of disease or injury. Health status is influenced by practices such as activity levels, dietary habits, and smoking. There are a number of measures on which residents of HNHB LHIN differ from the provincial average. These measures must be considered in the planning and delivery of health care services:
 - More than 13% of HNHB LHIN residents rate their health as 'fair' or 'poor' which is higher than the provincial average.⁵
 - More HNHB LHIN residents indicate that they are limited in their daily activities due to a physical or mental health condition and more residents describe having pain or discomfort that prevents them from engaging in activities.
 - There are approximately 20% of HNHB LHIN residents with high blood pressure or arthritis and 6% with Chronic Obstructive Pulmonary Disease (COPD). There are 8% of HNHB LHIN residents with asthma and nearly the same rate with diabetes. The prevalence of each of these chronic conditions in HNHB LHIN is higher than the Ontario rates.⁶
 - At a rate of 55%, more people in the HNHB LHIN have a body mass index score that indicates they are overweight or obese.⁷
 - The rate of 'potential years of life lost' or deaths that occur prematurely is higher in the HNHB LHIN than the provincial average.
 - Smoking rates in HNHB LHIN are the highest in the province at 24%⁸, with significant variation within different regions of the LHIN.

⁴ 2011 Census of Canada, Statistics Canada

⁵ Statistics Canada, Canadian Community Health Survey, 2013

⁶ Statistics Canada, Canadian Community Health Survey, 2011-12

⁷ Statistics Canada, Canadian Community Health Survey, 2013

⁸ Statistics Canada, Canadian Community Health Survey, 2013

3. IHSP 2016-19 Priorities:

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 December 2014, the HNHB LHIN Board reaffirmed quality as a priority of its refreshed strategic plan. This pillar reflects the focused work of the LHIN on fostering a strong culture of quality, and also on continuously driving towards improved performance and health outcomes for the people we serve. The Quality Guidance Council (QGC) continues to inform the quality agenda within the HNHB LHIN, support communication, and act as ambassadors within the various sectors. It is anticipated that the role of QGC will evolve and expand in 2016-17 as HNHB LHIN aligns with strategies, mandates, and structures required or recommended by the Ministry and/or Health Quality Ontario (HQP). In accordance with an obligation in their 2015-16 Service Accountability Agreements (SAAs), HSPs from all sectors submitted foundational quality documents to the HNHB LHIN - a Board-approved policy on quality, a balanced scorecard or quality indicators, and a quality plan. A review of these documents indicated that these quality culture enablers are well established in almost all HSPs. HSPs within HNHB LHIN were also required under their SAA to collect and report data regarding patient experience. This obligation aligns well with current efforts of organizations already engaged in patient experience, and acts as a catalyst for any organizations who had not yet embarked in this work. Throughout 2015, the HNHB LHIN staff worked to refine the practices and processes of performance management, including the definition of more standard performance measures. LHIN staff and HSPs are being challenged to expand indicator selection to identify outcome measures that demonstrate value and impact of service delivery investments. There has also been a focus on enhancing data quality to support more advanced analysis and decision making. These efforts will continue in 2016-17 and will both support the proposed health system transformation agendas and respond to the Office of the Auditor General of Ontario report recommendations.
PART 2: GOALS and ACTION PLANS
Goal(s):
• Identify and monitor big dot and whole system measures of health system performance. • Build capacity and promote knowledge translation within and between HSPs regarding quality and performance improvement. • Expand the Quality Guidance Council's mandate to support the evolving focus of quality and performance within the LHIN and align with provincial structures for quality improvement. • Implement actions and initiatives based on the Auditor General Report Response Work Plan.

Consistency with Government Priorities:							
The Patients First: Action Plan for Health Care released in February 2015 set goals of improving access, connecting services, providing information, and protecting or sustaining the health system. This action plan as well as implementation of any potential health system transformation initiatives supports and will be a catalyst for quality and performance improvement throughout the system.							
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						
	2016-17		2017-18		2018-19		
Examples:	Status	%	Status	%	Status	%	
Engage with HSPs and other stakeholders to confirm whole system measures. Create a method and structure to regularly monitor these measures and address areas of concern or opportunity.	In progress	50	Complete	50			
Continue to review existing measures by functional centre, program and/or sector to ensure the best possible indicators are being collected to inform decision making. Determine how these indicators align with the whole system measures.	In progress	40		40	Complete	20	
Develop and/or compile web-based resources to support HSPs build capacity and knowledge regarding quality and performance improvement.	In progress	50		50			
An annual review of HSP quality plans to identify themes, challenges, success, and opportunities to conduct ongoing improvements. The local process will reflect and augment the quality improvement reviews conducted by HQO.	Not yet started	100					
QGC will begin operating with an expanded scope and mandate that informs the quality culture, performance monitoring, and related plans for improvement across the HNHB LHIN.	In progress	60	Complete	40			
Implement relevant recommendations of the Office of the Auditor General of Ontario's audit as per the pan-LHIN work plan.	In progress	70	Complete	30			
How will we measure success?							
- Whole system measures are identified and regularly monitored by HNHB LHIN staff and stakeholder groups. - Functional centre and program measures are reviewed and improvements are initiated as required. - The number of web-based quality and performance improvement resources that are developed and compiled and the frequency of viewing of those resources. 100% review of the quality plans received by the HNHB LHIN. - The QGC mandate and terms of reference are expanded. The QGC effectively contributes to the quality agenda within the HNHB LHIN and is connected to provincial quality structures and priorities. - HNHB LHIN successfully implements activities according to the pan-LHIN work plan in response to the recommendations of the Office of the Auditor General of Ontario.							

What are the risks/barriers to successful implementation?
• The introduction of additional provincial or local priorities that are yet unknown may delay implementation of the planned quality initiatives. Capacity of LHIN staff to fully implement the activities and initiatives related to the multiple priorities (e.g. Office of the Auditor General of Ontario recommendations, transformational change, LHIN operations). • Limited data availability and decision support resources within some HSPs may impact the collection and monitoring of whole system measures and program level or functional centre indicators. • Engagement of QGC existing and new members during the evolution of its mandate and scope. Alignment of HNHB LHIN quality priorities and provincial quality agendas.
For each risk/barrier, describe the plan to mitigate the risk?
• Maintain flexibility in work plans and timelines regularly reviewing priorities and deliverables. • Regularly engage HSP leadership regarding whole system measures and performance. Clearly articulate what is feasible given data availability constraints. Provide ongoing support to HSPs regarding data quality and availability. • Collaborate with QGC members to revise terms of reference. Identify and support LHIN staff to act as liaison with HQO.
What are some of the key enablers that would allow us to achieve our goal?
• Dedicated resources for quality, risk management, and health information within the HNHB LHIN. • Opportunity to create shared understanding about whole system and outcome measures among HSPs. • Commitment of HSPs to quality and performance improvement.
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. 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
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. • Providers participate in interprofessional teamwork; coordination of tasks, services and care. • HSP's participate in inter-agency relationships to provide seamless, integrated service delivery.

Current Status:
The HNHB LHIN has successfully focused on three approaches to integrating service delivery: 1. Health Links – integrated service delivery into coordinated care plans for those individuals with multiple, complex, chronic conditions. 2. LHIN-wide Clinical Programs – integrating hospital-based clinical services following the concept of one LHIN-wide clinical program on multiple sites. 3. LHIN-wide Population Strategies – standardizing approaches to care for specific populations, so that services are coordinated, and access is equitable. While this work has further integrated service delivery at the individual level (Health Links) and the population level (LHIN-wide programs and strategies), there are still many barriers within the health care system that impact individuals as they seek care and detract from the aim of dramatically improving patient experience. Currently, there are very few examples of system-wide integration across the sectors of primary care, hospital care, and home and community care. Health Links is one example where all three sectors have come together to focus on the needs of the high-user population, developing individualized care plans, thus integrating service delivery one person at a time. In addition, the integrated comprehensive care (bundled care) expansion across the LHIN is an example of integrating both the hospital and home and community care sectors. By and large, however, sector lines remain intact and the individual is often left to integrate service based on their, or their loved one's needs. In the future state, the boundaries between primary care, hospital care and home and community care will be reduced as LHIN sub-regions focus on meeting the continuum of care needs of the population. This approach will reduce cross sector barriers and will integrate services on a local geographic basis.

PART 2: GOALS and ACTION PLANS
Goal(s):
Over the next three years, the HNHB LHIN will work with providers to develop population-based, geographically integrated LHIN sub-regions. These sub-regions will be geographically defined areas where providers from primary care, home and community care, LTC, and acute care, work in collaboration to ensure that every person has access to necessary health services. In order to achieve this, the HNHB LHIN will work on several key priority areas, bringing them together around the vision of integrated LHIN sub-regions. These key priority areas, which are described in other sections of this ABP, will include: • Primary Care • Home and Community Care • Health Links • Population Health and Wellness • LHIN-wide Clinical Programs • LHIN-wide Population Strategies, including the recognized populations of Indigenous/First Nations, and Francophone
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 <i>Patients First: Action Plan for Health Care</i> announced in February, 2015. Additionally, in December 2015, the Minister released <i>Patients First: A Proposal to Strengthen Patient-Centered Health Care in Ontario</i>. This discussion paper, which is currently in an active consultation phase, outlines the ministry's proposals to integrate the health care system, at the local level.

Action Plans/ Interventions: “We will deliver the following”	Please indicate the status of project (Not Yet Started, In progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2016-17		2017-18		2018-19	
	Status	%	Status	%	Status	%
Define LHIN sub-region geographies based on population and utilization data.	In progress	100				
Develop and implement a plan for integrating service delivery across sectors within each LHIN sub-region, including engagement of HSPs.	Not yet started	25		25		50
How will we measure success?						
- LHIN sub-regions identified and supported by HSPs. - Development of planning structure with clear roles, responsibilities and accountabilities for System Integration planning and implementation.						
What are the risks/barriers to successful implementation?						
- Alignment of multiple strategies with overall ministry direction. - System capacity to manage multiple change initiatives.						
For each risk/barrier, describe the plan to mitigate the risk?						
- Goals/activities will be prioritized as directions are clarified. - Engage clinician and senior administrative leadership from across sectors.						
What are some of the key enablers that would allow us to achieve our goal?						
- Physician and senior administrative leadership engagement. - Consistent integration tools, templates and processes utilized throughout each planning and integration process will ensure success of our goals.						
Additional Comments (i.e. additional information that supports the implementation/success of the goal).						
n/a						

ii. Primary Care

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improve the patient experience by integrating service delivery: Primary Care
IHSP Priority Description:
Primary care is the entry point to the health care system for most Ontarians. Primary Health Care providers carry out assessment and treatment as well as referral to secondary and tertiary care and community supports. How primary care performs can often have a cascading impact on other parts of the health care system. In fact, evidence shows that jurisdictions that have a strong foundation of primary care also have better health equity and overall better health system performance. Following the ministry's lead, the HNHB LHIN will work with primary health care providers on a local primary health care strategy that will contribute to a patient-centred, high performing, locally managed primary care sector that is seamlessly integrated into the health care system and organized around and responsive to the needs of Ontarians.
Current Status:
To support the ministry's development of the <i>Patients First – A proposal to Strengthen Patient Centred Health Care in Ontario</i>, LHINs were asked to provide some thoughts, from a primary care perspective on how performance could be improved in their region. They were specifically asked for initial planning considerations to support the primary care component of health system transformation. This included: • The identification of proposed LHIN sub-regions that will be the focal point for primary care planning and performance improvement. • Description of planned approaches to improve performance against key performance measures, including attachment and timely access to primary care. • Approaches to clinical leadership to facilitate performance improvement, including the type of lead, their roles and how the LHIN would work with them to advance the goals of the strategy. The HNHB LHIN Primary Care Reform Proposal was submitted to the ministry on October 9, 2015. While the original submission described seven LHIN sub-regions, based on further analysis and discussion, the HNHB LHIN is now considering five LHIN sub-regions which would include Hamilton, Niagara, Burlington, Brant and Haldimand-Norfolk. Engagement and planning specific to primary care will follow completion of the ministry's <i>Patients First: Proposal to Strengthen Patient-Centred Health Care in Ontario</i> consultations.
PART 2: GOALS and ACTION PLANS
Goal(s)
Integrating primary care will involve organizing and coordinating health care services around LHIN sub-regions where providers from primary care, home and community care, long term care homes and hospitals work in collaboration to ensure that every person has access to necessary health services. The goals of primary care reform include: 1. More effective integration of services and greater equity. 2. Timely access to primary care, and seamless links between primary care and other services. 3. More consistent and accessible home and community care. 4. Stronger links between population and public health and other health services.

A key objective of this approach is to achieve the government's goal of ensuring a primary care provider for every Ontarian that wants one.

Planning and integration of a primary care system in the HNHB LHIN will use a lens of health equity and will involve collaboration to meet the needs of the LHIN's Indigenous and Franco-Ontarian populations, as well as vulnerable populations and newcomers.

Consistency with Government Priorities:

In February 2015, Minister Dr. Eric Hoskins announced *Patients First: Action Plan for Health Care* as the blueprint Ontario is following to build a better health system that meets all of the critical and complex needs of its patients.

On December 17, 2015, the ministry took the next step in making that system a reality with the release of its Discussion Paper entitled *Patients First: Proposal to Strengthen Patient-Centred Health Care in Ontario*.

Planning and integration activities will also align with:

- *The Excellent Care for All Act (ECFAA)*.
- *French Language Services Act (FLSA)*.
- Aboriginal Health Network (AHN) Priorities.

Action Plans/ Interventions: "We will deliver the following"	Please indicate the status of project (Not Yet Started, In progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2016-17		2017-18		2018-19	
Examples:	Status	%	Status	%	Status	%
Engagement with public and health service providers, including primary care, to inform primary care system reform.	In progress	50		25	Complete	25
Completion of analysis to determine number of sub-LHIN regions for HNHB LHIN, and catchment areas for those regions.	In progress	100				
Engagement with sub-LHIN regions to develop clinical and administrative leadership for each region.	In progress	50	Complete	50		

How will we measure success?

Primary care integration will result in the following outcomes for patients and citizens:

- Improved access:
 - Attachment to a primary care provider (key focus area).
 - Same day and next day access to primary care appointments.
 - Access to primary care in the evening or on a weekend/holiday.
- Improved integration:
 - Primary care appointments within seven days post-hospital discharge.
 - Readmission to hospital within 30 days for select medical conditions.
 - Avoidable Emergency Department (ED) visits.
- Improved effectiveness:
 - Preventative care compliance rates, including cancer screening and immunizations.
- Improved patient-centered experience.

What are the risks/barriers to successful implementation?
• Primary care engagement: ○ Successful implementation will require highly engaged primary care providers to collaborate in system design to achieve desired outcomes for patients and citizens. • Areas of high need for primary care physicians in the HNHB LHIN: ○ The HNHB LHIN has identified communities of high need for primary care physicians to ensure that there is a primary care provider for every Ontarian that wants one. • Availability of primary care data: ○ In order to design and integrate a primary care system, the HNHB LHIN will require reliable data about primary care resources and services.
For each risk/barrier, describe the plan to mitigate the risk?
• The HNHB LHIN will leverage strong relationships with the HNHB LHIN Primary Care Network (PCN) and primary care providers to inform implementation. • The HNHB LHIN will work closely with LHIN sub-regions leaders, as well as with Health Force Ontario, to understand local community primary care needs to inform the ministry's Managed Entry program and recruitment of physicians. • The HNHB LHIN will work closely with the ministry, LHIN sub-regions leadership, and primary care providers to obtain reliable and accurate data.
What are some of the key enablers that would allow us to achieve our goal?
• Communication and engagement with public and providers • Effective change management and communication strategies • E-health technologies can be leveraged to enable integration of providers and services • Strong physician leadership
Additional Comments (i.e. additional information that supports the implementation/success of the goal).
n/a

ii. Home and Community Care

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by integrating service delivery: Home and Community Care
IHSP Priority Description:
The ministry's "<i>Patients First: A Roadmap to Strengthen Home and Community Care</i>" (2015), identified a three year plan as an initial phase in transforming the way care in the home and community is delivered. LHINs' strength in identifying and planning local health care services will continue to support the ministry's direction for Home and Community Care through moving forward with plans to identify the health care needs of the LHIN's population at the sub-LHIN level. Key strategies to strengthen Home and Community Care in sub-LHIN areas include: • Adoption of a "one sector" model where providers of home care services work together to effectively operate as one care sector to coordinate and optimize home and community care for adults with frailty or long term chronic conditions. • Enhance the capacity of HNHB Community Support Services (CSS) agencies to support older adults with lower care needs. • Increase access to care coordination and home care services for clients with complex care needs. • Implement a bundled care model that will improve the patients experience through better coordination between hospital and home care.

- Improve care transitions from hospital to home by providing patients with information on the home care services they will receive following discharge.
- Personal Support Services (PSS) Wage Enhancement Initiative.

