



Annual Business Plan 2017-18

**Hamilton Niagara Haldimand Brant
Local Health Integration Network
Annual Business Plan 2017-18**

TABLE OF CONTENTS

1.	Letter of Transmittal	1
1.1.	Context	3
2.	French Language Services	13
3.	Indigenous Peoples	18
4.	Operationalizing the Priorities	25
4.1.	Digital Health	25
4.2.	Health and Wellness of the Population	28
4.3.	Health Links	31
4.4.	Home and Community Care	34
4.5.	Mental Health and Addictions	38
4.6.	Hospice Palliative Care	44
4.7.	Population Based Strategies and Clinical Program Integration	47
4.8.	Primary Care	57
4.9.	Sub-Regions	60
4.10.	System Capacity and Seamless Transition to Avoid Alternate Level of Care	63
5.	LHIN Operations and Staffing Tables	69
6.	Integrated Communications Strategy	72
7.	Community Engagement	78

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June 29, 2017

Mr. Tim Hadwen
Assistant Deputy Minister
Health System Accountability and Performance Division
Ministry of Health and Long-Term Care
5th Floor, Hepburn Block, 80 Grosvenor Street
Toronto ON M7A 1R3

Dear Mr. Hadwen:

**RE: Hamilton Niagara Haldimand Brant Local Health Integration Network
2017-18 Annual Business Plan**

I am pleased to provide you with the 2017-18 Annual Business Plan (ABP) for the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN). The ABP is a key component of the accountability framework between the LHIN and the Ministry of Health and Long-Term Care (ministry), operationalizing the Integrated Health Service Plan (IHSP) by providing annual goals and action plans for each IHSP priority. The IHSP is a three year plan for the LHIN, and this ABP (2017-18) represents the second year of the LHIN's 2016-19 IHSP.

The HNHB LHIN aligned the strategic priorities outlined in the 2016-19 IHSP with Patients First: Ontario's Action Plan for Health Care (February 2015), which focused on four key goals:

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

These goals – improving access, connecting and integrating services, supporting people and patients, and making decisions based on value and quality – are reflected in the HNHB LHIN strategic aim and directions:

“To Dramatically Improve the Patient Experience through Quality, Integration and Value”



Ontario

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

Mr. Tim Hadwen

More recently, the passing of the *Patients First Act, 2016* has expanded the mandate of the LHIN to plan, fund, integrate and manage the performance of the local health system, including the provision of services for the care of persons in home. The *Patients First Act, 2016* enables transformative change in Ontario's health system by focusing on the following five key components:

1. Identify LHIN sub-regions as the focal point for integrated service planning and delivery, in order to achieve effective integration of services and greater equity.
2. Improve timely access and greater integration of primary care.
3. Achieve more consistent and accessible home and community care.
4. Develop linkages between LHINs and Boards of Health in order to create stronger linkages to population health and public health.
5. Ensure the inclusion of indigenous and francophone voices in health care planning.

The ABP for 2017-18 has incorporated the priorities identified by the Minister of Health and Long-Term Care in his May 1, 2017 Mandate letter to the LHIN. The ABP also outlines how these priorities, along with continued priority commitments of the ministry and the LHIN, will be met in terms of goals and action plans for achieving transformation in HNHB LHIN that are consistent with Patients First. The ABP follows the guidelines provided by the ministry, including:

- The HNHB LHIN context for planning
- Details relating to French Language Services, Indigenous Peoples and other key priorities
- A summary of LHIN operations and staffing plan
- Communications and Community Engagement

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

Sincerely,



Janine van den Heuvel
Board Chair

c: Donna Cripps, Chief Executive Officer, HNHB LHIN

1.1. Context

B. Mandate (confirmation of the LHIN's mandate) and Strategic Directions

The Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) was established under the *Local Health System Integration Act, 2006, (LHSIA)* with a mandate to plan, fund and integrate the local health care system.

The HNHB LHIN is accountable to the Ministry of Health and Long-Term Care (ministry) for achieving this mandate, and the Annual Business Plan (ABP) is a key component of this accountability framework. It operationalizes the Integrated Health Service Plan (IHSP) by providing annual goals and action plans for each IHSP priority. The IHSP is a three-year plan for the LHIN, and this ABP (2017-18) represents the second year of the LHIN's 2016-19 IHSP.

The HNHB LHIN aligned its priorities outlined in the 2016-19 IHSP 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 action plan strengthened the government's commitment to put patients first by improving their health care experience and health outcomes and focuses on four key goals:

- 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.

These goals are also reflected in the HNHB LHIN's strategic aim and directions as outlined in its five-year Strategic Health System Plan (SHSP):



More recently, the passing of the *Patients First Act, 2016* expanded the mandate of the LHIN to plan, fund, integrate and manage the performance of the local health system, including the provision of services for the care of persons in their home. *The Patients First Act, 2016* enables transformative change in Ontario's health system by focusing on the following key components:

1. Identify LHIN sub-regions as the focal point for integrated service planning and delivery, in order to achieve effective integration of services and greater equity.
2. Take on responsibility for primary care planning in order to improve timely access to and greater integration of primary care.

3. Transfer responsibility for service management and delivery of home and community care in order to achieve more consistent and accessible home and community care.
4. Develop linkages between LHINs and Boards of Health in order to create stronger linkages to population health and public health.
5. Ensure the inclusion of Indigenous and Francophone voices in health care planning to:
 - make sure that culturally safe care is available for Indigenous Peoples; and
 - meet the requirements of the *French Language Services Act*.

In 2017-18, the LHIN in accordance with the Government's new Agencies and Appointment Directive, received a mandate letter from the Minister advising the LHIN of collective overarching key priorities and outlined key priorities for 2017-18.

The 2017-18 ABP details the priorities, goals, and action plans for achieving transformation in the HNHB LHIN that are consistent with the *Patients First Act, 2016* and the Minister's 2017-18 mandate letter to the LHIN.

C. Overview of the LHIN's current and forthcoming programs/activities

Services Currently Provided in the HNHB LHIN

The HNHB LHIN allocates nearly \$3 billion annually to a variety of local health service providers (HSPs). Each HSP is held accountable to the strategic directions of quality, integration and value through its Service Accountability Agreement (SAA). Across the HNHB LHIN there are 188 separate SAAs covering hospital corporations Long-Term Care Homes (LTCHs) and community services.



Nineteen providers hold multiple SAAs, but each SAA contains provisions for the range and scope of services to be provided through the LHIN funding, and expected outcomes. All LHIN-funded organizations are guided by the priorities outlined in the SHSP, IHSP and ABP. What follows is an overview of the LHIN's approach to quality, integration and value outlining how the LHIN works with providers to dramatically improve the patient experience.

Quality

This strategic direction reflects the commitment of the HNHB LHIN to foster a strong culture of quality, and continuously work in collaboration with our HSPs towards improving performance, experience, and health outcomes for the people we serve. The LHIN supports and encourages the development and delivery of consistent, high quality services and programs, monitors system level outcomes, and manages performance.

The Regional Quality Table (RQT), formerly the Quality Guidance Council, continues to inform the LHIN's quality agenda, supports communication, and its members act as ambassadors within the various sectors.

The Clinical Quality Lead serves as a liaison between the RQT and Health Quality Ontario (HQP). This supports communication and alignment between the local and provincial quality structures.

The RQT expands on the current work of the LHIN with a focus on a culture of quality, quality obligations, patient experience and a cross-sector approach which has been strengthened by the inclusion of the home and community services sector. The RQT is an action-oriented body, with a role in focusing on regional quality challenges and initiatives, as well as connecting regional and provincial priorities and structures. The ultimate goal of aligning the quality agenda and engaging communities is to create and promote a culture of quality that will improve patient outcomes and experience of care.

The mandate of the RQT is evolving to include the following functions:

- Develop and support culture foundations and quality enablers within HSP sectors and systems.
- Celebrate quality and build capacity and capability for quality throughout the system.
- Develop and implement strategies to foster systems-level thinking and innovation.
- Establish and monitor “big dot” outcomes level metrics.
- Monitor LHIN key performance indicators (i.e., Ministry-LHIN Accountability Agreement (MLAA) indicators).
- Encourage sharing of best practices and utilization of clinical pathways.
- Implement and promote LHIN-wide patient experience framework and improvements.
- Inform an annual integrated regional quality plan.
- Communicate regularly and broadly about quality issues and receive updates as appropriate.
- Identify and support the implementation of cross-sector Quality Improvement Plan (QIP) priorities related to Quality Based Procedures (QBPs), Health Links implementation, as well as specific areas of emphasis of quality important for the LHIN.
- Engage providers in a culture of quality care through widespread distribution amongst clinicians of best practice strategies, implementing known effective models of care and building engaged communities of practice within the identified priority areas.
- Improve partnerships and integration amongst providers in providing the best quality patient-centred care.
- Identify enablers and barriers to clinical practice change and designing implementation strategies to leverage enablers and minimize barriers.

Each year, the HNHB LHIN staff work to refine the practices and processes of performance management, including the definition of more standard performance measures. LHIN staff and HSPs identify outcome measures that demonstrate value and impact of service delivery investments. In accordance with an obligation in their 2016-17 SAAs, HSPs from all sectors submitted a quality plan. A review of these documents indicated that cultures of quality are well established in almost all HSPs. This has been demonstrated by the ongoing improvement in data quality, performance management/escalations and decision making. HSPs 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 that have not yet embarked in this work. The obligations of the quality plan and reporting patient experience data to the HNHB LHIN will continue in 2017-18.

Health system performance broadly recognizes that all HSPs must collaborate and contribute to system improvement and performance. An obligation was included in the 2016-17 SAAs and will continue in 2017-18 such that all providers will strive to meet the targets for health system performance indicators. HSPs are to engage in activities, including LHIN-wide initiatives that result in the demonstrated improving trends on key performance indicators such as those found in the MLAA. Progress on achieving the key performance indicators of the MLAA are reported regularly to the LHIN Board of Directors (Board). The HNHB LHIN will continue to collaborate with the ministry and HSPs around new measures of performance.

With the passage of the *Patients First Act, 2016* the LHIN's focus on quality will expand in 2017-18 to include both a system-level perspective and responsibility for quality and patient safety as an organization delivering home and community care. With the transfer of the Community Care Access Centre (CCAC) into the LHIN, the HNHB LHIN is now accountable for the implementation of a QIP effective 2017-18.

Integration

The HNHB LHIN and its HSPs have a shared accountability to build a health care system that provides the best possible experiences and health outcomes for patients and their families. Integrating service delivery is a means to improving patient experience and outcomes. System integration means that all HNHB LHIN residents 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 easier navigation and seamless transitions at various points along the continuum of care.
- Providers participate in inter-professional teamwork; coordination of tasks, services and care.
- HSPs participate in inter-agency relationships to provide seamless, integrated service delivery.

Integration refers to a spectrum of activities that describes how different people, programs, and organizations can work together towards a common vision. It is not just about mergers and amalgamations – it is also about formal partnerships and collaborations of all types that create value for patients, through:

- Expanding access to services
- Enhancing capacity of services
- Meeting patient needs
- Expanding to meet previously unmet need
- Making services available to a broader range of patients
- Improving quality of service, outcomes and experience

As an important side benefit, integrating service delivery leads to stabilized, sustainable programming, allowing benefits for patients and family to be realized.

Over the coming year, the HNHB LHIN will continue to work with providers on the development of population-based, geographically integrated LHIN sub-regions. Sub-regions are 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. Sub-regions will help the HNHB LHIN focus on a smaller geographic area and better understand and address patient needs at the local level and ensure people receive high quality care that makes a difference in their lives and is accessible, integrated, and consistent.

By looking at care patterns through a smaller, more local lens the LHIN will be able to better identify and respond to community needs and ensure patients across the LHIN have access to the care they need, when and where they need it. This includes the needs of Francophone Ontarians, Indigenous Peoples, newcomers and other individuals and groups within the HNHB LHIN whose health care needs are unique and who often experience challenges accessing and navigating the health care system.

Sub-regions will serve as a focal point for service alignment and integration, using population-based planning to achieve performance and quality improvement as measured by a set of province-wide consistent indicators.

Value

The HNHB LHIN is committed to providing value for tax dollars by:

- Streamlining administration of the health care system and directing savings into patient care.
- Effectively managing operational, financial and strategic risks, while meeting business objectives, accountability and transparency requirements.

As health system commissioners, the HNHB LHIN staff and Board make health system recommendations and decisions based on evidence, equity, performance and risks with the needs of the patients and communities at the centre of our decision making

In 2017-18, the HNHB LHIN will further develop its role as health system commissioners focusing on quality, volume, price, enterprise risk management and accountability. The creation of sub-regions provides new opportunities for the LHIN to apply the tenets of commissioning at a more local level while ensuring alignment with government priorities and objectives. Outcome-based performance will be improved by working with the health sector to enhance existing frameworks while developing new quality frameworks that are consistent and flexible to address sub-region key priorities. As sub-region planning continues, the HNHB LHIN will explore population health needs, and prioritize funding to support the availability of and access to programs and services that support the best possible outcomes.

While commissioning is a complex process which takes time to fully implement, by adopting a commissioning strategy, the HNHB LHIN will continue to work in partnership with HSPs in a manner that is aligned with accountability agreements and obligations. Provider engagement will be a key success factor for advancing the LHIN's role in commissioning. This involves the engagement of Boards, executives, and/or staff to articulate expectations and performance standards. The HNHB LHIN will regularly engage with HSPs, with a focus on ensuring that performance issues are addressed at the time of SAA negotiations. The engagement will involve strategies to focus upon:

- Data Quality – financial and statistical
- Governance – ensuring a clear understanding of their 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 transferring and/or ceasing funding

In 2017-18, HNHB LHIN's strategic direction of value will also be enhanced through addressing the pan-LHIN responses to the nine recommendations identified as part of the 2015 LHIN audit by the Office of the Auditor General of Ontario (OAGO). In the upcoming year, the LHIN will assess its implementation of the responses to each OAGO recommendation and maintain evidence of the implementation around the following key areas:

- Performance Capacity
- Patient Satisfaction
- Data Quality and Performance
- Complaints Management
- Community Engagement
- Leading Practices
- System Integration
- Decision-Making Process

Plan for Future Services

Ontario's 14 LHINs have been responsible for planning and funding of hospitals, LTCHs, community services and mental health and addiction (MHA) services. Under the *Patients First Act, 2016*, the LHINs will be responsible for home care (previously the function of Ontario's 14 CCACs) and primary care planning to ensure that patients are getting better coordinated care, and that the health system is more integrated and responsive to local needs.

While the HNHB LHIN will continue to focus on key priorities related to our mandate of planning, funding, integrating and managing performance within the health system, 2017-18 will see the transfer of HNHB CCAC assets and resources to the LHIN. This transfer will require significant focus to ensure a smooth transition for patients and families and will enable the LHIN to begin to look at new models of system navigation and care coordination across the health system using the sub-region planning areas.

Minister's Mandate Letter

As part of the Government's new Agencies and Appointments Directive, all Board governed agencies, including LHINs, will receive a mandate letter annually from the Minister outlining the broad service and performance expectations for the upcoming fiscal year.

The 2017-18 mandate letter will guide LHIN planning as they move to the transformation phase enabled by the Patients First legislation; the foundation to build a more sustainable, efficient and accessible health care system for future generations.