Current Status:

The HNHB LHIN continues to act as an “Early Adopter” to implement the amendment in the *Home Care and Community Services Act, 1994* which allows CSS agencies to be approved to provide PSS. The HNHB LHIN is testing standards and definitions for the Community Care Access Centre (CCAC) and CSS agencies to operate as “one sector” as described in the associated Ministry Policy Guidelines for the PSS regulatory amendment, including:

- Intake and assessment.
- Care coordination.
- Waitlist management.
- Complaints management.

The Early Adopter work is directly aligned with system priorities outlined in the ministry’s Patients First strategy such as integration, consistency, capacity, quality and value. The outcomes of this work will strengthen relationships between sectors, standardize and improve consistency in the quality and amount of care provided to individuals at home and in the community, enhance the capacity of CSS agencies to provide PSS, and improve integration across all sectors including primary and acute care.

The HNHB CCAC continues to experience a growing number of referrals from hospital, which have increased 4.6% in the past year and 23.8% in the last three years.⁹ Although the number of inpatient referrals has remained relatively constant, there was a 13.2% increase in referrals from hospital emergency departments in the past year. The increase in hospital referrals for individuals with complex home care needs has caused a system flow pressure that must be addressed with improved integration and expanded capacity of CSS agencies to provide care for clients with lower home care needs. In 2015-16, the HNHB LHIN approved \$3 million in new funding to CSS agencies to provide PSS. This funding increased the LHIN’s investment to \$7M to support this initiative.

Additionally, the HNHB LHIN is actively working on other strategies outlined in the Roadmap to Home and Community Care, notably the Integrated Comprehensive Care Program (ICCP). The ICCP, also described as “bundled care”, is based on key elements of the St. Joseph’s Healthcare Hamilton (SJHH) program of the same name and will strengthen the integration of health care services between hospital and home and community care.

The ICCP model of care enables testing of Integrated Funding Models (IFM), also called “bundled funding”, which aligns with the Roadmap for Home and Community Care. To enhance this model, the HNHB LHIN and Ontario Telemedicine Network (OTN) are working with SJHH to pilot the integration of telehomecare into their existing ICCP care path for patients with COPD/Congestive Heart Failure (CHF). Telehomecare offers remote patient monitoring that will provide patient centered care and care close to home, increase access to services for patients, and minimize the complexity of how care is organized and delivered.

Key issues:

- Increasing demand for home care services, both in number of individual clients and the complexity of their care needs. This will cause further pressure in the home and community care sector.
- With the CCAC prioritizing clients with “complex” care needs, and CSS agencies prioritizing clients with “low” care needs, a gap may develop for patients with “moderate” care needs.
- Aligning “bundled funding” with a “bundled care” model of service delivery for patients discharged from hospital care to home care.

⁹ HNHB CCAC System Flow Perspectives for the period ending November 30, 2015.

- As the HNHB ICCP expands across all hospital sites, the use of Telehomecare technology may need to be modified to align with the ICCP model of care.
- Meeting provider and public expectations that individuals requiring home and community care supports will receive timely access to the right level of care.

Successes of past year:

- Expanded capacity of CSS agencies to provide a total of 76,424 hours of PSS to approximately 1,250 individuals across the HNHB LHIN as of November 2015.
- The HNHB LHIN has engaged with the Change Foundation to host a number of engagement sessions with front-line professionals in home and community care, acute care, mental health (MH) and primary care to understand their experiences with family caregivers and how they may be supported or improved. This work will inform future planning related to family caregiver and patient experiences within the HNHB LHIN and provincially.
- Patient experience surveys administered to individuals transitioned from CCAC to CSS yielded the following results:
 - 95% satisfied or very satisfied with the recent change to a new in-home care provider.
 - 97% satisfied or very satisfied with the level of dignity and respect received from their new in-home care provider.
 - 95% satisfied or very satisfied with the level of involvement in making care decisions related to care received from new in-home care provider.
 - 95% rated the quality of care from their new in-home care provider as seven or above on a scale of one to 10.
- Conducted multiple focus groups with clients and families related to the transition from CCAC to CSS for home and community care. Feedback was used to adjust future strategy for transitioning clients within the one sector model.
- Implemented Phase 2 of the PSS Wage Enhancement Initiative.
- Development of ICCP program, and implementation for specific subset of medicine patients (COPD and CHF) at Joseph Brant Hospital (JBH) in October 2015, with Hamilton Health Sciences (HHSC) beginning implementation in January 2016.
- SJHH successfully implemented telehomecare into their ICCP in Oct 2015. As the HNHB ICCP expands, there will be opportunity for the role of telehomecare to be evaluated within the context of the IFMs.

PART 2: GOALS and ACTION PLANS

Goal(s):

Each of the goals for the home and community care sector focus on improving patient and caregiver experience. This will be accomplished by fully implementing the one sector collaborative care model between the CCAC and CSS agencies for providing PSS.

HNHB LHIN activities focused on strengthening home and community care include:

- Implement a collaborative care model between the CCAC and Community Assisted Living and Supportive Housing providers to deliver PSS to eligible clients in the home and community.
- Implement year three of the ministry's PSS Wage Enhancement Initiative

New goals for the 2016-17 ABP:

- Develop and implement waitlist management process for PSS that is consistent with the "one sector" model and is clear and transparent to the public.
- In alignment with ministry strategic direction, including the Levels of Care Framework, improve public understanding and expectations related to accessing home and community care.
- Identify process for tracking all PSS services delivered by community agencies to ensure that the level of service required matches the level of service need and that service maximums are not exceeded.
- Participate in provincial evaluation of IFMs to monitor outcomes of the ICCP.

Consistency with Government Priorities:

In 2015, the ministry released the Patients First strategy, including an Action Plan for Health Care and a Roadmap to Strengthen Home and Community Care.

Both outline system priorities of integration, consistency, capacity, quality and value. The HNHB LHIN's goals and activities align with the Minister's direction to strengthen home and community care by:

- Putting clients and caregivers first
- Improve client and care giver experience
- Drive greater quality, consistency and transparency
- Plan for expanded capacity
- Modernize delivery
- Identify the unique needs of Indigenous and Francophone populations

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.					
	2016-17		2017-18		2018-19	
	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.	Completed	100				
Implement PSS Wage Enhancement Initiative.	Completed	100				
Develop and implement waitlist management process for PSS that is consistent with the "one sector" model and is clear and transparent to the public.	In progress	50	Completed	50		
In alignment with ministry strategic direction, including the Levels of Care Framework, improve public understanding and expectations related to accessing home and community care.	In progress	50	Completed	50		
Identify process for tracking all PSS services delivered by community agencies to ensure that the level of service required matches the level of service need and that service maximums are not exceeded.	In progress	75	Completed	25		
Participate in provincial evaluation of IFMs to monitor outcomes of the ICCP.	In progress	50	Completed	50		
How will we measure success?						
• Overall client satisfaction and confidence with health care in the community. • Percentage of home care clients with complex needs who received their personal support visit within five days of the date that they were authorized for PSS. Improving trend towards meeting the LHIN's Ministry-LHIN Accountability Agreement (MLAA) indicator. • Percentage of home care clients with complex needs who received their nursing visit within five days of the date they were authorized for nursing services. Improving trend towards meeting the LHIN's MLAA indicator. • 90th percentile wait time from community for CCAC in-home services: application from community setting to first CCAC service (excluding case management). Improving trend towards meeting the LHIN's MLAA indicator. • Improved public understanding of home and community care services, as measured through engagement sessions hosted by CSS providers. • Reduced 30 day readmissions for clients returning home from hospital with home care services.						

What are the risks/barriers to successful implementation?
• Demand for home and community care services is expected to increase in coming years due to demographic shifts. This will present challenges related to cost and human resources in this sector. • Delineation between population groups outlined in policies for attendant care outreach, PSS, and assisted living for high risk seniors.
For each risk/barrier, describe the plan to mitigate the risk?
• Ongoing capacity planning related to home and community care services, including collection of performance metrics (e.g., number of hours of service delivered) and patient outcomes in each sub-LHIN region. • Engage with the LHIN Collaborative and Early Adopter Working Group to further understand relationships between multiple policies influencing home and community care.
What are some of the key enablers that would allow us to achieve our goal?
• Electronic patient tracking system to monitor the number of PSS hours received by any individual across various services. This will ensure that no individuals exceed the maximum hours of allocated PSS. • Ongoing support from the LHIN Collaborative and LHIN (Chief Executive Officer) and CEO Council. • Effective partnerships between the CCAC and CSS agencies. • Existing networks, such as the Home and Community Care Collaborative, Primary Care Network and Health Links tables. • Continued participation in provincial IFM project and Community of Practice.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).
n/a

iii. Health Links

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by integrating service delivery: Health Links
IHSP Priority Description:
The government's <i>Patients First: Ontario's Action Plan for Health Care</i> plans focus on the commitment to put people and patients first by improving the health care experience, reducing gaps in care and strengthening patient-centered care. Integrated service delivery means the system will focus on patient-centered care. This includes supporting the advancement of Health Links, a new model of care to improve care for patients living with complex chronic conditions. Health Links is an essential component of health system transformation priorities under the government's <i>Patients First: Ontario's Action Plan for Health Care</i>, and it will form part of the foundation for sub-LHINs along with Primary Care, and Home and Community Care reforms. Health Links act as a catalyst for improving quality of care and represents a cornerstone in the 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 patients with complex chronic conditions. • Alignment and integration – focusing on care transition points. • Planning across the continuum – plan of care that incorporates all aspects of a patient's needs and goals. • Initiatives planned and implemented to support the new model of care will continue to include collaboration with the LHIN's Indigenous and Francophone populations.

Current Status:
Initiatives planned and implemented to support the new model of care will continue to include collaboration with the LHIN's Indigenous and Francophone populations. The LHIN has established a governance structure to support the advancement 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. ▪ Promoting knowledge transfer and capacity building. • Working Groups: ○ Care Planning Working Group: ▪ Support the development of common approaches to support patient-centered care planning. ▪ Developing guidelines, tools and templates for universal use based on best practice. ○ Analytical Working Group: ▪ Supports the work to define and identify the five percent patient population in real-time with a focus on patients living with Mental Health and Addictions (MHA), palliative and frailty. ▪ Supports the work to analyze outcomes for those patients with coordinated care plans completed.

PART 2: GOALS and ACTION PLANS						
Goal(s):						
Enhance the health care experience for patients with greatest needs through the advancement of the Health Link model of care: • Provide patient-centered effective coordinated care. • Improve the delivery and coordination of care for defined populations living with complex chronic conditions. • Enhance patient experience. • Improve the quality of care through cost effective approaches.						
Consistency with Government Priorities:						
Health Links were introduced as a key commitment in the ministry's Ontario's original Action Plan for Health Care in 2012 to transform the system through increasing access to integrated, quality service to Ontario's patient population living with complex conditions.						
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.					
	2016-17		2017-18		2018-19	
	Status	%	Status	%	Status	%
Continue to advance the implementation and standardization of the Health Link model of care based on a patient-centered model of care and best practices.	In progress	25		25		25
Provide leadership, coordination and support for the HNHB LHIN Health Link governance structure. (annual)	In progress	100		100		100

Include the Health Link model of care as part of the planning for the new sub-LHINs.	In progress	100				
Monitor and track the performance related to Health Links including those related to outcomes, and terms and conditions of funding. (annual)	In progress	100		100		100
Continue to support the Health Links initiative at the provincial level by collaborating with other LHINs and the ministry (annual).	In progress	100		100		100
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 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 in real-time the patients that make up the current five percent utilization cohort, and process re-engineering the workflow associated with identification and referral. • 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.						
For each risk/barrier, describe the plan to mitigate the risk?						
• Health Links will continue to 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 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 integrated IT and funding resources. • Advancement of the government's <i>Patient First: A Proposal to Strengthen Patient-Centered Health Care in Ontario</i>.						

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 and a focus on team work. • Coordination of services across providers both vertically and horizontally. Major transformation of the health care system needs to more easily linked, if not incorporate, several domains including management, service delivery (health and social) and funding. The HNHB LHIN will continue to work with the ministry to work together to ensure the necessary reform is in place.

iv. Health and Wellness of the Population

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by embedding a culture of quality throughout Health and Wellness of the Population
IHSP Priority Description:
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. The HNHB LHIN is committed to improving health equity within the context of the health system by incorporating a population health approach and health equity lens into planning, funding, and integrating health services. The application of the LHINs health equity framework and social determinants of health will be applied to identify opportunities; with a focus on our priority target populations (Indigenous Peoples, French speaking population, migrant agricultural workers, newcomers and homeless). Partnership and collaboration with local public health units will also serve to strengthen efforts and offer a complete continuum of services in the community.
Current Status:
In September 2015, the HNHB LHIN formed the Health Equity Action Plan (HEAP) Working Group to support the LHIN in its efforts to improve population health outcomes by eliminating health inequities and barriers to accessing health services, and improving patient experience and healthcare outcomes. The HEAP Working Group will collaborate with the LHIN to advise on health equity priorities and to assist in the development of an annual health equity action plan. Opportunities to integrate equity into the work of the HNHB LHIN include: • Identifying vulnerable or marginalized populations. • Understanding the population and local needs. • Considering the impact of the social determinants of health and how they intersect. • Identifying mitigation strategies. • Monitoring and evaluating process and outcome measures. As the LHIN continues to understand the local needs of the population through the work of the HEAP Working Group, three initial target populations for focus have been identified for further study in the coming year: • Migrant Agricultural Workers (MAWs) • Newcomers • The Homeless

The activities of the HEAP Working Group will be guided by the HNHB LHIN's Health Equity Planning Framework that was adopted in 2014. Continued planning and development of the action plan will ensure alignment with the ministry, provincial priorities, HQO and shared LHIN initiatives.

In addition, partnership with local Public Health Units (PHUs) will add a population health perspective to the assessment of community needs, and the planning and integration of health services. The HNHB LHIN has begun to work with PHUs to identify areas for coordination and collaboration in strategic planning to improve population health and wellness.

Smoking cessation has been identified as an initial and immediate opportunity to build collaborative relationships with local PHUs. In the commitment to foster ongoing partnership with local PHUs, other opportunities for collaboration will be explored. The HNHB LHIN is partnering with the Central West Tobacco Control Area Network and local PHUs to help endorse the "You Can Make It Happen" campaign which offers a comprehensive source of information, tools and resources about tobacco cessation for health care providers. The campaign also supports the use of the 5A model (Ask, Advise, Assess, Assist, Arrange) which offers a simple framework for minimal contact tobacco intervention that healthcare providers can integrate into daily practice to ensure that for every patient, at every visit, tobacco use status is queried and documented. The HNHB LHIN will assist to increase the number of health care providers implementing the 5A model.

Migrant Agricultural Workers:

- Each year, more than 38,000 legal temporary contract positions are available in Canada for migrant workers. The HNHB LHIN employs the greatest number Migrant Agricultural Workers (MAWs) (up to 8,000 workers). While MAWs are covered by Ontario Health Insurance Program (OHIP), the vast majority does not access health care services and those who do need urgent health care typically go to walk-in clinics or EDs. A number of practical and systemic barriers to MAWs accessing healthcare services include: a fear of being sent home, a lack of awareness of available primary care services, lack of transportation etc.
- The most common health conditions include: injury / trauma, and gastrointestinal, musculoskeletal, ocular, skin, respiratory, and urinary problems.
- To improve access to health care services, in 2014, the HNHB LHIN supported the implementation of a MAW health program at Grand River and Quest Community Health Centres (CHCs) in Brantford and St. Catharines, respectively. The primary care-based model is Nurse Practitioner (NP)-led and supported by a team of professionals including a Registered Nurse (RN), an outreach worker, a translator, and volunteers. Together, these programs saw 427 clients.
- Due to the success of the program, the HNHB LHIN approved new funding for Quest CHC to expand their program in the Virgil and Vineland communities, and for Grand River CHC to expand its program to the Simcoe and Delhi communities.

Newcomers:

- 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.
- In September 2015, Ontario committed to collaborating with the Government of Canada and other partners to support the permanent resettlement and integration of approximately 10,000 Syrian refugees. Through partnership and collaboration, the LHIN facilitated local planning and coordination of health care services and resources in preparation for refugees planning to resettle in the HNHB LHIN.
- In order to align with *Patients First: Ontario's Action Plan for Health Care*, the HNHB LHIN will work with the HEAP Working Group to develop a targeted approach to improve newcomer health.

The Homeless:

- Housing is a fundamental human need as it is the foundation for economic, social and physical well-being. Homelessness is an extreme form of poverty and social exclusion and precarious housing and homelessness contribute to complex physical and mental health issues, which are made worse by the lack of access to supports and services.
- Homelessness refers to the experience of people without safe, affordable, appropriate, permanent housing which they can return whenever they choose.
- Reported homelessness estimates that 200,000 individuals, youth and families experience homelessness per year. Thirty thousand Canadians experience homelessness on any given night, and as many as 50,000 make up “hidden” homelessness (e.g. couch surfers, or individuals that stay with family or friends).
- Homelessness exacerbates the risk factors for developing many acute and chronic diseases and make vulnerable populations more dependent on emergency services.
- The HNHB LHIN will collaborate with the HEAP Working Group to identify the LHIN's role in issues of homelessness and housing.