2017-18 Minister's Mandate Letter – Key Priorities

Recognizing that the implementation of the *Patients First Act, 2016* will be a multi-year journey, the 2017-18 LHIN mandate letter outlines five collective key priorities that need to be central through transformation phase:

- Improve the patient experience by putting the patient voice at the centre of health care planning and by delivering care that is responsive to patients' needs, values and preferences.
- Address the root causes of health inequities by strengthening the social determinants of health, investing in health promotion, and reducing the burden of disease and chronic illness.
- Create healthy communities by improving access to primary care and reducing wait times for specialist care, MHA services, home and community care and acute care for patients when they need it, which will reduce variation in access across the province.
- Break down the silos between our health care sectors and providers to ensure seamless transitions for patients, and to ensure that providers work together to provide patient-centred care.
- Support innovation by delivering new models of care and digital solutions to make accessing care easier for patients and more efficient for health care providers.

2017-18 Minister's Mandate Letter – Additional LHIN Responsibilities

The Minister's mandate letter also outlines two additional over-arching responsibilities for LHINs in 2017-18, including:

- Responsibility for creating an integrated service delivery network that includes primary care providers, inter-professional health care teams, hospitals, public health, MHA and home and community care to ensure a more seamless patient experience.
- Responsibility to remain fiscally responsible and manage the LHIN budget in a prudent manner to ensure programs and services are effective, efficient, and sustainable into the future; and to further streamline and increase the efficiency of administration and ensure savings are reinvested into front line patient care

2017-18 Minister's Mandate Letter – Deliverables and Outcomes

In alignment with the key priorities and additional LHIN responsibilities outlined above, LHINs are asked to make progress on the priorities outlined in Figure 1 in 2017-18. Each section within this ABP describes how these, and other ongoing LHIN priorities, will be addressed in 2017-18.

As LHINs deliver on the 2017-18 mandate, all LHINs will ensure the following key pillars are maintained and strengthened:

- Promote health equity, and reduce health disparities and inequities.
- Respect the diversity of communities in the planning, design, delivery and evaluation of services, including culturally safe care for Indigenous Peoples and meeting the requirements of the *French Language Services Act (FLSA)*.
- Continue to strengthen local engagement with Francophone and Indigenous communities.
- Work with HSPs and communities to plan and deliver health services.

Figure 1: LHIN Outcomes Outlined in Minister's Mandate Letter to LHINs

Transparency and Public Accountability	- Continue to be accountable for outcomes and report on your progress toward achieving health system performance targets. - Collaborate with the ministry to develop performance targets to measure the success of transformational activities and publicly report on progress and outcomes. - Effectively manage all operational, strategic, and financial risks encountered by the LHIN while ensuring alignment with government priorities and achievement of business objectives.
Improve the Patient Experience	- Establish and engage your Patient and Family Advisory Committee(s) to ensure patients and families are involved in health care system decision-making. - Work towards improving transitions for patients between different health sectors so that patients receive seamless, coordinated care and only tell their story once. - Support patients and families by implementing initiatives that reduce caregiver distress.
Build Healthy Communities Informed by Population Health Planning	- With input from patients, caregivers and partners, assess local population health needs, patient access and wait times and the capacity of health providers to serve the community. - Through sub-regional (community level) planning, identify how providers will collaborate to address health gaps, and improve patient experience and outcomes.
Equity, Quality Improvement, Consistency and Outcomes-Based Delivery	- Work with the sector to both enhance existing and develop new performance and quality measurement frameworks that are consistent and flexible to address regional priorities. - Work with local clinicians at a community level to support implementation of quality standards in partnership with Health Quality Ontario (HQQ). - Promote health equity and recognize the impact of social determinants of health to reduce or eliminate health disparities and inequities in the planning, design, delivery and evaluation of services by: - Identifying high-risk populations and working with public health and local community partners on targeted interventions to improve access to appropriate and culturally sensitive care, and improve health outcomes, including through sub-region planning. - Ensuring engagement with Indigenous leaders, providers and patients to guide investments and initiatives. - Assessing the capacity of health service providers within LHIN sub-regions and the extent to which Francophone citizens are provided with an active offer of health services in French, and develop a plan to strengthen health services in French.
Primary Care	- Continue to build primary care as the foundation of the health care system and work with health care providers to develop sub-region plans that: - Use an equity lens to assess the number and proportion of primary care providers based on the needs of the local population. - Improve access to primary care providers, including family doctors and nurse practitioners. - Facilitate effective and seamless transitions between primary care and other health and social services. - Improve access to inter-professional health care providers to ensure comprehensive care. - As a priority, develop and implement a plan with input from primary care providers, patients, caregivers and partners that embeds care coordinators and system navigators in primary care to ensure smooth transitions of care between home and community care and other health and social services as required. - Support the integration of Health Links into sub-regional planning with input from primary care providers.
Hospitals and Partners	- Work with system partners to improve how people move through the health system to avoid unnecessary hospital stays, reduce the length of time people must spend in hospital, including the emergency room, and reduce the number of people who are waiting in a hospital bed for the right level of care. - Support hospitals to enable the adoption of innovations in patient care, like bundled care.
Specialist Care	- To improve access to specialty care, work with providers to further reduce wait times and drive appropriate care utilization starting with people suffering from musculoskeletal (MSK) pain, and those suffering from mood disorders. - Support enhanced connections and communications across networks of providers to drive more effective and appropriate specialist referrals.
Home & Community Care	- With input from patients, caregivers and partners: - Reduce wait times and improve coordination and consistency of home and community care so that clients and caregivers know what to expect. - Continue to implement the initiatives in Patients First: A Roadmap to Strengthen Home and Community Care. - A key priority for 2017-18 is the completion and consolidation of the transition
Mental Health and Addictions	- Based on the advice from Ontario's Mental Health and Addictions Leadership Advisory Council, work with local partners and other sectors to expand access to mental health and addictions services that: - Expand access to structured psychotherapy and supportive housing. - Establish referral networks with primary care providers. - Make access to community mental health services a priority for sub-region planning, in collaboration with community and social service providers and partners. - Support the provincial opioid strategy, and provide support to connect patients with high quality addictions treatment.
Innovation, Health Technologies and Digital Health	- Champion Ontario as a leading ecosystem to adopt and scale new and innovative health technologies and value-based processes. - Support the ministry's Digital Health Strategy, once published, including but not limited to: - Ensuring that any Hospital Information System (HIS) renewal decisions are consistent with HIS Renewal Advisory Panel clustering recommendations and reflect a commitment to reduce the overall number of HIS instances in the province. - Implementing or expanding existing virtual models of care or digital self-care models that are consistent with existing provincial initiatives. - Supporting the delivery of digital solutions to improve patient access and navigation as well as referrals to specialists, and further expand online consultation between primary care providers and specialists.

Seven Day Health Care System

The Patients First Action Plan for Health Care, 2015 identifies providing faster access to the right level of care as a key objective to improving people's health care experience. This is especially true for persons needing access to acute care services. Unfortunately, many HNHB LHIN hospitals report individuals waiting many hours in the Emergency Department (ED) to be admitted to a hospital inpatient bed. Access to acute care beds can be impacted by patient flow pressures which are made worse when the number of people being discharged slows down. There are general observations and assumptions that the flow of discharges is not consistent during the week, with numbers of discharges dropping over weekends and during holidays; however, this has not been verified.

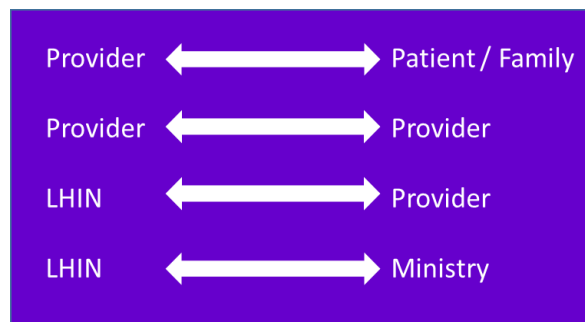
In the Fall of 2016 LHIN hospitals experienced increasing pressures on access to acute care beds. This pressure peaked in late December 2016 leading the HNHB LHIN Patient Flow Steering Committee to support an in-depth review to identify barriers to the establishment of a Seven Day Discharge Planning Model which was undertaken in January 2017. By mid-February 2017, more than 70 key informant interviews had been completed with partners/practitioners within the LHIN that contribute to seamless and timely discharges from acute care beds to the community. These partners include but are not limited to: acute care inter-professional staff and physicians, former CCAC staff, staff of complex continuing care and rehabilitation programs, staff of LTCHs and retirement homes, primary care physicians, community pharmacy, and supportive housing and mental health care practitioners.