PART 2: GOALS and ACTION PLANS

Goal(s):

As articulated within the IHSP, the following goals are identified to improve population health and wellness:

- Incorporate a population health approach and equity lens into planning, funding and integrating health services.
- Improve equity of access to health services for target and vulnerable populations.
- Improve equity of experience for target and vulnerable populations.
- Build partnership and collaboration with local Public Health Units (PHUs) and other stakeholders to improve population health outcomes.

Consistency with Government Priorities:

The above noted goals and actions plans to support the achievement of these goals are consistent with the provincial government and LHIN priorities as reflected in:

- *Patients First: Ontario's Action Plan for Health Care*
- *Patients First: A Proposal to Strengthen Patient-Centered Health Care in Ontario*
- The ECCFA
- *French Language Service Agreement (FLSA)*
- (AHN) Priorities
- Smoke-Free Ontario Strategy
- Ontario Healthy Kids Strategy
- Poverty Reduction Strategy

Action Plans/Interventions: “We will deliver the following”	Please indicate the status of project (Not Yet Started, In progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column					
	2016-17		2017-18		2018-19	
Examples:	Status	%	Status	%	Status	%
Design and implement a health equity action plan for the HNHB LHIN.	In progress	50		25	Complete	25
Apply the health equity planning framework to planning for priority populations: MAWs.	Complete	100				
Apply the health equity planning framework to newcomer health and other populations as identified through the HEAP Working Group.	In progress	25		25	Complete	50

Develop health equity indicators and outcomes measures to enhance system performance in alignment with HQO.	In progress	50		25	Complete	25
Collaborate with the ministry to develop and implement a health equity training strategy to enhance awareness and knowledge of health equity and population health principles and tools (e.g. HEIA).	In progress	50	Complete	50		
Implement a health equity lens using the Health Impact Assessment Tool in funding and planning decisions.	In progress	25	Complete	75		
Identify with Public Health areas for coordination and collaboration in strategic planning to improve population health and wellness in HNHB LHIN. (e.g. smoking cessation)	In progress	25		25		25
How will we measure success?						
• Increase the ability and confidence of the LHIN and of HSPs to apply a health equity lens and population health approach to planning (e.g. use of the HEIA tool). • Improve knowledge base of LHIN communities, assets, health-related programs, and Human Health Resources (HHR). Knowledge base will inform funding decisions based on current and predicted need and trends in vulnerable populations. • Increase the number of health service providers using the HEIA Tool during their planning activities. • Improve health system performance monitoring through establishment of health equity indicators, identification of and focus on outcome measures, and enhance performance review and risk assessment processes. • Increase number of HSPs using the Public Health 5A minimal contact tobacco intervention to support provincial efforts to reduce smoking rates.						
What are the risks/barriers to successful implementation?						
• Engaging HSP leadership into taking an approach that is broader than the health care system alone. • Level of health service providers' knowledge, capacity and capability to apply a health equity lens to planning activities. • Ability to implement standardized indicators and compare data across LHINs.						
For each risk/barrier, describe the plan to mitigate the risk?						
• Articulate and demonstrate the positive 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. • Offer training and education to enhance health equity knowledge of HSPs. • Collaborate with HQO, LHINs and Public Health to develop common dataset.						
What are some of the key enablers that would allow us to achieve our goal?						
• Continued collaboration and partnership with the ministry and HQO to prioritize addressing unequal distribution of the social determinants of health. • Identify Health Equity champions to assist in awareness and adoption of health equity knowledge and practices. • Continued open and timely communication with the ministry's Health Equity Branch, HQO and Health Equity LHIN Leads to ensure appropriate engagement and strategic communication opportunities to support ministry priorities 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						

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:
The HNHB LHIN is home to a sophisticated network of hospital-based programs and services, providing a full range of secondary and tertiary specialized services to residents of our LHIN and beyond. LHIN-wide integrated clinical programs will provide specialized services to LHIN residents, based on the key concept of ‘one clinical program – multiple sites’. The goal of LHIN-wide clinical programs is to ensure that all residents across the LHIN have access to a coordinated program, following the same care delivery and quality standards, regardless of where they live. LHIN-wide integrated clinical programs will coordinate and standardize hospital-based 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. • LHIN-wide integrated clinical programs means that systems are designed/redesigned to ensure the person is at the centre of care: ○ Put clients and caregivers first. ○ Care is client and caregiver-centred. Everyone who has needs that can be reasonably met in the home or community will receive support to do so. ○ Improve client and caregiver experience. ○ Clients and caregivers understand the support they can expect and they experience a timely, responsive system. Service delivery information is publicly available and easily accessible. ○ Drive greater quality, consistency and transparency. Consistent, high quality, expert informed care available throughout the province. Use of standardized tools, support and strengthen the quality of services and programs delivered. ○ Plan for and expand capacity. ○ Investments focus on increasing capacity and improving performance in the home and community care system. ○ Modernize delivery. ○ Updated funding models, consistent assessment approaches, workforce planning and improved technology are used throughout the sector. • Ongoing ministry and local priorities will continue to influence clinical service planning for key populations, programs, and systems, including but not limited to: ○ Increased awareness and knowledge transfer of hospital and specialty clinical care providers regarding Indigenous and Francophone population health and cultural needs will be achieved. ○ Initiatives planned and implemented within these strategies will include and collaborate with the LHIN’s Indigenous and Francophone populations. ○ Integrated clinical programs can help to improve patient access and support seamless quality care as envisioned through Health Links and LHIN sub-regions.
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.

Reducing variation in services and ensuring equity in health outcomes can be achieved through clinical program integration and the implementation of Quality Based Procedures (QBP). The HNHB LHIN has addressed these two strategies through the implementation of integrated care and integrated funding models, which utilize integrated teams to provide coordinated care across the continuum (transitioning care from hospital to the community) for a defined patient population.

Key issues:

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

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 Medicine Services: HNHB LHIN hospitals enhanced the integration of Laboratory Medicine through the rebranding of the LHIN Laboratory Council to CoLabs.
With rebranding, an aligned vision for laboratory medicine services was developed and collaborative strategic planning was initiated incorporating all hospital sites.
 - LHIN-wide endorsement and enhancement of testing restrictions and discontinuation recommendations were made to reduce unnecessary testing for patients.
 - Initial implementation of Choosing Wisely Canada evidence based recommendations related to laboratory medicine testing to reduce unnecessary testing for patients was introduced. Initial work at the Brant Community Healthcare System (BCHS) site looked at urine culture utilization and optimization and the model for implementation is being reviewed for spread across other sites.
 - Analysis of opportunities for the implementation of standardized orders for use in EDs related to testing restrictions and discontinuations related to: abdominal pain, chest pain, and sepsis.
 - The "Standards 2 Quality" quality management program was sustained across the LHIN and transparently shares quality key indicator data across all sites.
 - An ongoing strategic focus on quality was actualized through the appointment of BCHS leader Dr. Katherine Chorneyko as a Provincial Quality Clinical lead for Pathology to facilitate development and implementation of quality management programs.
 - A transfusion medicine regional committee was designed with a co-chair physician and administrative lead model.
 - A regional microbiology team was enhanced through the addition of all hospital partners. Continues to meet regularly and review key indicators for microbiology testing on a quarterly basis.
 - Enhancement of services to Niagara Health System (NHS) was achieved through redirection of testing from public health to the regional microbiology time and resulting in improved turnaround time and patient flow through the hospital.
 - Appointment of an executive medical director to provide medical leadership and further enhance integrated quality across the system.
 - A single contract negotiation for hematology analyzer at three organizations improving turnaround time and providing system savings of \$500,000.
 - An additional \$1m in revenue anticipated over a 12 month period was initiated in fall 2015 resulting from a transfer of microbiology testing from Central Ontario Hospital Procurement Association to the regional microbiology program in Hamilton.
- Diagnostic Imaging (DI): All HNHB LHIN hospitals were 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 continues to be facilitated through a LHIN-Wide DI Steering committee, to align and integrate administrative and clinical practices for DI across all HNHB LHIN HSPs:

- To understand the challenges in young people (pediatrics up to the age of 18) receiving timely access to pediatric Magnetic Resonance Imaging (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 and potential opportunities to improve access were identified.
- DI Leaders from across the LHIN participate in the National Early Adopter Network of Choosing Wisely Canada to learn about effective methods to ensure appropriateness of MRI and Computed Technology (CT) scans.
- A hospital CEO and DI Chief were identified to enhance the leadership of the DI Steering Committee and revise terms of reference (TOR) to strive for future alignment.
- Initial work on patient priority booking template realignment was started to ensure more timely access for patients with more urgent clinical needs.
- Identification of rapid protocol times across the LHIN relating to MRI scans of: brains, cervical spine, thoracic spine, lumbar spine, knees and shoulders was completed.
- Ophthalmology: All HNHB LHIN hospitals completing cataract surgery continued to be engaged in planning to target improved wait time performance with regards to the MLPA target:
 - The HNHB LHIN Ophthalmology Leadership Committee continues to support the implementation of the LHIN-wide five year CSP for vision.
 - Transparent sharing of cataract surgeon wait times through hospital websites was sustained to improve the ability of all physicians and eye care professionals 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 teleophthalmology screening program for patients with diabetes who were not receiving annual screening for diabetic retinopathy was sustained, improved and enhanced to include glaucoma screening.
 - Knowledge transfer on smoking cessation strategies were shared with ophthalmology steering committee members to support population and public health strategies due to the high smoking rate in the HNHB LHIN and the impact on patient's vision.
- Orthopedics and Total Hip and Total Knee Replacements: The HNHB LHIN Orthopedic Leadership Steering Committee continues to work to develop and implement LHIN-wide improvement strategies. These strategies consist of the following LHIN-wide initiatives:
 - Implementation of standardized pre and postoperative physician order sets, patient care pathways and patient educational material for total joint replacements (TJR).
 - Hip Fracture Working Group has established partnerships between organizations for the management of hip fracture patients. The working group has developed a plan to implement the Hip Fracture QBP Clinical Handbook and develop standardized processes across all hospitals.
 - Implementation 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.
 - Increased volume of patients seen through RJAP in Niagara region with additional resource at NHS St. Catharines site.
- Centralized Intake/Coordinated Access: The HNHB LHIN continued with readiness activities to prepare clinical program areas for the development of centralized intake mechanisms, including initial developments of standardized referral forms and primary care engagement. The HNHB LHIN has also collaborated with other LHINs within the south west cluster to:
 - Share intake workflows and common referral forms for the purpose of designing central intake systems.
 - Collaborate with Waterloo Wellington (WW) LHIN to participate in a market sounding exercise to understand potential for electronic centralized intake solutions.

PART 2: GOALS and ACTION PLANS

Goal (s):

To support system-wide improvements, integrated clinical program committee structures will support and align the development of consistent standards, data and evidence driven processes, and quality outcomes for patients, to achieve one clinical program across multiple sites. This will be achieved through a phased approach and aligned with provincial quality-based procedures in Ontario.

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.
- Protect and sustain current clinical services by enhancing appropriateness of care.
- Inform people and patients through data and education to make the best decisions about their health.

Care for patients will be improved through the planning, implementation and evaluation of LHIN-wide integrated clinical programs:

- Cancer
- Laboratory Medicine
- DI
- Thoracic
- Vascular
- Orthopedics
- Ophthalmology

Engagement and leadership from hospital management and medical staff will drive and sustain integrated clinical programs in the HNHB LHIN, focusing on:

- The health needs of the population:
 - Enhance physician and leadership knowledge regarding Francophone and Indigenous Populations within the HNHB LHIN across integrated clinical areas.
- The services required to meet those needs:
 - Analysis of existing resources, patient demand, capacity to provide care and potential gaps.
 - Aligned volume allocation models and principles will be utilized as appropriate.
- The organization and integration of those services may include as appropriate:
 - LHIN sub-region planning.
 - Independent Health Facility (IHF) services.
- Through continuous monitoring and improvement the LHIN will work closely with hospital senior leadership to monitor progress toward system level indicators, to identify opportunities for improvement, and to organize potential additional program areas for LHIN-wide integration.

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 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, including the unique needs of the Francophone and Indigenous populations. These priorities align with the *Patients First: Action Plan for Health Care* announced by Minister Hoskins in February, 2015, and the Discussion Paper entitled *Patients First: Proposal to Strengthen Patient-Centered Health Care in Ontario*, released on December 2015 to support health system improvements needed to meet the needs of Ontarians:

○ Access- Improve access –providing faster access to the right care. ○ Connect- Connect services –delivering better coordinated and integrated care in the community, closer to home. ○ Inform-Support people and patients –providing the education, information and transparency they need to make the right decisions about their health. ○ Protect- Protect our universal public health care system –making decisions based on value and quality, to sustain the system for generations to come. • The ECFAA • FLSA • AHN Priorities							
Action Plans/ Interventions: “We will deliver the following”		Please indicate the status of project (Not Yet Started, In progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
		2016-17		2017-18		2018-19	
Examples:		Status	%	Status	%	Status	%
Laboratory Medicine Program:							
To review the CoLabs governance model for future sustainability.		Not yet started	100				
To develop a comprehensive strategic plan for Laboratory Medicine within the LHIN.		In progress	100				
Develop a standardized Request for Proposal (RFP) for transfusion medicine equipment to facilitate future integration of LHIN-wide service delivery.		In progress	100				
Sustain and enhance quality improvement performance measures across the LHIN through quality management and medical directors.		In progress	100				
Continue as early adopters for Choosing Wisely protocols expanding the spread of work done Emergency Departments (EDs), urine cultures to all hospital sites.		In progress	50	Complete	50		
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		25	Complete	25
Identify LHIN-wide opportunities for improvement through current state assessments within DI services, such as rapid assessment benchmark times.		In progress	25	Complete	75		
Complete a review of opportunities for improvements for pediatric MRI access for Priority 4 (non-urgent) cases.		In progress	100				
Implement a common referral form for MRI and CT referrals within the LHIN to support an opportunity for future centralized, coordinated access to DI services.		In progress	50	Complete	50		
Ophthalmology (Vision Care):							
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, while enhancing understanding of capacity, demand and gaps in care.		In progress	25	Complete	75		

To continue to understand variation in patient access to timely cataract surgery across the LHIN and through sub-region planning work to reduce variation through aligned strategies and oversight by the Steering Committee.	In progress	25		50	Complete	25
Improve Ophthalmic Surgeon's awareness of their Wait 1 and Wait 2 times to enhance patient's timely access to care through data analysis and surgeon scorecard use.	In progress	50	Complete	50		
Review surgical booking management optimization and intake processes to improve timely access to surgical care for cataracts.	In progress	25		50	Complete	25
Orthopedics and Total Hip and Total Knee Replacements						
Oversee strategies to achieve LHIN-wide wait time targets for TJR surgery and maximize performance with existing volumes, including development of a telemedicine opportunities	In progress	25		50	Complete	25
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	50		25	Complete	25
Evaluate effectiveness of partnerships between small and large hospitals for the management of hip fractures.	In progress	25		25		25
Review surgical booking management optimization to improve timely access to surgical care for joint replacement.	In progress	50		30	Complete	20
How will we measure success?						
- Individuals will have timely access to the most appropriate specialized service at the most appropriate location: - Identification of program size, scope and distribution for clinical services, with creation of defined implementation plans as needed. - Implementation and ongoing monitoring of evaluation and performance metrics, including the following MLAA performance and monitoring indicators: - Sustained or increased percentage of surgeries completed for priority 2-4 within wait time targets (cancer, cataract, hip and knee). - Sustained or Increased percentage of diagnostic scans (MRI and CT) completed for priority 2-4 within wait time targets. - Wait times for specialized procedures will be reduced: - Improved access to timely specialist care (Wait 1) and treatment (Wait 2) with necessary care provided closer to home. - Programs will follow common care standards and approaches, across hospital sites: - Adoption of common assessment, referral, placement/admission, and 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. - Programs will demonstrate consistent commitment to leading practice and quality standards: - Maintenance of LHIN-wide hospital participation in CSP tables with standardized quality measures.						