Preliminary analysis of the interview content reveals clear themes across the system with strong agreement between sectors on the most challenging issues. A final report will be submitted to the Patient Flow Steering Committee in June 2017 that will organize barriers and provide a potential time frame for solutions; short, median and long term. This information will inform future work plans.

Patient Experience: Let's See What We Can Do Together

Feedback from patients, caregivers and HSPs tells us that despite multiple databases and information sites, it is still difficult to access and understand what services and programs are available to meet patient needs. This includes health services, social services, and other community supports. Patients and caregivers also report that gaps exist across transition points, they are not always well connected and they may need to find the next level of care and services on their own. Providers have also commented that it can be difficult to know what services patients are receiving and if there is duplication in service delivery and/or waitlists.

To address these challenges the HNHB LHIN will develop a two-pronged strategy to support navigation within the local health care system, enhance patient experience, and ensure good stewardship of health system resources. The strategy and related initiatives will support a "let's see what we can do together" approach. This concept will be woven into four different types of relationships.



In 2017-18 the HNHB LHIN will develop and implement the following:

- Profile and build on HNHBHealthline (an online resource) and My Health GPS transitioned to the HNHB LHIN from the HNHB CCAC.

- Create education materials so that HSPs and health system partners are aware of how to access and utilize HNHBHealthline and My Health GPS. Similarly ensure that materials are easily available to patients, families, and members of the public.
- An inventory of other databases and information portals will be conducted with a focus on social and community programs and services that can support individuals to live to their optimum level of health, well-being, and independence.
- Analyze data from HNHBHealthline and My Health GPS to better understand what services are being requested, and what needs exist by sub-region.
- Develop a program and campaign to create or support a culture of 'let's see what we can do together'. This may include communications materials, scripting for staff (including LHIN, Service Provider Organization (SPO), and HSPs), leadership modelling, and performance monitoring.

D. Environmental Scan of Opportunities and Risks

The HNHB LHIN encompasses Brant, Burlington, Haldimand, Hamilton, Niagara and most of Norfolk County - a geographic area of approximately 6,500 km² including both urban and rural areas. There are approximately 1.44 million people in the LHIN, representing about 10.4% of the population of Ontario¹ and the LHIN's population is projected to grow 7.4% over the next ten years.²

The following summarizes some of the key characteristics of the LHIN:

- The LHIN's population is aging. More than 260,000 people, aged 65 or older live in the HNHB LHIN and this number is projected to increase to approximately 360,000 by 2025 (which is a projected increase of more than 35%). Among seniors, the largest growth will be those 75 years and older.³ HNHB LHIN currently has the largest population of older adults, 75 years and older, in Ontario.⁴
- The LHIN has a diverse population. For 17% of residents, neither English nor French is their first language. Francophone, First Nations, Inuit, Métis, and urban Indigenous people are recognized populations in the LHIN. Compared to Ontario, the HNHB LHIN has a lower percentage of immigrants (19%) and visible minorities (10%).⁵
- About 2.3% of the LHIN population is defined as Francophone. Almost 80% of the LHIN's Francophone population resides in Hamilton and Niagara.⁶ Niagara, Welland and Port Colborne have the highest percentage of Francophone population compared to the overall population among communities within the LHIN.
- There are two First Nation reserves in the HNHB LHIN – Six Nations of the Grand River (SNGR) Territory, which has the largest population of all First Nation communities in Canada, and Mississaugas of the New Credit First Nation (MNCFN).
- In the HNHB LHIN 36,700 people identified themselves as “Aboriginal” in the 2011 National Household Survey, of which approximately 50% live on reserve.⁷

¹ 2011 Census of Canada, Statistics Canada.

² Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHealth Ontario.

³ Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHealth Ontario.

⁴ 2011 Census of Canada, Statistics Canada.

⁵ 2011 Census of Canada, Statistics Canada.

⁶ 2011 Census of Canada, Statistics Canada.

⁷ <http://www12.statcan.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=HR&Code1=3504&Data=Count&SearchText=hamilton&SearchType=Begins&SearchPR=35&A1=All&B1=All&Custom=&TABID=1>

- As of December 2015, SNGR band membership included 26,503 individuals and represented a similar population distribution to that of First Nations Peoples across Canada with half living on reserve and half outside their home territory.^{8,9} MNCFN is also located within the HNHB region and maintains a registered population of 2,324 people of which 58% live off-reserve.¹⁰
- While the LHIN has a similar population proportion of low income families as Ontario (13.9%), the rates of individuals living in poverty within Hamilton's urban core (37%) are approximately 2.5 times the provincial average. Compared to the Ontario average, the HNHB LHIN also has a higher percentage of lone parent families and a lower percentage of adults with high school and post-secondary education.¹¹

Socio Demographic Characteristics

While the LHIN's overall population is similar to the provincial population on a variety of socio-demographic characteristics, there are some distinct differences between and within the sub-regions.

Health Status

Health can be measured as perceived or self-reported indicators, as well as the presence or absence of disease or injury. Self-reported health can show aspects of health not captured in other measures.

More than 13% of LHIN residents rate their health as 'fair' or 'poor', which is higher than Ontario's rates. In addition, more LHIN residents say they are limited in their activities because of a physical or mental condition or health problem and have pain or discomfort that prevents them from engaging in activities.¹²

Illness, Disease and Death

LHIN residents have higher prevalence of people with multiple chronic conditions compared to the provincial average. Approximately 20% of LHIN residents have been diagnosed with high blood pressure or arthritis, 8% with diabetes, 8% with asthma, and 6% with Chronic Obstructive Pulmonary Disease (COPD).¹³ Increasing trends in the prevalence of diabetes, high blood pressure, and mood disorders have been reported since 2005.¹⁴

Death rates reflect the overall health of the population. Ischemic heart disease, dementia and Alzheimer's disease, lung cancer, and stroke were the top four leading causes of death in the HNHB LHIN. Potential years of life lost rates are useful for measuring the number of years of life "lost" from deaths that occur "prematurely" (i.e. before age 75). The rate of potential years of life lost within the HNHB LHIN are higher than provincial rates.¹⁵

Healthy Practices

Poor health practices, such as physical inactivity or poor dietary habits, may increase the risk of chronic disease, disability, and death. The rates of smoking are 24% in the LHIN, this is the highest rate in the province and is significantly higher than the provincial average of 18%. There is a significant degree of variation in smoking rates within the LHIN, with rates ranging from 9.9% to 37.3%.¹⁶

⁸ <http://www.sixnations.ca/MembershipDept.htm>

⁹ <https://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.cfm>

¹⁰ <http://www.newcreditfirstnation.com/community-profile.html>

¹¹ 2011 Census of Canada and 2011 National Household Survey, Statistics Canada.

¹² Statistics Canada, Canadian Community Health Survey, 2013.

¹³ Statistics Canada, Canadian Community Health Survey, 2013.

¹⁴ Statistics Canada, Canadian Community Health Survey, 2005-2013.

¹⁵ Death/Death Summary Tables, Statistics Canada, 2011.

¹⁶ Statistics Canada, Canadian Community Health Survey, 2013.

Activities that promote health, prevent disease, and reduce the risk of injury are important elements in the health and wellness of a population. These activities require individuals to be engaged in their health care and can be facilitated through an effective relationship with a primary physician. In the HNHB LHIN 96.3% of adults had a primary care provider, compared to 95.3% for Ontario.¹⁷

2. French Language Services

PART 1: IHSP Priority Description

The *French Language Services Act (FLSA) Ontario, 1986* guarantees the right for Ontarians to communicate and receive services in French from government and crown agencies within designated areas. Within the HNHB LHIN, designated areas include the cities of Hamilton, Welland and Port Colborne.

In its preamble, the *LHSIA* sets out the expectation that LHINs will comply with the *FLSA*. The *Patients First Act, 2016* builds on previous legislation and practice, highlighting the importance of providing health services in French and of considering French language services in planning. The *FLSA* reinforces the expectation that LHINs comply with the *Act* in the planning, design, delivery and evaluation of services.

PART 2: Engagement and Planning with the French Language Planning Entity and Francophone Communities towards Enhanced Access

Engaging and Planning with the French Language Planning Entity:

The HNHB LHIN has entered into a funding and accountability agreement with the local French Language Planning Entité (FLPE), which forms the basis of a partnership with the FLPE.

The FLPE's role is to assist and advise the LHIN in identifying the needs of French-speaking populations in the HNHB LHIN, and strategies to meet those needs. The FLPE is to provide advice to the LHIN on:

- Methods of engaging the Francophone community in the area.
- The health needs and priorities of the Francophone community in the area, including the needs and priorities of diverse groups within that community.
- The health services available to the Francophone community in the area.
- The identification and designation of HSPs for the provision of French Language Services (FLS) in the area.
- Strategies to improve access to, accessibility of and integration of FLS in the local health system.
- The planning for and integration of health services in the area.

In collaboration with the FLPE, the HNHB LHIN develops a Joint Annual Action Plan (JAAP), which aligns with the priorities outlined in the LHIN's IHSP. Based on the JAAP, the FLPE provides an annual work plan and a community engagement plan that follows the requirements of the Community Engagement Guidelines and Toolkit. The LHIN and the FLPE meet regularly, through the Joint Liaison Committee (JLC), to review progress on the JAAP, the work plan and the community engagement plan. This review process is particularly focused on the outcomes of activities that provide data to inform evidence-based decisions.

As part of its work plan this year, the FLPE produced a report entitled - Portrait of French- Speaking Immigration in the HNHB and Waterloo Wellington (WW) LHINs, Entité2, (November 2016). This report provides a base of information on a key segment of the French-speaking population in the HNHB LHIN, highlighting that 16.5% of the Francophone population are recent immigrants to Canada, largely from Africa and Europe. Francophone immigrants are generally younger than the rest of the Francophone population. Subsequent work will engage with this population, in order to provide the LHIN with advice on their needs relative to access to FLS.

¹⁷ Health Care Experience Survey results October 2015 to September 2016, Ontario Ministry of Health and Long-Term Care.

The HNHB LHIN engaged with HSPs and the FLPE regarding the *Patients First Act, 2016* with a specific focus on FLS. The HNHB LHIN facilitated six sub-region engagement sessions with HSPs and health system partners, and obtained feedback on how the system can better address the needs of French-speaking Ontarians.

Engaging with Francophone Communities:

The HNHB LHIN participates on two Francophone collaborative tables in the designated areas of Hamilton and Niagara (which includes Welland and Port Colborne). These tables (comprised of a number of health system partners including LHIN-funded HSPs, Public Health Units, municipalities, Boards of Education, and the FLPE) provide the opportunity to inform and to foster collaboration and develop initiatives to enhance health services in French and strengthen the Francophone communities.

PART 3: Addressing the Needs and Concerns of the Local Francophone Community

The 2011 census identified more than 30,000 people across the HNHB LHIN whose mother tongue was French. This population resides in all areas of the HNHB LHIN, with approximately 51% in Niagara, 26% in Hamilton, 13% in Burlington, 6% in Brant and 4% in Haldimand and Norfolk. Of significance, however, is the fact that only half of the Francophone population lives in the areas designated under the *FLSA* (Hamilton, Welland and Port Colborne), where identified and designated services are focused. The census identifies that the Francophone population is older than the general population in the HNHB LHIN with approximately one in four Francophone in Niagara and one in five in Hamilton over the age of 65.

Key issues to ensuring access to services in French are:

- The variability of health system literacy and experiences among different Francophone subpopulations (e.g., Ontario-born, immigrants, refugees).
- Approximately half of the HNHB French-speaking population lives outside of the designated geographic areas, where services in French are limited.
- Language barriers between patients and caregivers and HSPs.
- The awareness of health system partners regarding the health needs of the French speaking people and the availability of information/evidence about Francophone communities.
- The ability to provide equitable access to quality services in areas where the Francophone population is small.
- A shortage of bilingual health professionals.

Based on engagement with Francophone communities, the JAAP prioritizes a number of needs and concerns and identifies action plans to begin to address them.

Vulnerable Populations

The impact of the language barrier is more severe on French-speaking vulnerable populations. The 2017-18 JAAP maintains a focus on new immigrants, refugees, seniors living in isolation and patients with mental health issues. In 2017-18, the HNHB LHIN will develop plans to increase awareness of and access to services in French for these populations. These plans will be based on additional analysis from the FLPE on the needs of this population, in order to inform evidence-based discussion and decisions.

Mental Health and Addictions

In 2016-17, the HNHB LHIN completed an FLS needs analysis for MHA including demographic landscape, system gaps and bilingual staff capacity. In 2017-18, the HNHB LHIN is participating in the Provincial System Support Program (PSSP) in order to inform the work of the Provincial Mental Health and Addictions Leadership Advisory Council. The PSSP is led by the Centre for Addictions and Mental Health (CAMH) and the ministry. The purpose of the PSSP is to better understand the MHA needs of Francophone populations, along with system gaps and recommendations for change.

Based on this work, and in partnership with the FLPE, the LHIN will identify specific opportunities to improve access to MHA services in French, including the implementation of a telepsychiatry service, based on the model of the Northern Psychiatric Outreach Program (NPOP).

Enabling Technologies

Distance technology, such as Ontario Telemedicine Network (OTN) or any enabling technology can enhance access to FLS by connecting staff resources with dispersed and low volume clients. In 2016-17, the HNHB LHIN has continued to facilitate and support provincial education sessions on diabetes through OTN.

In 2017-18 the HNHB LHIN will lead a pan-LHIN group of FLS Coordinators working to:

- Evaluate technological options to provide distance care in French.
- Explore the possibilities of partnerships.
- Inventory best practices for use of telemedicine.
- Develop a provincial approach to coordinated access to FLS through technology.

Facilitating Recruitment of Bilingual Staff

A shortage of bilingual health care professionals is one of the challenges to the delivery of quality services in French. One of the causes of this shortage, is a lack of connection between education programs in French and HSPs, resulting in a difficulty in recruiting and retaining staff.

At the end of 2016-17, the HNHB LHIN, in collaboration with the Francophone Interagency Table in Niagara coordinated a recruitment tour, where bilingual health students from various programs and colleges visited five HSPs in one day. The purpose was to facilitate connections and potential recruitment. The results of this tour will be evaluated, with the potential to expand it to other areas within the HNHB LHIN.

Inclusion of an FLS Lens on the Collaborative Care Model

Since 2014, the HNHB LHIN has been working with the (legacy) HNHB CCAC and LHIN-funded assisted living and supportive housing agencies to implement a “one sector” model for the provision of personal support services (PSS). In 2016-17, the HNHB LHIN worked on the identification of existing FLS capacity among the agencies that participate to the Collaborative Care Model. In 2017-18 the HNHB LHIN will be working to improve capacity in French within the PSS system, including an emphasis on recruiting bilingual staff.

PART 4: Compliance with the *French Language Services Act*

As a Crown agency the HNHB LHIN has two roles with respect to FLS. It must ensure both its services, direct and indirect that it funds are available in French to the Francophone population. Once the LHIN takes on responsibility for the provision of home care service, there will be an added responsibility to ensure those services are available in French.