What are the risks/barriers to successful implementation?
• In-year priorities may delay or defer goals/activities as outlined. • Practice, cultural and change management barriers – different styles of practice, organizational culture and administration/operational demands may lead to challenges in aligning practices. • Human Resources (HR) labour agreements may impact the timing, distribution and implementation of resources distributions. • Limited resources may be allocated to change management strategies, to build coherent new teams and units.
For each risk/barrier, describe the plan to mitigate the risk?
• Goals/activities will be prioritized if new in-year priorities are added. • Engage physician and administrative leadership in processes. • 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.
What are some of the key enablers that would allow us to achieve our goal?
• Physician and leadership engagement and alignment. • Distribution of wait time hours and QBP volumes based on population needs and to those providers delivering the highest quality services with best patient outcomes. • Consistent use of integration planning tools, templates and processes utilized throughout clinical services and integration planning to ensure success of our goals.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).

v. 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 "<i>Patients First: Ontario's Action Plan for Health Care</i>", speaks of 'putting patients first' by: • Focusing on the person and not the illness. • Providing care that is coordinated and integrated. • Helping people understand how the system works so they can access the right care in the right place. • Engaging patients when making changes to the health care system. The HNHB LHIN-wide population-based strategies refer to service delivery models/programs and supports the Minister's Action Plan by focusing on specific populations with the goal of optimizing their health status (wellness) while supporting their healthcare needs. This is achieved by ensuring each strategy considers the following principles: • Access that is equitable, timely and optimizes opportunities to provide care in the community setting (right care in the right place). • 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. • Services are coordinated, integrated and transitions across the continuum are seamless from the person's perspective • Programs and/or services are coordinated with other initiatives (not duplicated).

- Information/knowledge of program resources are readily available to primary care, health service providers and the public.

This approach supports the HNHB LHIN's direction to focus planning and delivery of healthcare services at geographically integrated sub-LHIN regions. LHIN strategies such as restorative care have been implemented through a standardized delivery model across LHIN sub-regions. Specific population-based strategies that will be a focus of LHIN activities over the next three years include:

- Older adults and caregivers.
- Persons transitioning across the health care continuum.
- Persons with complex and chronic health conditions (Cerebral vascular accident – Stroke, Diabetes, COPD, CHF, Acquired Brain Injury (ABI) and Dementia).
- Persons who would benefit from a Hospice/Palliative approach to care or end-of-life care.
- People who suffer from a mental health condition or addictions.
- Children and youth (including maternity).
- Health and wellness of Indigenous Peoples.
- Access to French Language Services (FLS) for the Francophone population.

Initiatives planned and implemented within each of these strategies will consider the cultural and healthcare needs of the LHIN's Indigenous Peoples and Francophone population.

Current Status:

Older Adults and Caregivers:

- The LHIN's population, similar to Ontario's and other jurisdictions, is aging. In 2015, over 260,000 people age 65 or older lived in the HNHB LHIN. This number is projected to increase to 360,000 by 2025, with the greatest growth occurring in the population age 75 years and older.¹⁰ In addition to managing their own health issues, older adults may fulfill a caregiver role for their spouse or another family member.
- To support older adults and caregivers, HNHB LHIN activities have focused on:
 - Enhancing access to restorative programs that maintain or improve functional and cognitive status.
 - Adoption of best recommendations that facilitate standardized care across LHIN rehabilitative programs.
 - Enhancing processes to support caregivers knowledge of and access to respite services.
- In 2015-16, a Smart Mobile Assess Restore Team (SMART) model was fully implemented across six HNHB LHIN hospital sites. This program targets seniors who are at risk of functional decline at their time of admission to hospital. The SMART model provides hospitalized seniors that have restorative capacity with access to a mobile 'dedicated inter-professional team-based integrated model'. Interventions are provided to patients in their current location i.e. ED or acute care with the exception of individuals admitted to a restorative or rehabilitation bed. As of September 2015, 1363 individuals were seen by SMART teams and 81% were discharged home.
- The HNHB LHIN continues to support restorative programs located across the HNHB region that include; Assess Restore (AR), Slow Stream Rehab and Convalescent Care. These programs, which total 187 beds in 2015-16, support individuals who need access to restorative care to regain their optimal functional status following an acute illness. As of September 2015, programs reported that 79% of individuals admitted were discharged home.¹¹
- In 2015-16, Ontario LHINs supported a second two year mandate for the Rehabilitative Care Alliance (RCA). This initiative is a collaborative effort of 14 LHINs to affect positive changes in rehabilitative care that focus on supporting improved patient experiences and enhancing the adoption and effectiveness of clinical and fiscal priorities.

¹⁰ Population Projections, LHIN, Ontario Ministry of Health and Long Term Care, IntelliHEALTH Ontario

¹¹ HNHB LHIN level data, health service provider Q2 2015 assess restore and slow stream rehabilitation reports.

- To support caregivers' access to respite services in 2015-16, the HNHB LHIN collaborated with LHIN-funded community respite providers to streamline and coordinate access to respite services.
- The HNHB LHIN has 85 Long-Term Care Homes (LTCH) with over 10,300 beds. The LHIN's occupancy rate for May 2015 was 99% with the average length of stay reported at 2.9 years.¹² The HNHB LHIN reports minimal idle beds on a weekly basis.
- In October 2014, the Ministry announced an Enhanced LTCH Renewal Strategy to redevelop approximately 31,000 LTCH beds impacting 300 LTCHs across the province. The HNHB has 42 LTCHs for a total of 3,883 beds that need to be redeveloped by 2025. All LTCHs with beds identified for redevelopment were required to complete a ministry survey as to the status of their redevelopment plans.

Transitions Across the Health Care Continuum:

- The majority of people admitted to hospital return home when their care is completed, however; patients can experience barriers when transitioning from hospital to the community for reasons that extend beyond the healthcare system.
- These barriers can be rooted in social determinants of health such as income, social/family support network and physical environment.
- Overall patient flow in hospitals can be impacted by a number of factors including, but not limited to:
 - Increased demand – since April 2008, overall ED visits in the HNHB LHIN have increased by 29% (36,522 in April 2008¹³ to 47,232 reported in September 2015¹⁴). In 2015, the HNHB LHIN reported the second highest admission rate in the province¹⁵, increasing demand for in-patient hospital services.
 - Increased complexity – since April 2008, ED visits for complex patients (CTAS I-III non-admitted and all admitted CTAS I-IV) have increased by 60% (21,716 April 2008¹⁶ to 34,787 reported in September 2015).
 - Access to discharge destinations – in 2015-16, the number of people waiting for an alternate level of care (ALC) ranged from 406 to 469. Of note: the provincial definition of ALC is a person occupying a bed in hospital that no longer requires the intensity of resources/services provided in a care setting (acute, complex care, mental health or rehabilitation), must be designated ALC by the physician or her/his delegate.¹⁷
- Opportunities to facilitate smooth transitions across the health care continuum requires a range of partners to work together in a new and innovative way to establish a local health system where transitions from a patient's perspective are seamless or for select populations are supported.

Complex and/or Chronic Conditions:

- Ontario's population is aging and while people are living longer, a growing number of older adults are living with the combined effects of a decline in physical function, medical problems and the development of chronic diseases. As people age they may be further confronted with the challenges of dementia.¹⁸
- The HNHB LHIN is working with HSPs and other stakeholders with a focus on specific complex/chronic conditions to:
 - Provide people with the knowledge and tools to manage their chronic conditions.
 - Improve access to services and specialist care, including priority populations such as Indigenous Peoples.
 - Increase access to evidence-based models of care that demonstrate improved outcomes.
 - Optimize opportunities to increase access to community based care.

¹² MOH LTCH System Report for May 2015. Released October 2015.

¹³ Access to Care (April 2008), ER Historical Public Reporting & P4R Hospital Comparison Report.

¹⁴ Access to Care (November 2015), ER Fiscal Year Report.

¹⁵ Ibid.

¹⁶ Access to Care (April 2008), ER Historical Public Reporting & P4R Hospital Comparison Report.

¹⁷ Access to Care (2015), Alternate Level of Care Provincial Definition.

¹⁸ Walker David. Caring for our Aging Population and Addressing Alternate Level of Care. June 2011.

Diabetes:

- As of June 2014, 134,106 people were living with Diabetes across the HNHB LHIN; this represents 12% of the HNHB LHIN population and is the third highest across all Ontario LHINs.¹⁹ This has increased from 8% in 2011-12.²⁰
- Diabetes Education Programs (DEPs) provide tools and skills needed to support people living with or at risk of developing Diabetes, and are located across the HNHB region:
 - The HNHB LHIN funds eight Adult DEPs at the following sites: Bridges Community Health Centre (CHC), North Hamilton CHC, Centre de santé communautaire Hamilton-Niagara (CSCHN), (BCHS), HHSC, Niagara Health System (NHS), SJHH, and Norfolk General Hospital (NGH).
 - The HNHB LHIN also funds four Pediatric DEPs which are located at HHSC, NHS, BCHS, and JBH.
 - In addition to the LHIN-funded DEPs, there are three ministry-funded DEPs: Caroline Family Health Team (FHT) DEP, Garden City FHT DEP, and Niagara Medical Group FHT DEP; as well as two Aboriginal DEPs: Six Nations DEP, De Dwa Da Dehs Nye>s Aboriginal Health Access Centre (DAHC); and one Diabetes Initiative: Southern Ontario Aboriginal Diabetes Initiative (SOADI).

Stroke:

- The HNHB LHIN continued to show improvements in stroke indicators. The Ontario Stroke Network (OSN) annual report card demonstrated improvements in eight indicators from the previous report card.²¹ The LHIN is the top performer for tPA indicators: door-to-needle (DTN) time and proportion who receive tPA.²²
- Integrated stroke unit (ISU) care has been implemented in Hamilton, Brant, Haldimand and Norfolk. The establishment of an ISU at BCHS in June 2013 has been shown to improved access to acute stroke unit care at BCHS from 34.3% to 84.4%.²³ In addition, the opening of the ISU has resulted in an increased proportion of patients discharged to inpatient rehabilitation in the HNHB LHIN to 36.4%.²⁴
- Further integration opportunities have been identified in Hamilton, Burlington and Niagara.
- A successful Community Stroke Rehabilitation Model (CSRM) is ongoing in Brant, Haldimand and Norfolk. The HNHB LHIN has engaged with JBH and the Central South Regional Stroke Network to develop and implement an ISU model in Burlington.

COPD and CHF:

- Due to their progressive nature, COPD and CHF are the two most common reasons for readmissions to hospital in the HNHB LHIN. Although the rate of readmissions for CHF has remained relatively constant, the rate of readmissions due to COPD has shown a downward trend from 2011 (20.3% readmission ratio) to 2014 (18.5% readmission ratio).
- A community-based resource for individuals with COPD called “Caring for my COPD” was implemented at four sites in 2014-15. In 2015-16, this program began offering outreach sites in areas with an identified high level of need including Norfolk and Niagara regions. Additionally, sites were able to offer improved transportation support for clients to attend the program.
- The HNHB ICCP is being implemented across all HNHB LHIN acute care hospital sites for hospitalized patients with a diagnosis of COPD and/or CHF who will be discharged home. These patients will be followed and receive home care for up to 60 days post hospital discharge.
- Key features of the program include integrated care coordinators to develop and manage personalized action plans, standardized care pathways, timely access to medical expertise, and 24/7 availability of a care team member.

ABI:

- A review of HNHB LHIN ABI resources identified long wait times to access residential programs and limited access to community transitional bedded programs.

¹⁹ Key Performance Measures for the Ontario Diabetes Strategy. June 2014. Health Analytics Branch, Ministry of Health and Long-Term Care.

²⁰ Statistics Canada, Canadian Community Health Survey, 2011-12.

²¹ Ontario Stroke Network Report Card 2013-14.

²² Ontario Stroke Network Report Card 2013-14.

²³ Brant Community Health Care System schedule 1 Q2 2015/16 report to the HNHB LHIN

²⁴ Ontario Stroke Network Report Card 2013-14.

Through the review, the LHIN identified an opportunity to enhance ABI services within the HNHB region through the development and implementation of a community transitional program.

Dementia:

- The prevalence of dementia in the HNHB LHIN is increasing, and evidence shows that caregivers providing care to persons with moderate to severe cognitive impairment are more likely to report physical, emotional, financial or social distress.^{25,26,27}
- HNHB LHIN Dementia Network has been reconvened and has a renewed focus on positively impacting the experience of those living with dementia, their families and caregivers.
- The HNHB Dementia Network has engaged multiple stakeholders at local and provincial levels to ensure alignment of an HNHB dementia strategy.

Hospice Palliative Care (HPC):

- In 2015-16, the LHIN's Hospice Palliative Care Regional Council developed a three year work plan that focused on four priority areas that align with the Declaration of Partnership and Commitment to Action. These include:
 - Broader access and increase timeliness of access for all patients and their families who could benefit from a palliative care approach.
 - Strengthening hospice palliative care service capacity and human capital in all care settings.
 - Improving integration and continuity of hospice palliative care service delivery across all care settings.
 - Strengthening accountability and introduce mechanisms for shared accountability for hospice palliative care across the HNHB LHIN.
- The HNHB LHIN continues to support patients to receive hospice palliative care in the community, hospitals and LTCH settings.
- The LHIN provides funding to five Residential Hospices for a total of 42 beds through funding provided to the HNHB CCAC for personal support and professional (nursing) services. The HNHB LHIN also supports Good Shepherd Centre Hamilton's Emmanuel House, a ten bed assisted living program that provides residential palliative care services. As of November 2015, 562 individuals have received care at the residential programs.²⁸
- Other palliative care assets in the HNHB LHIN include:
 - Interdisciplinary Palliative Care Shared Care Outreach Teams located across the HNHB LHIN.
 - Palliative Care Volunteer Visiting Program.
 - Palliative Pain and Symptom Management Consultant Program.
 - Prevalence of Alternate Forms of Physician Payments.
 - Interdisciplinary Community-Based and Physician Education Programs.
 - Links to McMaster Department of Family Medicine and Division of Palliative Care.
 - Two Cancer Centres (Hamilton and Niagara).
 - 100 designated hospital based complex care end of life beds.

Mental Health and Addictions (MHA):

- In Ontario, the MHA sector is characterized by a multitude of service and support providers, of agencies and of levels of government accountability, and of funding sources. Furthermore, stigma is a barrier across the sector and across society as a whole.
- Ultimately, this results in barriers for individuals trying to navigate the system, and a lack of coordination across existing services.

²⁵ Sinha, S. K. Living Longer Living Well. MOHLTC. December 2012.

²⁶ Canadian Institute of Health Information, Supporting Informal Caregiver-The Heart of Home Care August 2010.

²⁷ Alzheimer's Society of Ontario, Dementia Evidence Brief: HNHB LHIN. July 2012.

²⁸ HNHBCCAC HNHB LHIN Hospice Data April to November 2015. CHRIS Database.

- The MHA sector within the HNHB LHIN is yet another complex system in and of itself. There are 38 organizations that are located in and funded by the HNHB LHIN (either as its sole funder, or as one of multiple or many funders) to provide mental health and/or addictions services.
- This includes five hospital organizations who provide both inpatient and outpatient services, and 33 community service providers (HNHB LHIN Self Reporting Initiative (SRI), 2015). Those 38 organizations operate 530 inpatient beds (including 88 forensic beds) and 261 programs at 97 sites (ConnexOntario, 2015).
- In order to meet the unmet need and demand for this population a shift in how strategic planning and resource allocation has historically occurred in the HNHB LHIN is required. The strategic planning process currently underway has shifted from funding based on past-year allocations to focused investments in integrated service delivery that meets the needs of targeted populations.

Maternal Child & Youth:

- The LHIN continues to support and engage with provincial and regional Maternal Child and Youth networks. 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.
- The Southern Ontario Maternal Child Network (SOMCHN) promotes and supports the regional coordination of services and recommends integration opportunities by bringing clarity to roles and addressing gaps and redundancies in services.
- Where appropriate, the LHIN works in partnership with PCMCH and SOMCHN to support and implement resulting recommendations.

Key Issues:

- Lack of clarity for patients, family members and referring partners related to the population served and services available within rehabilitative care.
- Competing priorities for health service providers with health service providers identifying the need to prioritize and stage involvement in health care improvement initiatives.
- The resources required to implement best practice recommendation for community stroke rehabilitation across the LHIN.
- The increasing number of individuals newly designated ALC. The HNHB LHIN has seen a 30% increase in the number of people designated ALC each month in hospitals (490 August 2011 to 627 in November 2015).²⁹
- Access to affordable subsidized assisted living / supportive housing options.
- Access to supervised supportive housing and/or group homes for the population with acquired brain injury (ABI) and Developmental Disabilities.
- Access to basic male secure LTC home beds.
- The increasing proportion of individuals identified with behavioural needs and supports as a barrier to discharge from hospital.³⁰
- Technology that supports documentation and sharing of information between Palliative Shared Care Outreach Team members.
- The LHIN's ability to meet the expectations of HNHB LHIN LTCHs with respect to Behaviour Supports Ontario (BSO) resources, when reports that favor and support embedding BSO resources within each LTCH over the LHIN's current BSO LTCH Mobile Team model.

Successes of past year:

Transitions – Patient Flow

- Expansion of the Transitional Bed Program which began in October 2014 to 15 sites (170 beds) across Hamilton, Burlington, Niagara and Brant communities. The program provides an alternative, community based option for individuals ready for discharge from acute care hospital beds but are unable to return home to pre-hospital living arrangements.