In order to ensure a standard assessment of LHIN compliance with the *FLSA*, the LHINs' FLS Coordinators developed a foundational document and checklist to gauge LHIN compliance in terms of:

- Corporate obligations.
- Communication and the principles of Active Offer.
- Internal capacity to provide services in French.
- Planning and community engagement.
- Accountability of HSPs.
- Working with the FLPE.
- Process of identification and designation.
- Reporting.

The same checklist, with minor modifications, has also been used to assess legacy CCAC compliance. Once the transition of the CCAC to the LHIN is complete, an updated readiness check will be undertaken to identify gaps and opportunities for the new organization. A work plan will then be developed to address those priority gaps.

At the time of the *FLSA*, the ministry ‘designated’ certain HSPs to deliver quality and permanent services in French. At that time, the ministry also ‘identified’ a number of HSPs expected to work towards designation. In the HNHB LHIN, there are two ‘designated’ HSPs and 31 ‘identified’ HSPs.

The LHIN holds all HSPs accountable for the provision of FLS, through the SAAs. In order to do this, the HNHB LHIN uses a FLS report template for identified agencies to determine their readiness to work towards designation, including provincial performance indicators on Active Offer.

For non-identified agencies, the HNHB LHIN uses a FLS report template to identify HSPs for the provision of FLS, which takes into account the population and its health needs within sub-regions. Designated HSPs that provide services in French under the provision of the *FLSA*, will submit a French language implementation report to the LHIN.

A review of HSP FLS reports in 2016-17 revealed that:

- 100% of identified agencies submitted their FLS reports on time.
- 98% of non-identified agencies submitted their FLS reports.
- The number of French-speaking clients served in French with the French Language identified agencies has increased.
- The legacy CCAC's FLS compliance plan was in its implementation phase and a FLS committee was in place following a phased work plan.

Based on the results of the 2016-17 review, in 2017-18 the HNHB LHIN and the health system partners, will develop a plan to reinforce and clarify HSPs' accountability for the provision of FLS and the reactivation of FLS planning among identified agencies. To that end, HNHB LHIN monitors HSPs progress/performance with respect to FLS implementation.

As required by the Funding and Accountability Agreement between the LHINs and the FLPE, the HNHB LHIN continues to work with the FLPE to coordinate planning efforts.

PART 5: Goals and Action Plans

Goal(s):

- Access to linguistically appropriate care for French-speaking communities is enhanced through joint action with the FLPE.
- The needs of the Francophone community are acknowledged and incorporated into LHIN planning and service delivery.
- The LHIN has a plan in place to move to compliance with the requirements of the *FLSA*.

Action Plans/ Interventions:

Action Plans/ Interventions: "We will deliver the following"	<i>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.</i>					
	2017-18		2018-19		2019-20	
Examples:	Status	%	Status	%	Status	%
Vulnerable Population						
Improve and increase information on health needs of the Francophone population, including immigrants.	In progress	25%	Completed	100%		
Raise the awareness of health system partners to French-speaking vulnerable populations, including Francophone newcomers.	Not yet started	25%	In progress	25%	In progress	25%
Improve information and navigation skills for Francophone immigrants.	In progress	25%	In progress	50%	Completed	25%

Mental Health							
Improve information about and raise awareness of system gaps.	In progress	25%	Completed	50%			
Improve access to psychiatric care through distance technologies such as OTN.	In progress	25%	Completed	50%			
Enabling Technologies							
Evaluate technology options to provide distance care.	In progress	25%	Completed	50%			
Explore the possibilities of partnerships.	In progress	25%	Completed	50%			
Inventory of best practices for use of telemedicine.	In progress	50%	Completed	50%			
Develop a provincial approach to coordinated access to FLS through technology.	Not yet started	25%	Completed	50%			
Increase Capacity of Health Bilingual Staff							
Facilitate the recruitment of bilingual staff, including interns and volunteers.	In progress	75%	Completed	50%			
Home and Community Care							
Improve capacity for services in French.	In progress	50%	Completed	50%			
Compliance with FLSA							
Reinforce and clarify HSPs' accountability for the provision of FLS.	In progress	50%	Completed	50%			
Develop a FLS plan to address priority gaps, including active offer within the new LHIN.	In progress	50%	Completed	50%			
Consistency with Government Priorities:							
Ontario's Patients First: Action Plan for Health Care: The goals outlined are consistent with the Minister's Patients First: Action Plan for Healthcare and are motivated by the following: • Focusing on people not just their illness. • Help patients understand how the system works so they can find the care they need when they need it.							
How will we measure success?							
The Patients First provincial work stream for FLS is in the process of developing specific FLS indicators, which will be consistent across all LHINs, and which may include the following: • Number of FL-identified agencies who submit their FLS reports. • Number of FL non-identified agencies who submit their FLS report. • Number of FL-identified agencies who put in place a mechanism to receive complaints or patient experience feedback. • Number of FL-identified agencies who have an "Active Offer" strategy. • The HNHB LHIN will align its measures of success to the provincial indicators.							
What are the risks/barriers to successful implementation?							
• Successful partnerships. • Shortage of bilingual health professionals.							
For each risk/barrier, describe the plan to mitigate the risk?							
• Regular engagement and collaboration with HSPs. Facilitate connections between education/training partners and HSPs.							

What are some of the key enablers that would allow us to achieve our goal?
- Distance technologies such as OTN to connect health resources with dispersed patients. - The FLPE engages Francophone groups and communities and relays information and expectations to the HNHB LHIN. - Collaboration of health system partners. - The Pan-LHIN FLS coordinators' three-year work plan which includes Francophone patient experience, Designation guide, LHIN renewal, Telemedicine, FLS indicators. - Tools, processes and initiatives that support and favor the inclusion of FLS into planning activities, i.e., the Health Equity Impact Assessment (HEIA). - Awareness of the health needs of Francophone communities at the governance and leadership levels.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).
n/a

3. Indigenous Peoples

PART 1: IHSP Priority Description
By listening and learning from local communities, the HNHB LHIN maintains a strong focus on the holistic 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 local relationships and partnerships that will contribute towards improving the health outcomes for present and future generations. Strategies to support this include: i. Knowledge Building through Education – support education and training opportunities that engender acceptance, trust and respect for Indigenous cultures. ii. System Navigation – improve the experience of Indigenous patients and families navigating the mainstream health care system. iii. Respectful Partnerships – help to facilitate strategic partnerships between Indigenous and non-Indigenous HSPs. iv. Engaging Communities – continue to explore new opportunities for meaningful engagement with Indigenous community members.
PART 2: Indigenous Engagement and Inclusion in Health Care Planning
Background: - Throughout 2016-17, the HNHB LHIN initiated and participated in numerous activities and action plans rooted in respectful engagement, meaningful inclusion and harmonized partnerships with local Indigenous partners. - The priorities and outcomes arising from these action plans were further strengthened by the ministry's commitment, through Patients First: Ontario's Action Plan for Health Care 2015, to be more inclusive of Indigenous voices in system planning and service delivery that will enable culturally appropriate care and incorporate traditional approaches to healing and wellness. - In addition, the release of the Truth and Reconciliation Commission of Canada's Final Report and Calls to Action, followed by The Journey Together: Ontario's Commitment to Reconciliation with Indigenous Peoples, signaled a pivotal cultural shift in how the health system views and develops relationships with Indigenous Peoples. - Consistent with these government priorities, the LHIN remains firmly committed to working alongside local Indigenous partners to dramatically improve the health and well-being of Indigenous Peoples through community-driven approaches to care that incorporates Traditional beliefs, knowledge and ways of being.