²⁹ Access to Care, ALC Throughput Ratio Report.

³⁰ Access to Care (November 2015), HNHB LHIN Monthly ALC Performance Summary Report.

Individuals accessing the program are medically stable and ready for discharge from hospital. The program provides an environment that supports individuals to recover their strength and independence along with the time to be able to plan for the most appropriate permanent, community based living arrangements.

The program has accumulated >27,977 days - avoided Hospital ALC days.

- Implementation of Standardized Discharge Practices and Processes supporting the Home First Philosophy across LHIN hospitals.
- 106 fewer people waiting in hospital for an alternate level of care (441 November 2015 compared to 547 in November 2014) and 17,257 fewer ALC days for the same reporting period.³¹
- Targeted strategies to improve patient flow have been noted in the improved time to in-patient bed at the following sites from previous fiscal year (2014-15) to Q2 2015-16:
 - 64% improvement at NGH – 15.0hrs to 5.3hrs.
 - 48% improvement at West Lincoln Memorial site – 44.9hrs to 23.2hrs.
 - 47% improvement at JBH – 46.5hrs to 24.5hrs.
 - 45% improvement at Greater Niagara General site – 43.5hrs to 23.8hrs.
 - 38% improvement at Welland site – 32.7hrs to 20.2hrs.
- Recognition letters received in 2015 from the ministry identifying outstanding performance ED performance by the following LHIN hospitals:
 - Greatest improvement in 90th percentile ED LOS:
 - St. Catharines General site – high volume hospital group.
 - Greater Niagara General site – medium volume hospital group.
 - Welland site – low volume hospital group.
 - SJHH – teaching hospital group.
 - Lowest 90th percentile ED LOS:
 - Haldimand War Memorial Hospital – medium volume hospital group.

Older Adults – Restorative:

- An evaluation of the SMART program for its impact on ALC designation/days/need for restorative programs for specific populations showed positive results (1,363 individuals admitted to SMART program):
 - 23% decrease in the number of ALC days for patients discharged to Complex Care-Low Tolerance Long Duration (LTLTD) which includes assess restore and complex care restorative (3,744 ALC days for April 1st 2015- September 30 2015 compared to 4,886 ALC days between April 1st 2014 to September 30th 2014).³²
 - Lower acute ALC rate for SMART participants as compared with the HNHB LHIN acute ALC rate as measured by HNHB LHIN acute ALC rate 16.6% September 2015,³³ compared to SMART participant's acute ALC rate 15.1% September 2015.³⁴
 - 81% of individuals discharged home from acute care (Source: six hospital HSP reports)
 - 28% increase in patient function from admission to discharge as measured by pre and post Barthel activities of daily living index (Source: two hospital HSP reports).
- Developed HNHB LHIN SMART evaluation logic model and Pan-LHIN Assess Restore Enhanced Service Delivery evaluation logic model both of which informed the provincial Pan-LHIN logic model developed by the RCA to reflect AR initiatives across all 14 LHINs.
- As of September 2015, 79% of individuals admitted to HNHB LHIN restorative programs were discharged home.³⁵
- A review of LHIN restorative programs against the ministry AR Guideline as well as the new standard definitions for rehabilitative care revealed that the programs align with the new “activation/restoration” level of rehabilitative care.

³¹ Access to Care (November 2015), ALC Trending Report.

³² HNHB LHIN level data from 6 month period from April 1 2015-November 30 2015 compared to the same 6 month period in 2014 for the 6 hospitals with SMART implemented. Access to care iPort.

³³ Access to care iPort

³⁴ Six hospital health service provider reports.

³⁵ HNHB CCAC Transitional Care Program Report 2015-16 Q2 Report September 2015.

- As of March 31, 2016, a local HNHB Rehabilitative Care Alliance (RCA) virtual network was established to implement the provincial standard definitions for rehabilitative care. In December 2015, 72 rehabilitative care providers in the HNHB LHIN completed a mapping tool to assess the current rehabilitative care programs against the standard definitions for rehabilitative care developed by the RCA.
- Areas of misalignment/challenges and opportunities to support alignment with the new definitions were identified.
- Consistent referral and information package for Convalescent Care across all Convalescent Care provider sites.
- Expansion of convalescent program to provide care closer to home for Niagara On The Lake residents. Pleasant Manor LTCH agreed to implement a 12 bed convalescent program.
- As of September 2015, the LHIN's BSO programs reported:
 - BSO Connect, 'one place to call', linked 739 clients to services. One hundred percent of caregivers/clients that called were connected to service. Sixty one percent had no prior services before calling BSO Connect.
 - Community Outreach (Crisis) Team served 643 clients and discharged on average 73% with longer-term community supports in place to prevent future crisis.
 - BSO Hospital Clinical Lead a new initiative implemented to support persons diagnosed with cognitive impairment and responsive behaviours where their history of, or existing behaviours, presented a barrier to discharge. In the first four months of operation the two Clinical Leaders successfully diverted five persons waiting to access a behavioral assessment bed to LTC and two individuals waiting for LTC to Retirement Home, 72 medically and behaviourally complex inpatients have either been successfully transitioned to, or are on the path to, settings that require less resources than acute care settings. A review of Integration Decision Support (IDS) data the average LOS for individuals waiting ALC where behaviours identified as a specialized care need has decreased from 37.33 days per patient to 23.93 days per patient when comparing the same time period without the Clinical Leader support in 2014-15 and with the Clinical Leader support in 2015-16.
 - BSO LTCH Mobile Team:
 - Supported 803 clients transitioning to/from LTC. The team has experienced a 232% growth in transitions compared to the same period last year. Referrals for transitional support contribute to over 50% of all LTCH Mobile referrals.
 - Served 638 clients and together with the transitional support provided 23,245 is the number of direct client-based services/interaction.
 - 94.7% of LTCH Home staff surveyed (N= 38) report the information the BSO LTCH Home Mobile team provided was helpful; 89.5% were satisfied with the BSO transitional support provided, and 92.1% reported they would refer to the BSO transitional support again.
- Wellness – the LHIN participated in 15 community site visits to obtain direct feedback from participants and explore opportunities to standardize LHIN-funded Falls Prevention and Exercise classes. Between April 2015 and December 2016, approximately 6,919 individuals participated in Falls Prevention and Exercise classes across 189 sites in the HNHB region.

Diabetes:

- Three percent increase in number of individuals accessing a LHIN-funded Diabetes Education Program (DEP) program in the HNHB LHIN comparing the first two quarters of 2014-15 and 2015-16.
- Introduction of self-referrals for DEP programs. Three hundred and forty individuals accessed a DEP program through self-referral at Q2 2015-16.
- Improved access to specialized services for Six Nations DEP and DEP clients:
 - Partnership with HHSC DEP developed for regular clinical consultations with advanced DEP team (Nurse Practitioner, Clinical Nurse Specialist, and Advanced Dietitian) and Six Nations DEP team through OTN.
 - Knowledge transfer and capacity building through Six Nations DEP team job shadowing with HHSC DEP team.
 - Direct referral access to Nephrology consultation for DEP clients with mild to moderate renal insufficiency that are unattached to primary care.
- Development and endorsement of a coordinated access model to improve and standardize access to DEP programs.
- Planning and coordination of LHIN-funded Paediatric Diabetes Education Programs (PDEPs) was initiated through formation of a Paediatric Diabetes Leaders Committee.

- This includes working with the PCMCH and the ministry to implement a
- New standardized reporting methodology for PDEPs for 2015-16. As of Q2 2015-16, 772 children and youth with diabetes have accessed a PDEP, for a total of 3928 clinical interactions.³⁶

Stroke:

- Completed final evaluation report of Community Stroke Rehab Model (CSRM) results. Cost analysis reveals a potential cost avoidance of \$564.95 per person due to decreased inpatient rehabilitation LOS as well as potential inpatient rehabilitation admission avoidance.
- Decreasing trend in average LOS within inpatient rehabilitation with launch of integrated stroke unit (ISU) and launch of CSRM, with an average decrease of 6.6 days. Individuals post mild, moderate and severe stroke all demonstrated improvements in reintegration to normal living and functional independence. Ninety percent of individuals achieved their goals.
- Individuals received timely access to in-home rehabilitation services within three days. Care was delivered by a consistent team over 80% of the time.
- In December 2015, JBH received the final approval as a telestroke site to improve technology enabled access to neurology consultation regarding administration of the clot busting medication (tPA) in the ED.

ABI:

- An ABI/Stroke Community Transitional Program Advisory Committee has been formed and a current and future state value stream has been completed for the development of an integrated ABI system.
- HNHB LHIN Board approved funding to support the development of a community transitional ABI-Stroke Program.

COPD:

- As of November 2015, 956 individuals have been enrolled in the "Caring for MY COPD" program since its inception.
- The ICCP was one of six projects chosen to participate in the provincial Integrated Funding Model project. The phased implementation of the ICCP program started in September 2015, with JBH (Burlington) enrolling patients in October and HHSC targeting to enroll patients in Winter 2016.

Dementia:

- Funded Self-Care for the Caregiver program through the Alzheimer Society of Brant, Haldimand Norfolk, Hamilton and Halton, which will educate caregivers on how to support themselves and care recipients with dementia.

Hospice Palliative Care:

- Development of a three year Work Plan for the HNHB Hospice Palliative Care Regional Council with specific deliverables and timelines.
- Early identification working group recruited three LHIN providers to pilot the Early Identification and Prognostic Indicator Guide. Training undertaken in January 2016.
- 96.4% of LTCH completed a survey relating to Advanced Care Planning reporting that 99% of homes review the advanced care plan with the resident or Power of Attorney/Substitute Decision in Maker (POA/SDM) with any change in condition.

MHA:

- Promote resiliency and well-being in Ontarians:
 - Expanded existing evidence-informed training for families, caregivers and other non-health professionals across the LHIN, specifically, Mental Health First Aid, Safe Talk, Applied Suicide Intervention Skills Training [ASIST], and Talking About Mental Illness [TAMI].
 - Expanded evidence informed training opportunities for Francophone and Indigenous populations

³⁶ HNHB Paediatric Diabetes Education Program (PDEP) Quarterly Statistical Reports, Q2 YTD 2015-16.

- Ensure early identification and intervention:
 - Enhanced and expanded early intervention services for youth ages 17 - 24, including opening of the Youth Wellness Centre in Hamilton and expanding the Early Intervention programs in Niagara and Six Nations and De dwa da dehs nye Aboriginal Health Centre.
 - Implementation of a Youth Mobile Outreach team in partnership with colleges, universities, street-involved and homeless youth organizations and methadone clinics.
- Expand housing, employment supports and diversion and transitions from the justice system:
 - Expanded mobile crisis rapid response teams and crisis intervention training (CIT) with Police across the LHIN in specific geographic sub-regions within the HNHB LHIN.
- Provide the right care, at the right time, and in the right place.
 - Enhance existing successful training programs for specialized therapies/interventions for health professionals, including sustaining achieved outcomes and spreading implementation further across the LHIN: Dialectical Behavioural Therapy (DBT) and Collaborative Assessment and Management of Suicidality training and supervision.
 - Expand Assertive Community Treatment (ACT) team services in Niagara through the implementation of a second ACT team.

Maternal Child and Youth:

- 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.
 - MHA 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 2016-17 LHIN-wide population based strategies are in place and have the following goals.

Transitions Across the Health Care Continuum:

- Reduce the number of days individuals wait in hospital for an alternate level of care (ALC) through:
 - Optimizing and exploring opportunities to enhance access to community-based transitional programs for existing and new populations.
 - Decreasing ALC days to Behavioural Health Transition Units (BHTU) through BSO Clinical Leads ability to divert clients and successfully transitioning clients from hospital to community (including LTC) and improving flow through the BHTU's.
 - Decreasing ALC days for individuals who are at risk of exhibiting responsive behaviours due to cognitive impairment from dementia or other neurological conditions by having a supportive plan when transitioning across the health care system.
 - Implementation of Home First Refresh ALC avoidance processes:
 - Early engagement and discharge planning - 48 hour conversation for admitted patients.
 - Referrals to CCAC 48 hours prior to ALC designation.
 - Family meetings prior to ALC designation.
 - Implement electronic solutions to support the implementation of the provincial Resource Matching and Referral (RM&R) standards for Acute to CCAC. Explore electronic solution for RM&R for Acute to Rehab & Complex Care.
 - Implement electronic solution for ED notification to CCAC, hospitals and primary care.

- Admission Avoidance strategies for the population presenting to the ED with no medical reason to admit.
- JBH to pilot with opportunity for potential to spread.
- Implement and evaluate an integrated discharge planning role at two LHIN hospitals.

Older Adults and Caregivers:

- Improve access to LHIN-funded restorative programs by optimizing current capacity and resources; this will include:
 - Opportunities for earlier discharge through the referrals to in home rehabilitation.
 - Implement standard definitions for rehabilitative care developed by the RCA.
 - Utilize standardized provincial rehabilitative care capacity planning framework.
 - Develop a process for early identification of persons who would benefit from restorative programs (identified on admission).
- Continued implementation of the SMART Team model including an evaluation as to its impact on the person's outcomes including LOS, and ALC designation/days/need for restorative programs for specific populations.
- Identify sites where exercise and falls prevention programs are located and explore opportunity to incorporate other wellness programs i.e. diabetes education in collaboration with municipalities as appropriate (i.e. seniors wellness hub).
- Explore opportunities for sustainability of public funded exercise programs within retirement homes.
- In collaboration with LHIN-funded respite health service providers increase public awareness of available respite services and how to access them.

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

Diabetes:

- Improve access to Diabetes Services through the implementation of a standardized coordinated access model.
- Integrate Diabetes Services into Chronic Kidney Disease Clinics.
- Improve access to timely and appropriate paediatric diabetes care for children and youth through standardization of processes for accessing tertiary paediatric care.

Stroke:

- Develop an ISU model in Niagara in collaboration with senior leaders at NHS, the CSRSN and the district stroke coordinator.
- Identify opportunities that will facilitate the further integration of stroke services between HHSC and SJHH.
- Complete an evaluation of the CSRM to determine applicability to other LHIN areas and populations.
- Develop an ISU model in Burlington in collaboration with senior leaders at JBH and the CSRSN.

ABI:

- Development of a community transitional program that will be a component of an integrated Community ABI system that facilitates early community reengagement.

COPD and CHF:

- Implement the ICCP for COPD and CHF in all acute care hospitals by March 2016 and participate in the provincial evaluation of the program.

Dementia:

- Conduct environmental scan of dementia-related services in the HNHB LHIN to facilitate value stream mapping and development of dementia strategy.
- Complete an environmental scan of Memory Clinic resources within the HNHB LHIN.
- In consultation with provider networks, such as the Dementia Network, develop and implement a HNHB dementia strategy that integrates services, builds community capacity, enhances supports for caregivers and aligns with provincial directions.

Hospice Palliative Care:

- Evaluate the early identification guide pilot and based on outcomes, develop a plan for spread and sustainability.
- A regional education and implementation plan is developed and recommendations regarding funding and accountability are submitted to the LHIN.
- Establish a process for reporting on provincial indicators. Develop and initiate reporting on a set of regional indicators.
- Identify HNHB LTCH practices/processes related to Advance Care Planning (ACP) to identify best practices and opportunities for standardization.
- One hundred percent of HNHB LHIN LTCHs will have a standardized process for ACP based on best practices in place that is reviewed with staff annually.

MHA:

- The HNHB LHIN MHA Advisory Group has developed a three year MHA strategic plan and has established the following five goals to support this priority:
 1. Ensure alignment of the HNHB-LHIN MHA strategy with the overall MHA provincial strategy.
 2. Reduce variation and increase standardization of services and programs across the HNHB-LHIN.
 3. Increase capacity within the MHA sector to meet the needs and the demand of complex clients.
 4. Improve access to MHA services across the HNHB LHIN including increased MHA capacity with primary care, considering the unique needs of the LHIN's Indigenous and Francophone communities.
 5. Reduce stigma within the MHA sector.

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 SOMCHN, 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 Government of Ontario's 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 MHA strategy to enhance services for children and youth, consistent with Ontario's Moving on Mental Health Strategy.

Consistency with Government Priorities:

- The LHIN's population based strategies align with the Minister's Patient First Action Plan by promoting a coordinated, standardized and integrated approach to service delivery that puts the Patient First. Examples of how the LHIN's Population Based Strategies (to varying degrees) support the Action Plan's four key objectives are provided below:
 - Access:
 - Improve coordination of care for persons with complex medical conditions.
 - Improve support for caregivers caring for individuals with dementia.
 - Improve access to services and specialist care, including priority populations such as Indigenous Peoples.
 - Connect:
 - Increase access to restorative and convalescent care.
 - Improve access to hospice palliative care services/supports.
 - Inform:
 - Providing individuals with diabetes with the information needed to manage their condition and prevent complications.
 - Protect:
 - Implementation of innovative delivery models.
- In addition, the HNHB LHIN's population based strategies align with targeted priorities including HPC and Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action (December 2011).