HNHB LHIN Indigenous Partners:

- The HNHB LHIN currently supports Indigenous health programs and services through funding to four Indigenous HSPs: De dwa da dehs nye>s Aboriginal Health Centre (DAHC), Native Horizons Treatment Centre (NHTC), and two First Nation communities - SNGR and MNCFN.
- Cumulatively, these HSPs deliver community-driven and culturally-based programs and services including MHA, case management, crisis intervention, palliative care, patient navigation and advocacy, Traditional medicine, in-home services and supports, caregiver supports, and LTC.
- The HNHB LHIN also collaborates regularly with other local Indigenous health and social service organizations, including three Friendship Centres, Southern Ontario Aboriginal Diabetes Initiative (SOADI), Native Women's Chapters, as well as several Indigenous housing organizations.
- Through the formation of the HNHB LHIN Indigenous Health Network (IHN), the HSPs and Indigenous organizations listed above have developed stronger partnerships with each other and the LHIN. Collectively, the IHN strengthens the voice of Indigenous communities and provides essential advice and direction on local health care priorities, planning and service delivery.
- Through the IHN's connection and engagement with local Indigenous community members across all LHIN sub-regions, the network brings forward the diverse perspectives and experiences of First Nations, Inuit, and Métis Peoples (FNIM) living both on reserve, off-reserve and in urban/rural settings.

Sub-region Planning with Indigenous Partners:

- In 2016-17, the HNHB LHIN met regularly with Indigenous partners to develop a plan for appropriate and equitable inclusion in sub-region planning. These discussions included three meetings with SNGR health care providers and physicians, four meetings with the IHN, bi-monthly updates at IHN business meetings, and SNGR representation at six LHIN-wide sub-regions planning sessions.
- Based on the feedback provided, key considerations for sub-region planning will include recognition of the diverse community health needs across each sub-region, the complexities of navigating Indigenous and mainstream health care services, and the need for planning decisions that reflect community-driven approaches to care. Indigenous partners also noted the strength and importance of planning together across all sub-regions to strengthen the voice of Indigenous communities while also addressing capacity limitations among local agencies.
- Moving forward, Indigenous partners have committed to quarterly sub-region planning meetings and will be identifying core expectations in regard to Indigenous Peoples health that must be considered in planning and decision making across all sub-regions.

HNHB LHIN Indigenous Health Network Sub-region Community Engagement:

- To guide the HNHB LHIN and Indigenous partners in effectively planning and delivering health care services for Indigenous communities at a sub-region level, the IHN hosted two community engagement gatherings in Niagara and Brantford respectively, attended by approximately 200 individuals. Participants included Indigenous community members and local health care providers working together to learn, share, and discuss current experiences, barriers, and opportunities to improve health care for Indigenous Peoples.
- Feedback from these two engagements included recommendations in the areas of cultural safety, Traditional medicine, MHA, diabetes, home and community care, and end-of-life (EOL) care. This information will be used by the LHIN and Indigenous partners to inform the directions of current and future sub-region planning and service delivery.

PART 3: Delivering Healthcare Services in Partnership with Indigenous Communities

The following action plans were advanced in 2016-17 to address the HNHB LHIN's top priorities in the area of Indigenous Peoples' health.

These action plans were developed and implemented in collaboration with Indigenous partners and aim to increase the capacity of the local health care system to provide care in a way that is culturally safe, appropriate and reflects the diverse experiences of Indigenous Peoples.

Key successes outlined below stem from the work of community partnerships as well as HNHB LHIN investments in cultural safety training, Traditional medicine, MHA, palliative care, and outreach services.

While many areas of opportunity and improvement remain, the success and achievements over the past year demonstrate a positive and evolving relationship between the LHIN, Indigenous partners, and mainstream HSPs.

HNHB LHIN Indigenous Health Network Action Plan

In 2016-17, the IHN continued to advance their 2015-2018 Strategic Plan which includes the following priorities:

1. Cultural Safety
2. Traditional Healing and Wellness
3. Strengthening the Family Unit
4. MHA
5. Chronic Disease Prevention

Key successes and achievements related to these priorities include:

- Between April 2016 and March 2017, the HNHB LHIN supported 316 health care workers to participate in San'yas Indigenous Cultural Safety Training program (ICS). Participants included HSP staff working in hospitals, primary care, community health centres (CHCs), home and community care, Community Support Services (CSS), MHA, LTC, and hospice palliative care.
- As of March 2017, 100% of the LHIN staff and 75% of the LHIN Board have participated in Indigenous Cultural Safety Training.
- In December 2016, DAHC received support from the LHIN for a Niagara-based adult mental health case manager and the enhancement and coordination of an outreach program model in Niagara. Through this initiative, DAHC has partnered with the Fort Erie Native Friendship Centre (FENFC), SOADI and other IHN organizations to broaden access to mental health services, patient navigation, primary care, and Traditional healing in Niagara.
- Three Aboriginal Patient Navigators (APNs) and two Aboriginal Child and Youth Mental Health Navigators continue to serve Indigenous clients across Hamilton, Niagara, Haldimand, Brantford, SNGR and MNCFN. As a result of increased awareness campaigning and improved communications with mainstream organizations, community members and health care staff have become more familiar with how to contact the APN program. This program has seen a consistent quarter over quarter increase in the number of referrals and individuals served from April 2016 to December 2016, providing a total of 2,167 clients with access to culturally appropriate services during this time period.
- To support the effective implementation of Health Links across the HNHB LHIN, Indigenous organizations including DAHC, SOADI, and three Friendship Centres have been engaged and identified as care partners involved in developing coordinated care plans for Indigenous community members in the Health Links model of care.
- Within the Six Nations Brant Health Link, SNGR has increased representation at Health Links planning tables and capacity building sessions to strengthen communication, collaboration, and coordination among SNGR and non-Indigenous HSPs.

Six Nations of the Grand River Territory Action Plan:

- Between March 2016 and May 2016, SNGR HSPs and physicians identified to the HNHB LHIN key priority areas to improve access to care for SNGR residents. Based on those priorities, the following outcomes were achieved to increase the capacity to deliver community-based programs and services:
 - Primary Care:
 - To enable and support a model of primary care that unifies SNGR physicians and their practices, the LHIN obtained approval from the ministry to add SNGR to the Managed Entry List of areas of high physician need. SNGR physicians are currently in the process of recruiting an additional physician to support the establishment of a Family Health Organization (FHO) primary care practice.
 - Traditional Medicine:
 - In June 2016, the LHIN supported SNGR's Ogowanohgwatae: (We Have Good Medicine) Traditional Medicine Program to increase access to Traditional medicine resources and advance the harmonization of Indigenous and mainstream approaches to care.

During the first four months of operation, December 2016 through March 2017, the OTMP helped 128 individuals through 431 visits, which included a combination of one-on-one healing sessions and cultural ceremonies¹⁸.

- Palliative Care and Home Care:

- In September 2016, the LHIN expanded SNGR's palliative care outreach team to sustain the delivery of in-home palliative services and support SNGR to provide care in a way that accommodates cultural, ceremonial and Traditional approaches. This enhancement also supported increased pain and symptom management and coordinated system navigation for individuals living in SNGR, MNCFN, and Haldimand.
- In addition to the priorities listed above, the HNHB LHIN is an active partner to SNGR's Degahahso:gweh (Sharing) Project. Funded by Health Canada the project focuses on improving coordination, collaboration, communication and integration of existing federally, provincially, and locally-funded MHA services. A key outcome of this work is to support smoother transitions and continuity of care across all MHA services offered by SNGR health and social service providers.
- SNGR's *Moving Forward on Harmonizing Indigenous and Western Medical Practices Project (Moving Forward Project)* also continues to progress in partnership with the ministry, Ministry of Indigenous Relations and Reconciliation, Ministry of Children and Youth Services (MCYS), and with support from the LHIN. Between April 2016 and December 2016, the *Moving Forward Project* convened a Traditional Medicine Advisory Council comprised of local Indigenous Medicine Practitioners, developed a local Decolonization/Indigenization Training and delivered the training to 52 community members, and hosted a two day Indigenous Medicine Practitioner retreat to discuss sustainability of practices and critical elements of developing referral systems.

PART 4: GOALS and ACTION PLANS

Goal(s):

Primary Care:

- Develop a local primary care strategy to improve transitions of care and strengthen communication pathways with community HSPs. This will be done in partnership with primary care physicians whose practices are located on SNGR Territory.