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.					
	2016-17		2017-18		2018-19	
Examples:	Status	%	Status	%	Status	%
Transitions Across the Health Care Continuum						
Expansion of transitional bed program in the community.	In progress	25	Completed	75		
Decreasing ALC days to Behavioural Health Units through implementation of Clinical Leads and exploring opportunities to access services remotely.	In progress	50	Completed	50		
Implement and evaluate an integrated discharge planning role at two LHIN hospitals.	Complete	100				
Decreasing ALC days for individuals who are at risk of exhibiting responsive behaviours due to cognitive impairment from dementia or other neurological conditions by having a supportive plan when transitioning across the health care system.	Complete	100				
Explore electronic solutions to support the provincial RM&R standards for Acute to CCAC and Acute to Rehab and Complex Care and ED notification to CCAC, hospitals and primary care.	In progress	50	Completed	50		
Implementation of Home First ALC avoidance processes.	Complete	100				
Pilot admission avoidance strategy for population that presents to ED with no medical reason to admit (e.g., failure to cope) at one hospital site.	Complete	100				
Earlier discharge from restorative programs through referral to in home rehab	Complete	100				
Implement standard definitions for rehabilitative care developed by the RCA.	Complete	100				
Utilize standardized provincial rehabilitative care capacity planning framework.	Complete	100				
Assess the SMART model initiative for its impact on LOS, ALC designation/days/need for restorative programs for specific populations.	Complete	100				
Identify sites where exercise and fall prevention programs are located and explore opportunity to incorporate other wellness programs.	In progress	50	Completed	50		
Explore opportunities for sustainability of public-funded exercise programs within retirement homes.	Completed	100				
Increase public awareness of available LHIN-funded respite services and how to access them.	Completed	100				
Chronic/Complex Conditions:						
Reengage with NHS to develop and implement an ISU model.	In progress	50	Completed	50		

Identify opportunities to further integrate stroke services at HHSC and SJHH.	In progress	50	Completed	50		
Complete the evaluation of CSRM to determine applicability to other LHIN areas and populations.	In progress	100				
Engage with JBH to develop and implement an ISU model.	In progress	30		30	Complete	40
Development of a community transitional program that will be a component of an integrated Community ABI system that facilitates timely community reengagement.	In progress	20		50	Complete	30
Improve access to Diabetes Services through the implementation of a coordinated access model.	In progress	25	Complete	75		
Integrate Diabetes Services into Chronic Kidney Disease Clinics.	In progress	25		50	Complete	25
Improve access to paediatric diabetes care for children and youth through standardization of processes for accessing tertiary paediatric care.	In progress	50	Completed	50		
Implement the ICCP for COPD and CHF in all acute care hospitals by March 2016.	Complete	100				
Complete environmental scan of dementia related services in the LHIN, including memory clinics.	Complete	100				
In consultation with provider networks, such as the Dementia Network, develop and implement a dementia strategy that integrates services, builds community capacity, and enhances supports for caregivers.	In progress	25		50	Complete	25
Hospice Palliative Care:						
Evaluate the early identification guide pilot and based on outcomes, develop a plan for spread and sustainability.	Complete	100				
A regional education and implementation plan is developed and recommendations regarding funding and accountability are submitted to the LHIN.	Complete	100				
Establish a process for reporting on provincial indicators. Develop and initiate reporting on a set of regional indicators.	Complete	100				
Identify HNHB LTCH practices/processes related to ACP to identify best practices and opportunities for standardization.	Complete	100				
100% of HNHB LHIN LTCHs will have a standardized process for ACP based on best practices in place that is reviewed with staff annually.	Complete	100				
MHA:						
Enhance and expand Early Intervention Services	In progress	50		25	Complete	25
Enhance and expand Mobile Crisis Rapid Response Teams(First Responder Model)	In progress	50		25	Complete	25
Implement staged screening and assessment tools for addiction and concurrent disorders clients	In progress	25		25		25
Expand MHA training for HSPs	In progress	50		25	Complete	25
Improve transitions between the Child and Youth, and Adult MHA sectors	In progress	25		25		25
Maternal Child & Youth:						
Collaborate with SOMCHN and participate in activities as identified.	In progress	25		50		25

Continue to support and participate 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.	In progress	75	Complete	25		
Collaborate with the LHIN's MHA strategy to enhance services for children and youth, consistent with Ontario's Moving on Mental Health Strategy.	In progress	25		50		25
How will we measure success?						
- Decreasing trend in the LHIN's ALC rate towards the LHIN's MLAA target. - The number of people waiting in hospital for LTCH is maintained at less than 140. - Decreasing trend in the LHIN's ED LOS for complex population towards the LHIN's MLAA target. - Decreasing trend in the LHIN's 30 day readmission rate for selected HIG conditions towards the LHIN's MLAA target. - Improved coordination of services for individuals with dementia and their caregivers (number of completed integrated care pathways). - Reduction in ALC days and LOS for patients that received care through the mobile AR model. - Implementation of standard definitions for LHIN rehabilitative services developed by the RCA has been initiated. - Application of the standardized rehabilitative care capacity planning framework. - Increase in number of seniors who participate in LHIN-funded Falls Prevention and Exercise classes. - Decreased youth ED presentations for MHA. - Reduced MHA apprehensions by Police. - Reduced ED use post-MCRRT intervention. - Improved identification of co-occurring (mental health and addictions) disorders. - Increased access to evidence-based DBT interventions. - Improved client satisfaction with MHA services and access to care. - Improved timeliness of initiation of adult services for youth transitioning to the adult system. - Participation in SOMCHN activities as identified. - Special Needs Strategy Coordinated Service Planning tables will have completed their submissions to the ministry and initiated implementation.						
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 community respite services. - Capacity of HSPs to collect and report multiple performance measures to determine program outcomes. - Continuing rise 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. - Increasing trend in the number of individuals newly designated ALC. - The complexity of the mental health and addiction system including multiple organizations, multiple funding sources, and multiple accountabilities to different ministries. - Risk of variation 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?						
- Revisit work plan and adjust as needed to 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, Primary Care physician Leads and Chief Medical Leads to identify drivers of admissions at hospitals that report higher admission rates than their peers.						

• 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. • Encourage Voluntary Integrations across the LHIN. • Contribute to cross-ministry initiatives: i.e. dual-diagnosis framework - ministry-MCSS. • Leverage collaborative partnerships to address social deprivation, including housing and employment. • LHIN-wide monitoring of planning between service delivery areas in the development and implementation of the Special Needs strategy.
What are some of the key enablers that would allow us to achieve our goal?
• Work with LHIN HSPs to share successes of integrated services. • Support from other LHINs in knowledge translation; sharing successes and challenges of related projects. • Committed partnerships between HSPs. • 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 scale and spread of the model beyond the five percent population. • Quality Improvement activities will support the broader implementation goals of the strategy. • 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. • Engagement activities with MHA stakeholder groups to continue. • Implementation of evidence informed initiatives that are known to make a difference for the MHA population • Committed partnership and continued collaboration between health service providers.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).
n/a

vi. Indigenous Health and Wellness

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by integrating service delivery: Indigenous Health
IHSP Priority Description:
By listening and learning from local communities, the HNHB LHIN plans to continue focusing on the wholistic health needs of Indigenous Peoples and how these needs can be harmonized with mainstream programs and services. Foundational to this focus will be the strengthening of relationships and partnerships that contribute towards improving the health outcomes for present and future generations. Strategies to achieve this vision include: • Knowledge building through education – support education and training opportunities that engender acceptance, trust and respect for Indigenous cultures. • System Navigation – improve the experiences of Indigenous patients and families navigating the health care system. • Respectful Partnerships – help to facilitate strategic partnerships between Indigenous and non-Indigenous HSPs. • Engaging Communities – continue to explore new opportunities for meaningful engagement with Indigenous community members.

Current Status:

According to the 2011 National Household Survey, there are 36,700 people in the HNHB LHIN who identify as Aboriginal, of which approximately 50% live on reserve. Six Nations of the Grand River Territory is the largest populated First Nations community in Canada, and is located within the HNHB region. As of December 2014, membership included 26,034 individuals and represented a similar population distribution to that of Canada with half living on the reserve and half living outside the territory. Mississaugas of the New Credit First Nation is also located within the HNHB region and maintains a registered population of 2,324 people of which 58% live off-reserve.

Patterns of urbanization and transient living amongst Indigenous Peoples have demonstrated the importance of addressing the unique health disparities experienced by individuals living both on reserve and in urban settings.³⁷ Within the HNHB LHIN, Indigenous community members living both on and off reserve have expressed numerous social conditions which negatively impact their health and well-being such as lack of transportation, poor connection to community, distrust in health care providers, and social misunderstandings of Traditional Indigenous ways of being.

The LHIN continues to support community led Indigenous health programs and services through funding to De dwa da dehs nye>s Aboriginal Health Centre, Native Horizons Treatment Centre, and two First Nations communities; Six Nations of the Grand River Territory and Mississaugas of the New Credit First Nation.

There are a number of additional Indigenous health and social service providers who, while not funded by the LHIN, collaborate with the LHIN through the HNHB Indigenous Health Network (IHN). These organizations include three Friendship Centres, SOADI, Native Women's Chapters, as well as several native housing 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.³⁸
- Feelings of mistrust with the healthcare system and experiences of poor treatment as a result of racism or discrimination were reported in an Urban Aboriginal Peoples Study in 2010, which sampled Indigenous people across 11 Canadian cities. Non-indigenous people were also surveyed in this study, of which 39% believed that Indigenous people experienced discrimination often.³⁹
- Indigenous Peoples continue to endure a greater burden of poor health stemming from a colonial legacy and intergenerational trauma that has resulted in low socioeconomic status, low education attainment, loss of language and culture, and other social determinants of health impacting physical, emotional, mental and spiritual health.⁴⁰
- 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 Hypertension, Diabetes, and COPD.⁴¹ Data from the Institute for Clinical Evaluative Studies (ICES) indicates a higher prevalence of chronic conditions, such as Diabetes, among Indigenous persons living on-reserve in the HNHB LHIN.
- According to Statistics Canada's Aboriginal Peoples Survey 2012, 62.8% of Ontario's Aboriginal Peoples self-reported a long-term health problem, such as asthma, arthritis, or high blood pressure.⁴²

³⁷ National Aboriginal Health Organization. (2009). *First Nations Urban Aboriginal Health Research Discussion Paper: A Report for the First Nations Centre*. <http://www.naho.ca/documents/fnc/english/UrbanFirstNationsHealthResearchDiscussionPaper.pdf>

³⁸ Firestone, M., Smylie, J., Maracle, S., and O'Campo, P. (2014). *Unmasking health determinants and health outcomes for urban First Nations using respondent-driven sampling*. *BMJ Open*. 4:e004978

³⁹ Allan, B., & Smylie, J. (2015). *First Peoples, Second Class Treatment*. Toronto, ON: Wellesley Institute.

⁴⁰ Greenwood, M.L., de Leeuw, S.N. (2012). *Social determinants of health and the future well-being of Aboriginal children in Canada*. *Paediatric Child Health* 2012;17(7):381-384. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3448539/pdf/pch17381.pdf>.

⁴¹ Health Canada. (2009). *A Statistical Profile on the Health of First Nations in Canada: Determinants of Health, 1999 to 2003*. Minister of Health: Ottawa, 2009. Retrieved from <http://www.hc-sc.gc.ca/fniiah-spnia/pubs/aborigutoch/index-end.php>

⁴² Statistics Canada (2012). *Aboriginal peoples survey, long-term health problems (self-reported) by Aboriginal identity, age group and sex, population aged 12 years and over, Canada, provinces and territories*. Retrieved from <http://www5.statcan.gc.ca/cansim/a37>

- This survey also reported that 13% of Aboriginal Peoples do not have a regular medical doctor compared to non-Aboriginal groups which reported 9.2% without a regular medical doctor.⁴³

Successes of Past Year:

In 2015-16 the HNHB IHN approved a new 2015-2018 Strategic Plan. Priorities were identified based on the health needs of local communities as well as the health-specific recommendations identified in the Truth and Reconciliation Commission of Canada's Final Report and Calls to Action. Five key priority areas were chosen:

1. Cultural Competency
2. Access to Traditional Healing
3. Strengthening the Family Unit
4. MHA and Suicide Prevention
5. CDPM

Achievements related to these priorities include:

- Three full-time Aboriginal Patient Navigators continue to operate in three LHIN zones: Hamilton/Burlington, Niagara, and Brant/Haldimand/Norfolk. From April 2015 to September 2015, 350 individuals have received access to cultural appropriate services through the Patient Navigation program.
- The Child and Youth Mental Health Aboriginal Patient Navigator Program was supported by the LHIN in late 2014-15, and continues to provide early identification and intervention for co-occurring disorders in youth.
- Between April 2015 and September 2015, this program helped to link 18 individuals to specialized services for MHA and the appropriate Traditional healing supports as requested.
- In November 2015, the LHIN, in partnership with Six Nations Health and Social Services, ministry, Ministry of Aboriginal Affairs, and MCYS, helped to plan and support a Six Nations Health Conference about harmonizing Indigenous wellness in medicine and health practices.
Attendance included over 200 registrants and 19 speakers from across Ontario, gathered to begin the conversation about partnerships that will lead to improved access to the best care that Traditional and mainstream medicine have to offer for Indigenous Peoples in the HNHB region.
- A plan was developed and initiated that would broaden access to Ontario's Indigenous Cultural Safety (ICS) Training to mainstream HSPs. As a result of this initiative, 160 healthcare workers were supported to complete ICS training, which included staff from five hospital corporations and five Diabetes Education Programs.
- In partnership with De dwa da dehs nye's Aboriginal Health Centre, two Niagara Diabetes Education Programs, and SJHH Teleophthalmology Program, the SOADI developed a model of care called 'Team Fridays' to bring together a number of services including Traditional healing, Diabetes Education, Retinal Screening, NP, Healthy Eating Seminars, and Foot care Clinics. This model offers clients a wrap-around, one-stop service that increases access to primary care and diabetic services for Indigenous Peoples.

PART 2: GOALS and ACTION PLANS

Goal(s):

MHA:

- Develop performance measures, monitor the implementation, and conduct an evaluation of the Child and Youth MH Aboriginal Patient Navigator.

⁴³ Statistics Canada.(2010). Access to regular medical doctor. Retrieved from <http://www.statcan.gc.ca/pub/82-625-x/2011001/article/11456-eng.htm>

Chronic Disease Priority:

- 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.

Cultural Safety Training:

- Develop and initiate a plan to expand Indigenous Cultural Safety Training to frontline health care professionals working in the hospital setting. Identify plan for improving access to ongoing training opportunities.
- 90% of LHIN staff will have completed online Indigenous Cultural Safety Training.

Patient Navigation:

- Develop and implement a communication strategy to educate Indigenous and non-Indigenous providers about the role of Aboriginal Patient Navigators and share patient success stories.
- Develop a resource toolkit to guide non-Indigenous health service providers to culturally appropriate supports and services in the community.

Traditional Healing:

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

Hospice Palliative Care

- In collaboration with the Hospice Palliative Care Council, develop and initiate a plan to deliver equitable access to high quality care and support for First Nation and urban Indigenous Peoples.

Engaging Communities

- Develop and initiate a strategy for regular, ongoing, and meaningful engagement with Indigenous community members.

Consistency with Government Priorities:

Improving health equity and reducing health disparities experienced by Indigenous Peoples across Ontario is a ministry priority identified in the Minister's *Patient First: A Proposal to Strengthen Patient-Centered Health Care in Ontario*. This proposal outlines the need to make changes that improve the supports and services for patients, families, and caregivers, in a way that respects traditional methods, is culturally appropriate, and ensures health care services are addressing the unique needs of First Nations, Métis and Inuit peoples.

The goals outlined are also consistent with the Minister's *Patients First: Action Plan for Healthcare*, focused on the following:

- Keeping Ontario healthy.
- Faster access and a stronger link to family healthcare.
- 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.					
	2016-17		2017-18		2018-19	
Examples:	Status	%	Status	%	Status	%
Mental Health and Addiction:						
Improve access to early intervention MHA services for Indigenous children and youth living in Hamilton, through the development of a partnership between the Child & Youth Mental Health Aboriginal Patient Navigator Program and SJHH Youth Wellness Centre.	In progress	75	Completed	25		
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	75	Completed	25		
Cultural Safety Training:						
Develop and initiate a plan to expand Indigenous Cultural Safety Training to frontline health care professionals working in the hospital setting. Identify plan for improving access to ongoing training opportunities.	In progress	75	Completed	25		
Ninety percent of LHIN staff will have completed online Indigenous Cultural Safety Training.	Complete	100				
Patient Navigation:						
Develop and implement a communication strategy to educate Indigenous and non-Indigenous providers about the role of Aboriginal Patient Navigators and share patient success stories.	Complete	100				
Develop a resource toolkit to guide non-Indigenous health service providers to culturally appropriate supports and services in the community.	Complete	100				
Traditional Healing:						
Develop a standardized referral protocol in collaboration with one LHIN hospital for referrals to Traditional Healing services or supports for Indigenous patients.	In progress	50	Completed	50		
Explore opportunities to increase access to Traditional Healing.	In progress	50	Completed	50		
Hospice Palliative Care						
In collaboration with the Hospice Palliative Care Council, develop and initiate a plan to deliver equitable access to high quality care and support for First Nation and urban Indigenous Peoples.	In progress	25		50	Completed	25

Engaging Communities						
Develop and initiate a strategy for regular, ongoing, and meaningful engagement with Indigenous community members.	In progress	75	Completed	25		
How will we measure success?						
- Number of additional materials/resources added to the HNHB Walk the Talk Health and Wellness Initiative, further enabling IHN member organizations to promote healthy living in their communities. - A plan for sustainability and expansion of Indigenous Cultural Safety Training for hospital staff is developed and implemented. - Number of clients referred by Aboriginal 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. - A resource toolkit has been developed and disseminated to Indigenous and non-Indigenous HSPs. - A plan to deliver equitable access to high quality Hospice Palliative care and support has been developed for First Nation and urban Indigenous Peoples. - Number of Indigenous people who attend LHIN engagement sessions.						
What are the risks/barriers to successful implementation?						
- Change management in hospital setting and Indigenous communities related to increasing access and referrals to traditional healing. - Availability of Traditional healers. - Absence of reimbursement policy/process for Traditional healers.						
For each risk/barrier, describe the plan to mitigate the risk?						
- Continue to partner with Six Nations Health Services to manage the relationship with Traditional Medicine Practitioners as demand for Traditional Healing rises. - Improving partnerships between the hospital sector and Indigenous health service providers through the IHN. - Identify barriers to community member engagement and work with the IHN to develop new opportunities for engagement.						
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						

vii. Francophone Health

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Dramatically improving the patient experience by integrating service delivery: 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 *French Language Service Act (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 (LHSA)* 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 they are offered; 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, Francophones from Ontario and other provinces where Francophones live in a minority situation) - health status, health needs and health-seeking behaviours are variable, with higher rates of health risk behaviours such as, smoking, physical inactivity, obesity and alcohol use (Ontario Student Drug Use and Health Survey, OSDUHS, 2013).
 - 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.
- The Francophone population is older than the overall population.

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. (100% of FLS identified agencies submitted their FLS report Vs 97% in 2014-15; 86% of LTCHs submitted their FLS report Vs 45% in 2014-15).
 - 45% of the Francophone clients of the identified agencies received their services in French (22% in 2014-15).
 - HNHB LHIN, in partnership with the French Language Planning Entity (FLPE) and the Réseau franco-santé du Sud, held a Forum on the Active Offer of FLS. Identified HSPs were invited to receive guidelines, legislation and resources regarding the provision of and Active Offer. This forum was an introductory session to identify in collaboration with HSPs the vision and strategies for the delivery of FLS, including the identification and designation of HSPs.
 - An FLS toolkit has been developed and distributed to the participants. Information about the Francophone Community, its health status, tools on the implementation of FLS, Human Resources and bilingual capacity, legislation and various resources and support programs enabling the provision of services in French are included in this FLS toolkit.
 - Two information and consultation sessions have been held in St. Catharines and Port Colborne to present services available in French. HSPs were welcomed to talk about their services and to engage the Francophone community. About 200 Francophones participated to those forums. According to the participants, they need to get more information on the services available rather than new services.
 - The French Citizen Reference Panel was held to nurture the development of the 2016-19 IHSP. More detail is provided in the supporting technical document "Citizen's reference Panel Input" inserted in the IHSP.
 - The HNHB LHIN promoted several OTN sessions on Living well with diabetes delivered by the Centre de santé. In the course of the year, we noticed an increase on the number of sites and participants across the province.

- HNHB LHIN participates to several initiatives led by the Réseau franco-santé du Sud such as the ‘Welcoming Community’ and ‘French Doc’. French Doc initiative consists in facilitating internships for bilingual students to designated and identified agencies. The placements concern: Occupational therapist, doctor, nutritionist, etc.
- In the course of the past year, HNHB LHIN and the FLPE identified a LTCH willing and able to provide services in French for frail seniors in Hamilton.
- A CCAC FLS compliance plan has been crafted and the collaboration is on-going in order to implement the plan that ensure services in French with the respect of the continuum of care.

PART 2: GOALS and ACTION PLANS

Goal(s):

- Increase knowledge and capacity of HSPs with respect to FLS, including Active Offer principles.
- Continue to work with FLPE to identify strategies to improve access to FLS for people who speak French.
- Develop and implement an FLS plan in collaboration with the LTCH identified to deliver services for Francophone in Hamilton.
- Develop and implement a strategy to increase the availability of services provided through OTN.
- Increase knowledge and data about the diverse French-speaking communities within the designated and non-designated areas and match these information with sub-LHIN sub-region.
- Work closely with the CCAC to implement their FLS compliance plan, as per the 2012 regulation attached to the *Community Care Access Corporations Act (CCACA), 2001, 6.1*.
- Review and reinforce the identification status of HNHB LHIN agencies.

Access:

- Ensure that the Francophone population can reasonably access health services in French.
- Ensure the ‘active offer’ of health programs as well as availability of French-speaking professionals.
- Ensure that programs and HSPs incorporate the principle of the FLSA and LHSIA in their business to address the needs/concerns of Francophone clients.

Connect:

- Strengthen and coordinate relationships and formal partnerships between agencies to improve the continuum of care of francophone patients.
- Enhance focus on home and community care, seniors and chronic disease management.

Inform:

- Support the active participation of Francophone in public consultations and community engagement activities.
- Continue to leverage HSPs’ awareness on the French-speaking community and their obligations in terms of equitable provision of services.

Protect:

- Use the best information available about the needs of Francophone, demographic trends, social determinants of health and the enhancement of Francophone-specific research to inform policy and program development to influence the health statuses of Francophone patients.

Consistency with Government Priorities:						
Action Plans/ Interventions: “We will deliver the following”	Please indicate the status of project (Not Yet Started, In progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2016-17		2017-18		2018-19	
Examples:	Status	%	Status	%	Status	%
Increase knowledge and capacity of HSPs regarding FLS: - Promote use of existing FLS resources. - Specific capacity-building projects. - Monitor HSPs progress/performance with respect to FLS implementation. - Build the foundation for an ‘active offer’ strategy - Review and reinforce the identification status of HNHB LHIN agencies. - 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	40		20	Complete	40
Continue to work with FLPE on an annual basis to identify strategies to improve access to French Language Health Services (FLHS): - Coordinate ‘joint liaison’ efforts with FLPE to ensure appropriate completion of 2016-17 Joint Annual Action Plan (JAAP). - Review and coordinate response to FLPE required annual submissions.	In progress	100				
Assess the system capacity for FLS and develop an integrated and integrative strategy: - Primary care. - Home and community care. - MHA. - Complex/chronic conditions. - Hospice palliative care. - Older adults and caregivers. - Transitions across the health care continuum.	Not yet started	25		25	Complete	50
Improve availability and access to services in French: - Continue to support education sessions on diabetes. - Explore telemedicine opportunities across LHIN sectors. - Access to LTCH beds in Hamilton	In progress	30		40	Complete	30
How will we measure success?						
- 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 clients of identified agencies who receive services in French.						

• Number of FL-identified agencies who have an 'active offer' strategy. • The CCAC's FLS compliance plan is on its implementation phase. • The implementation plan for FLS services regarding LTCH in Hamilton is crafted.
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?
• Continue to work with different partners to promote education in the health field. • Continue to work with partners to promote initiatives related to internship and volunteers programs. • Continue to promote the 'active offer' and recruitment strategies of bilingual staff. • Increase awareness and knowledge of providers.
What are some of the key enablers that would allow us to achieve our goal?
• The FLPE can assist the LHIN in engaging community, identifying gaps and bringing solutions. • Collaboration with various community partners who can bring solutions in the education field and community engagement. • Participation at collaborative Francophone tables. • Participation to the work developed with the FL coordinators provincial network.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).
• Continue to raise awareness of FLS obligations with HNHB 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 of Directors (Board) will make health system decisions based on evidence and performance.
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.

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 tenets 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 to enhance its relationship with HSPs. The LHIN will work in partnership with HSPs to meet their legal obligations.

The number and complexity of HSPs in our LHIN requires a prioritization based on the risk of not meeting performance obligations. Enterprise Risk Management (ERM) is a strategic approach to identify, assess, mitigate and communicate key risks to the organization.

A key strategic risk for the HNHB LHIN is ensuring that HSPs deliver high quality services effectively and efficiently in compliance with accountability agreements. The HNHB LHIN will build on current processes by more rigorously applying the ERM program to SAA management.

A key strategy for advancing the LHIN role in commissioning is provider engagement. This involves the engagement of Boards, executives, and/or staff to articulate expectations and performance standards.

The HNHB LHIN will regularly engage with HSPs especially ensuring that performance issues are addressed at the time of agreement negotiations. The engagement 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 continued to allocate 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 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.
- The LHIN revised the processes related to performance reporting, monitoring supplemental reports, risk reviews for HSPs from all sectors, and proposals for new funding or services.
- LHIN staff worked in collaboration with HSPs to improve data reporting and quality as required.

PART 2: GOALS and ACTION PLANS

Goal(s):

- Continue to develop performance and risk management processes and build capacity within the HSPs.
- Further spread of the concept of LHIN commissioning within the LHIN office.
- Health System Funding Reform (HSFR) will continue to evolve in alignment with the ministry.
- Administrative costs within the health sector will continually be reviewed and monitored.
- Develop asset maps identifying the distribution of health care services throughout the LHIN region.

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.					
	2016-17		2017-18		2018-19	
Examples:	Status	%	Status	%	Status	%
Further review, develop and /or refresh key ERM components, processes, and practices required to fully operationalize the Risk Identification and Management policy.	In progress	50		25	Completed	25
Further spread of the concept of LHIN commissioning within the LHIN office. Development of a methodology to review value of investment tool to further support Commissioning: • Development of a program/service sustainability plan should the current service/outcomes not be able to be sustained with current resources. • Ensure that all funding decisions are tied to LHIN priorities and decision making framework.	In progress	50	Completed	50		
HSFR will continue to evolve in alignment with the ministry: • Support continual implementation of HSFR. • Work in partnership with HSP leaders to collaboratively examine and optimize funding and service volume allocations within the LHIN. • Development of LHIN staff competency on the utilization of Health Based Allocation Model (HBAM) and Quality-Based Procedures (QBP) as performance improvement strategies.	In progress	50	Completed	50		
Continued review and monitoring of administrative costs within the health sector: • Assess current state. • Findings, conclusions and actionable recommendations.	In progress	50	Completed	50		
Create detailed asset maps and related data about the health services available within the LHIN region. Data will be used to inform planning, assessments of equity and access, and funding decisions.	In progress	30	Completed	70		
How will we measure success?						
• Refreshed ERM components are implemented. • Regular education scheduled for current and new HNHB LHIN staff (funding overview, HSFR, etc.). • 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. • Health care funding provides high quality services at the best price. • Services reflect local community needs.
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. • A lack of natural incentive to foster cooperation. • Some providers unaware of the processes required to implement effective quality at a reasonable cost. • Data quality and decision support resources vary among HSPs. • Significant number of providers with limited internal staff for review. • 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. • The HNHB LHIN will advance incentive systems for performance through new initiatives such as the Health Links and innovative accountability instruments such as memorandums of understanding (MOUs). • The HNHB LHIN engagement plan will focus on key identified gaps including: data quality, performance management, and fiduciary responsibility. • Effective ERM processes will rank providers based on performance, allowing staff to focus on areas of highest risk. • 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?
• 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

3.4. Enabling Strategies – eHealth

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Enabling Strategies: e-Health
IHSP Priority Description:
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 (SWO) LHINs, eHealth Ontario, and ministry. • Align with provincial strategic directions, leveraging emerging solutions and data repositories. • Leverage solutions that promote ease of integrations and interoperability with other systems. Successes of the past year: • ClinicalConnect™, a Regional Electronic Health Record, integrates data from 67 acute care hospitals, four CCACs and Oncology Centres in South West Ontario, plus from the Ontario Laboratories Information System (OLIS), the Southwestern Ontario Diagnostic Imaging Network (SWODIN), and the Health Outcomes for Better Information and Care (C-HOBIC) nursing assessment repository. • Over 37,000 physicians, clinicians and provider support staff are now authorized to use ClinicalConnect. • Conducted 12 training sessions across SWO for a total of 43 Privacy Auditors, and 36 Local Registration Authority' (LRA) orientation sessions for 197 LRAs. • Added capabilities for users at more hospitals to log into ClinicalConnect through Single Sign on or Contextual Launch from their HIS. • Provisioned Participating Organizations with access to lab data from OLIS; 140 organizations have access as of December 31, 2015. • Integrated diagnostic images via the Southwestern Ontario Diagnostic Imaging Network (SWODIN) from 26 hospitals. • Introduced new Frequent ED Visits flag in Patient Header of ClinicalConnect. • Integrated DynaMed®, an evidence-based, contextually-relevant clinical information resource with ClinicalConnect, initially for HNHB users. • Continued planning for the integration of the eHealth Ontario Acute Clinical Data Repository (CDR). • Established development schedule to enable users at acute care facilities to send eReferrals to CCACs using ClinicalConnect. • Canada Health Infoway approved funding for Planning Phase of Patient Portal Demonstration project. • Continued planning Limited Production Release of a portal-to-portal integration with REACH, a similar portal used in Mississauga/Halton. • The HNHB Change Management and Adoption team successfully working to further increase adoption in the LHIN. To date, 20 hospital sites, one CCAC, 875 Primary/Secondary Care Organizations, 116 Community Support Services Organizations and two Public Health Units in the HNHB LHIN have been adopted and their staff authorized to use ClinicalConnect. • CCAC's eSHIFT enables clinicians to remotely direct care through another provider at the patient's location. HNHB CCAC had their first patients (19) receive this service Sept 2015. CCAC will continue to expand use of eSHIFT and provide contextual launch from in 2016. • Continued work to allow users from ONE ID-federated organizations to access ClinicalConnect. • OLIS Data Collection Project, to send lab results from HNHB hospitals to OLIS, continues.

- Care plans from SW and WW CCACs available in ClinicalConnect; functionality to make ESC and HNHB CCACs' plans available also ready.
- Extensive work to pilot the MOHLTC's Coordinated Care Tool completed and live in three Health Links in HNHB LHIN (Brantford Six Nations, Hamilton East and Hamilton West).
- Investigated feasibility and options to integrate MOH Panorama Immunization system and data with ClinicalConnect. Presented to MOH.
- ClinicalConnect won third place in Canada Health Infoway's eConnect Challenge in the category of eReports of Services.
- Published article about ClinicalConnect in UK-based Health Management Journal in Dec 2015.
- Leveraged ClinicalConnect to start sending Radiology and Transcription reports to HRM from NHS and HHS. Remainder of HNHB hospitals expected to be live summer 2016.
- Integrated Decision Support (IDS): went live with sixth LHIN (Erie St. Clair) on Oct 30, 2015; New flags created for Health Links, chronic conditions, IFM (ICCP) projects; HNHB LHIN one of six LHINs chosen for integrated bundle work (IFM) pilot at the ministry.

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.
- Complexity of agreements with eHealth Ontario require considerable review/negotiation.
- Challenges to successfully implement best practices around change management and adoption.

PART 2: GOALS and ACTION PLANS

Goal(s):

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

Consistency with Government Priorities:

- eHealth will allow / secure exchange of patient information.
- eHealth is a critical success factor for health system transformation, and is a government priority.
- eHealth Ontario is playing the lead role in harnessing in support of the government's health strategy.
- Alignment with the eHealth Ontario directions and standards.

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.

	2016-17		2017-18		2018-19	
	Status	%	Status	%	Status	%
Examples:						
Increase ClinicalConnect adoption in HNHB LHIN.	In progress	60	Complete	40		
Use \$1.2M funding from Infoway to accelerate rollout and improve interoperability.	In progress	60	Complete	40		
Participate in Infoway's project to provide Single Sign On /	Not Yet Started	50		25	Complete	25

Contextual Launch from LTC.						
Health Links - Participate in Care Coordination pilot.	In progress	75	Complete	25		
Health Links – Assess and plan for real-time identification of patients.	In Process	50	Complete	50		
Pilot secure messaging using ClinicalConnect.	In progress	50	Complete	50		
Integrate and leverage Provincial assets once ready.	In progress	50		25	Complete	25
Leverage ClinicalConnect to feed HNHB hospital labs to Provincial OLIS database.	In progress	50		25	Complete	25
Expand use of Hospital Report Manager in HNHB LHIN.	In progress	50	Complete	50		
Plan patient portal using Infoway funding; implementation contingent on funding.	In progress	50		25	Complete	25
Provide Acute to CCAC eReferral via ClinicalConnect.	In progress	50	Complete	50		
Extend and enhance IDS expanded data sets.	In progress	75	Complete	25		
Extend DI-r and increase adoption.	In progress	50	Complete	50		
Resource Matching and Referral / Central intake.	In progress	75	Complete	25		
eConsult – pending MOH reimbursement.	Not yet started	25		25		
Plan eNotifications leveraging ClinicalConnect.	In progress	25		25	Complete	50
Plan integration of Panorama Immunization and Drug Database integration with ClinicalConnect.	In progress	50	Complete	50		
Trial OTN PCVC (Personal Video Conferencing).	In progress	25		25		25
Resource Matching and Referral (RM&R) / Central intake electronic solution planning. Participate in non-binding WW LHIN RFP process and solution review. Develop business case for HNHB LHIN.	In progress	50		25		25
How will we measure success?						
- Increased deployment of eHealth solutions across the continuum of care with sustained adoption - 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. - Expansion of eHealth projects and competing priorities outpacing capacity. - Recruitment challenges (non-competitive salaries, location). - Competing 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.						
For each risk/barrier, describe the plan to mitigate the risk?						
Mitigating Strategies: - Availability of: - 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.						
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.						
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 (\$)	2015-16 Projected Actuals	2016-17 Allocation	2017-18 Planned Expenses	2018-19 Planned Expenses
Salaries and Wages	3,700,000	3,700,000	3,700,000	3,700,000
Employee Benefits				
Hospitals of Ontario Pension Plan (HOOPP)	340,000	340,000	340,000	340,000
Other Benefits	428,282	428,282	428,282	428,282
Total Employee Benefits	768,282	768,282	768,282	768,282
Transportation and Communication				
Staff Travel	44,000	44,000	44,000	44,000
Governance Travel	13,700	13,700	13,700	13,700
Communications	55,750	55,750	55,750	55,750
Other Benefits	5,000	5,000	5,000	5,000
Total Transportation and Communication	118,450	118,450	118,450	118,450
Services				
Accommodation	360,000	360,000	360,000	360,000
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	206,945	206,945	206,945	206,945
Equipment Rentals	5,000	5,000	5,000	5,000
Insurance	12,000	12,000	12,000	12,000
Board Chair Per Diems	40,000	40,000	40,000	40,000
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	24,250	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	1,527,415	1,527,415	1,527,415	1,527,415
Supplies and Equipment				
IT Equipment	40,000	40,000	40,000	40,000
Office Supplies and Purchased Equipment	55,000	55,000	55,000	55,000
Total Supplies and Equipment	95,000	95,000	95,000	95,000
LHIN Operations: Total Planned Expense	6,209,147	6,209,147	6,209,147	6,209,147
Annual Funding Target	6,209,147	6,209,147	6,209,147	6,209,147
Variance	0	0	0	0

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Funding Breakdown	2015-16	2016-17
Operations	4,916,172	4,916,172
Aboriginal 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	824,475	824,475
Total	6,209,147	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	2015-16 Estimates as of March 31, 2016 FTEs	2016-17 Forecast FTEs	2017-18 Forecast FTEs	2018-19 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	2	2	2	2
Communication Assistant	0	0	0	0
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

Over the next year, continuing the implementation of the LHIN's SHSP, embarking on the first year of the 2016-19 IHSP, and fully realizing the Patients First focus 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 will continue to be sought through the realization of the LHIN's 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.

A strong communications strategy and plan are critical to support the execution of the Patients First focus, and will support and enhance the engagement activities of the LHIN. The communication strategy and plan will:

- 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 under a 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 and on the implementation – document successes and share them.
- Guide the communications and engagement activities of the HNHB LHIN (Board and staff) and HSP partners involved in initiatives contained in the 2016-17 ABP.
- 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.
- Provide accurate and timely information to all audiences.
- Be transparent and accountable to our shared audiences regarding timelines, outcomes and opportunity for participation/feedback.

Context

- Ontario's *Action Plan for Health Care*, announced in January 2012, was consistent with the principles of ECFAA and put LHINs at the center of the Patients First focus.
- The *Patients First: Action Plan for Health Care*, released in February 2015, built on the progress made since the original *Patients First: Action Plan for Health Care* and set clear and ambitious goals for Ontario's health care system in order to put patients at the center of our health care system by improving the health care experience:
 - Access:
 - Improve access - providing faster access to the right care.
 - Connect:
 - Connect services - delivering better coordinated and integrated care in the community closer to home; providing better home and community care.
 - Inform:
 - Support people and patients - providing the education, information and transparency Ontarians need to make the right decisions about their health.
 - Protect:
 - Protect our universal public health care system - making decisions based on value and quality, to sustain the system for generations to come.
- In May, 2015, *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 released.

- In early December 2015, the Office of the Auditor General of Ontario released its annual report, which included a value-for-money audit of Ontario's LHINs. The audit highlighted a number of findings and made a number of recommendations. The Annual Report also contained a value-for-money audit of Ontario's Community Care Access Centres which also included a number of recommendations.
 - In mid-December 2015, the ministry released *Patients First: A Proposal to Strengthen Patient-Centered Health Care in Ontario*. This discussion paper outlined structural changes to the health system including reforms that would see LHINs assume responsibility for home and community care and system integration, have greater involvement with primary care, and improve linkages with population health planning.
 - In early 2016, and on behalf of the ministry, the HNHB LHIN engaged numerous stakeholders including physicians, HSPs, patients, caregivers and citizens to solicit their comments and feedback related to the proposal. The feedback was shared with the ministry. Wide engagement and consultation with a deliberate focus on primary care providers will continue through 2016-17.
 - The HNHB LHIN will continue to have a critical role to play in key provincial initiatives such as HSFR, Health Links, health initiatives for seniors, and the expansion of QIPs into the primary and community care sectors.
 - The HNHB LHIN's 2016-19 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 and Caregivers.
 - 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, YouTube, etc.
- Other LHINs, especially neighbouring LHINs – SW, WW and MH.
- Ministry and other ministries (as appropriate and required)

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.

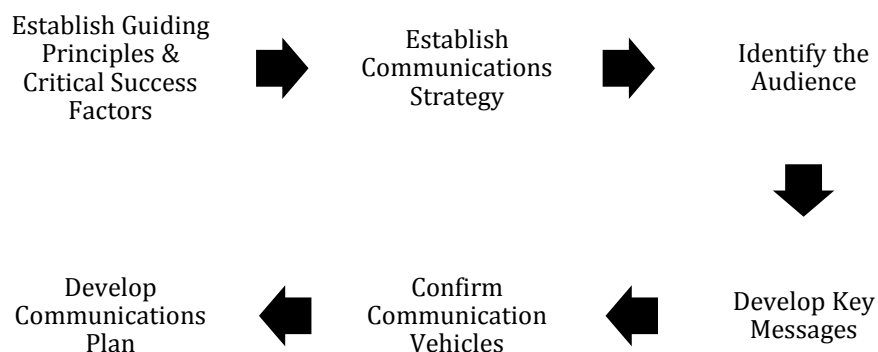
This framework will enable the HNHB LHIN to establish a clear process, and will minimize risk by identifying key stakeholders, key messages and communication vehicles up front.

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, 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

- The LHINs have made a significant contribution to Ontario's health care system over the past ten years.
- We've led change at the local and regional level to improve patient's experience and outcomes.
- We know that there is more work to be done.
- LHINs are looking forward to continuing to engage with care providers and community partners to get feedback on about how to make LHINs and our health care system more integrated, accessible and better for patients.
- We are committed to working collaboratively with the ministry and our partners to put patients first with better access to care no matter where they live.
- Strengthening the LHIN role in primary care will create a platform upon which a truly integrated health system can be built.
- We are committed to improving communications and connections between primary health care providers, hospital and home and community care.
- This would bring the planning closer to communities where services are delivered and would lay the foundation for broader system integration.
- In particular, that means working with our colleagues at CCACs to make sure that home care services continue during this transformation process and any eventual system changes.

- Over the past decade, the LHINs have developed knowledge about the health and health care needs of our local communities.
- We look forward to sharing and building on that knowledge with our partners and achieving the provincial priorities in Patients First: Ontario's Action Plan for Health Care.
- We look forward to building on our progress to date, and leveraging our expertise as we move forward to achieve an integrated health system in Ontario.
- Since its launch, Ontario has made progress in all four priority areas: increasing access, connecting services, informing patients and protecting our health care system. But we can do more to put patients first. Better care for patients means we need to make some changes.
- Working toward the next stage of the Patients First: Action Plan for Health Care, Ontario is designing a path to improve the patient experience and provide better access to care for Ontarians no matter where they live, including:
 - Improving communication and connections between primary health care, hospitals and home and community care for a smooth patient experience.
 - Making it easier for patients to find a family doctor or nurse practitioner when they need one, see that person quickly when they are sick, and find the care they need, closer to home.
 - Making it easier for doctors, nurses and other primary care providers to connect their patients to the health care they need.
 - Ensuring there is local planning so health care providers are available to patients where and when they are needed
 - Strengthening Indigenous involvement in the planning, design and delivery of health programs and services provided to Indigenous communities.
- Together with the ministry, we will undertake any changes carefully and in partnership with our health care partners to make sure that patients have ongoing, smooth access to the health care services they depend on, and we will update patients, caregivers and partners all along the way.

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 • Presentations to Board of Health and/or municipal councils
CRP Members	LHIN CEO	• Group sessions • Twitter
General Public (including some of 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
Physicians	LHIN CEO/LHIN physician lead	• Meetings/blog • Physician Newsletter • Twitter • Meetings, media
Francophone Community	LHIN	• Meetings, media
Indigenous Community	LHIN	• Meetings, media
Neighbouring LHINs	LHIN CEO	• Meetings, media
Ministry - MO, HSAPD-RCU and CMD	LHIN CEO/Board Chair/Communications	• Meetings • Teleconferences
Agencies with provincial/national mandate (i.e., Canadian Mental Health Association (CMHA))	LHIN	• Meetings, media

Evaluation

Identifying and tracking critical communications success factors will enable the HNHB LHIN to more effectively identify whether communication activities have been successful and develop additional strategies as may be appropriate. Critical success factors may include:

- HSPs across the HNHB LHIN are engaged early and frequently and can see how their participation is impacting implementation.
- For all communication / community engagement events held by the LHIN, opportunities for questions/answers will be provided to attendees to understand their literacy relative to LHIN activities/programs/initiatives.
- In addition, online surveys will be utilized, in conjunction with face to face feedback opportunities, to establish a literacy baseline which will inform the focus for communications in future years.
- Track the number of positive print or broadcast media articles/coverage focused on improved access to health services and an improved patient experience.
- Using social media metrics, measure audience reach and engagement through HNHB LHIN social media applications.

Through feedback mechanisms and ongoing assessment, the LHIN will monitor the effectiveness of communications vehicles and messages and will recalibrate and adapt plans as needed to support the achievement of the ABP's areas of focus. Performance measures to support the success factors listed above may include:

- The consistent use of relevant and applicable messaging in materials prepared by LHIN including LHINsight, CEO Blog, Twitter and the website.
- Level of engagement by stakeholders, health service providers, patients, clients, caregivers and the public in response to LHIN community and stakeholder engagement efforts/activities/events.
- Comments, complaints and concerns received by the HNHB LHIN.
- Comments received through engagement activity (feedback forms, interactive discussions.)

6a Community Engagement

In accordance with Community Engagement Guidelines (April 2011) and in keeping with the expectations of the *Local Health System Integration Act (LHISA 2006)*, all LHINs are required to develop and publish their Community Engagement plan. Plans are updated annually to reflect specific priorities and objectives in the current/upcoming year.

The HNHB LHIN's Community Engagement Plan provides an overview of the priority activities and associated community engagement mechanisms or strategies that will support achievement of the initiatives contained within this ABP.

Guided by the organization's strategic aim "Dramatically Improving the Patient experience through Quality, Integration and Value" and focused on achieving its identified priorities in 2016-17, the HNHB LHIN will fulfill its commitment to community engagement in the following ways:

Engagement Strategies and Best Practices

A variety of best practice strategies (see 7.4), appropriate to the desired objectives and identified level of engagement will be employed. The objectives of community engagement will be identified in advance for priority initiatives and will vary across the following engagement continuum.

Inform and Educate: To provide accurate, timely, relevant and easy to understand information to the community. This level of engagement will provide information about the LHIN, and offers opportunities for community members to understand the problems, alternatives and/or solutions. There is no potential to influence final outcome as this is one-way communication.

Gather Input: To obtain feedback on analysis and proposed changes. This level of engagement provides opportunities for community to voice their opinions, express their concerns and identify modifications. There may be potential to influence the final outcome.

Consult: To seek out and receive the views of community stakeholders on policies, programs or services that affect them directly or in which they may have a significant interest. This level provides opportunities for dialogue between community and the LHIN. Consultation may result in changes to the final outcome.

Involve: To work directly with stakeholders to ensure that their issues and concerns are consistently understood and considered, and to enable residents and communities to raise their own issues. In this level, community stakeholders may provide direct advice as this is a two-way communication process. This level will influence the final outcome and encourage participants to take responsibility for solutions.

Collaborate: To work with and enable stakeholders to work through options/solutions to find common ground or agreement.

Empower: Delegated stakeholder decision-making where final decision-making authority, leading to action is assigned to a committee (ad hoc, standing) or other organized body (project-related work group or task).

Identification of Stakeholders & Assessment of Impact and Outcomes

The HNHB LHIN is committed to leverage the knowledge, experience and expertise that currently exists within HNHB LHIN communities to achieve its objectives. Accordingly, a core principle of engagement is to identify existing stakeholder groups or entities, individuals or organizations which have interest in the outcomes of the initiative/project.

Stakeholders are individuals, communities, political entities or organizations that have a vested interest in the outcomes of the initiative. They are either affected by, or can have an effect on, the project. Anyone whose interests may be positively or negatively impacted by an initiative, or anyone that may exert influence over the initiative or its results is considered a project stakeholder. All stakeholders must be identified and managed/involved appropriately.

For the purpose of stakeholder identification, "communities" can be interpreted to mean geographic locations (i.e. a municipality in the HNHB LHIN region), communities of interest or communities of practice.

Community of interest (COI) - an informal, self-organized, network of individuals brought together around a common interest, issue, concern or opportunity. They need not meet physically and may only ever connect with one another on an ad hoc basis, around that common element.

Community of practice (CoP) - an Informal, self-organized, network of peers with a common area of practice or profession. Such groups are held together by the members' desire to help others (by sharing information) and the need to advance their own knowledge (by learning from others).

Engagement of Indigenous Peoples

The HNHB LHIN estimates that the First Nation, Métis and urban-based Indigenous peoples residing in the region represents almost two percent of the total regional population. First Nation, Métis, Inuit and Non-Status people face a number of health issues and challenges and their health status is below that of the general population. First Nation, Métis, Inuit and Non-Status people have identified a number of barriers to receiving equitable access to health services including jurisdictional and funding issues, lack of sensitivity to their culture, and a lack of targeted programs that focus on their particular health needs.

One of the main goals of the HNHB LHIN is to continue to work with the First Nation, Métis, Inuit and Non-Status peoples to improve their overall health status. The HNHB LHIN is committed to working with all Indigenous people to align health services with existing regional, provincial and federal health planning, health programming and service delivery systems to improve health outcomes.

Through the Aboriginal Health Network, the HNHB LHIN receives advice on a variety of topics reflecting on provincial and HNHB LHIN priorities pertaining to the First Nations people represented.

Engagement of HNHB LHIN Francophone community

The HNHB LHIN has a French-speaking population is approximately 30,000 or 2.3% of the population (2006). Close to 80% of the LHIN's Francophone population lives in Niagara and Hamilton. In the HNHB LHIN, Hamilton and Welland are officially designated under the FLSA.

The HNHB LHIN's commitment to equity and respect for diversity recognizes the requirements of the *French Language Services Act (FLSA)* and the legislation pertaining to the Engagement with the Francophone Community (January 2010) in serving Ontario's French-speaking community.

To do so, the HNHB LHIN engages with its Francophone community in partnership with the French Language Planning Entities (April 2011). FLS Entity #2 for HNHB LHIN provides advice and support to the HNHB LHIN with respect to: engaging the local Francophone community; identification and planning for health needs and priorities; the needs and priorities of diverse groups within the Francophone community; health services available to the Francophone community; the identification and designation of health service providers for the provision of French language health services; strategies to improve access to, accessibility of and integration of French language health services in the local health system; the integration of French language health services.

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	<i>French Language Services Act</i>
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	<i>Local Health System Integration Act</i>
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	MHA
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

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