Mental Health and Addictions:

- Conduct an environmental scan of MHA services accessed by Indigenous community members served through Indigenous organizations. The scan will identify where people access services in order to inform capacity, sub-regional gaps and areas of opportunity. This will be done in partnership with the IHN.

Cultural Safety:

- Improve cultural safety across the health system by increasing the number of HSP staff trained in San'yas Indigenous Cultural Safety Training and developing complementary strategies to share knowledge of local Indigenous communities and cultures:
 - 100% of the HNHB LHIN Leadership Team have completed San'yas Indigenous ICS.
 - Develop and implement a strategy for increasing the number of frontline home and community care staff trained in Indigenous Cultural Safety.
 - In partnership with the IHN, develop and distribute an HNHB Indigenous culture card to support education of local Indigenous cultures.
- In partnership with Cancer Care Ontario (CCO), develop and implement a standardized approach to increase Indigenous self-identification in hospitals:
 - Complete an environmental scan and summary of wise practices of current hospital self-identification methods within the HNHB LHIN and across Ontario LHINs.
 - Engage with Indigenous community members to identify current experiences, barriers, and opportunities related to respectful and safe self-identification in hospitals.

¹⁸ Source: 2016-17 Quarterly Supplemental Performance Reporting.

- Develop a standardized Indigenous self-identification method and identify one LHIN hospital to implement this method into hospital patient registration processes.

Traditional Healing:

With guidance from the SNGR Traditional Medicine Advisory Council, develop a standardized referral protocol in collaboration with one LHIN hospital for referrals to Traditional Healing services.

Hospice Palliative Care:

- In collaboration with the Regional Palliative Care Network (RPCN), develop and initiate a plan to deliver equitable access to high quality care and support for First Nations, urban and rural Indigenous Peoples.

Consistency with Government Priorities:

Ontario's Patients First: Action Plan for Health Care:

The goals outlined are consistent with the Minister's Patients First: Action Plan for Healthcare and are motivated by the following:

- Focusing on people not just their illness.
- Provide care that is coordinated and integrated so people receive the right care from the right providers.
- Help patients understand how the system works so they can find the care they need when they need it.
- Faster access and a stronger link to health care.

Patients First includes five key components, one of which is the inclusion of Indigenous voices in health care planning. The LHIN system will be more inclusive of Indigenous voices through a stronger role in system planning and service delivery that will enable culturally appropriate care and incorporate traditional approaches to healing and wellness.

Ontario's First Nations Health Action Plan

In May 2016, the ministry initiated a three-year action plan and investment to ensure Indigenous Peoples had access to more culturally appropriate care and improved outcomes. Priorities include seniors care and hospital services, life promotion and crisis support, primary care, and public health and health promotion.

The Journey Together: Ontario's Commitment to Reconciliation with Indigenous Peoples

In alignment with the Truth and Reconciliation Commission of Canada Final Report and Calls for Action, the Ontario government released a plan in May 2016 to work with Indigenous partners to address the legacy of residential schools, close gaps and remove barriers, support Indigenous culture, and reconcile relationships with Indigenous Peoples. Through HNHB LHIN initiatives such as Indigenous MHA programs, Traditional Medicine programs, and Indigenous cultural safety training, the LHIN continues to align with priorities that advance reconciliation with Indigenous Peoples.

Action Plans/ Interventions:						
Action Plans/ Interventions: “We will deliver the following”	<i>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.</i>					
	2017-18		2018-19		2019-20	
Examples:	Status	%	Status	%	Status	%
Primary Care:						
In partnership with primary care physicians primarily serving SNGR community members, develop a local primary care strategy to improve transitions of care and strengthen communication pathways with community HSPs.	In Progress	50%	Completed	50%		
Mental Health and Addiction (MHA):						
In partnership with the IHN, conduct an environmental scan of MHA services accessed by Indigenous community members served through individual organizations to identify where they access services to inform capacity, sub-regional gaps and areas of opportunity.	In Progress	50%	Completed	50%		
Cultural Safety:						
100% of the HNHB LHIN Leadership Team have completed San'yas ICS Training.	Completed	100%				
Develop and implement a strategy for increasing the number of frontline home and community care staff trained in Indigenous Cultural Safety.	Completed	100%				
In partnership with the IHN, develop and distribute an HNHB Indigenous culture card to support education of local indigenous cultures and ways of being.	Completed	100%				
Complete an environmental scan and summary of wise practices of current hospital self-identification methods within the HNHB LHIN and across Ontario LHINs.	Completed	100%				
Engage with Indigenous community members to identify current experiences, barriers, and opportunities related to respectful and safe self-identification in hospitals.	Completed	100%				
Develop a standardized Indigenous self-identification method and identify one LHIN hospital to implement this method into hospital patient registration processes.	In Progress	25%	Completed	50%		
Traditional Healing:						
With guidance from SNGR Traditional Medicine Advisory Council, implement a standardized referral protocol in collaboration with one LHIN hospital for referrals to Traditional Healing services.	In Progress	50%	Completed	50%		

Hospice Palliative Care:						
In collaboration with the RPCN, develop and initiate a plan to deliver equitable access to high quality care and support for First Nations, urban and rural Indigenous Peoples.	In Progress	50%	Completed	50%		
How will we measure success?						
• Number of HSP staff who complete San'yas Ontario ICS Training. • Survey HSPs that had 10 or more staff complete San'yas Ontario ICS Training three months following completion as to whether the training course influenced how they interact with Indigenous patients/people. • Number of individuals who received access to cultural appropriate care through the APN program. • Number of Indigenous community members and health care providers who attend IHN community engagement sessions and report to the IHN on attendee evaluation of the value of each session. • A standardized referral protocol for Traditional healing service has been developed and piloted at one LHIN hospital. • A standardized Indigenous self-identification process has been developed and implemented at one LHIN hospital. • A plan to deliver equitable access to high quality hospice palliative care has been developed for First Nation and urban and rural Indigenous Peoples.						
What are the risks/barriers to successful implementation?						
• The financial cost of San'yas ICS Training may limit the number of HSP staff that participate. • Limited administrative capacity of Indigenous organizations to fully participate in health care planning processes and LHIN regional tables. • Change management in hospital settings and Indigenous communities related to increasing access and referrals to Traditional healing. • Limited number of local Traditional healers and absence of reimbursement policy/process for Traditional healers.						
For each risk/barrier, describe the plan to mitigate the risk?						
• The LHIN will explore alternative options to provide ICS education. • The LHIN will identify various methods and opportunities to gather feedback and input into sub-region planning. • Continue to partner with Six Nations Traditional Medicine Advisory Council and the IHN to manage the relationship with Traditional Medicine Practitioners as demand for Traditional Healing rises. • Improving partnerships between the hospital sector, home and community care and Indigenous health service providers through the IHN and SNGR. • Identify barriers to community member engagement and work with the IHN to develop collaborative opportunities for engagement.						
What are some of the key enablers that would allow us to achieve our goal?						
• Visible results from the perspective of Indigenous partners as a result of partnering with the LHIN. • Fostering respectful relationships and meaningful collaboration to develop community action plans with Indigenous partners. • Leverage wise practices and lessons learned from other LHINs through the Provincial Indigenous LHIN Network.						
Additional Comments (i.e. additional information that supports the implementation/success of the goal).						
n/a						

4. Operationalizing the Priorities

4.1. Digital Health

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
ENABLING STRATEGIES: Digital Health
IHSP Priority Description:
Implement and advance the uptake of digital health solutions and support the Ministry's Digital Health Strategy.
Current Status:
The HNHB LHIN's Digital Health Strategic Plan outlines how technology solutions will enhance the way patients receive Care. The principles to guide and grow Digital Health will: • Adopt and scale new and innovative health technologies and value-based processes. • Support the ministry's Digital Health Strategy (when published) including but not limited to: ○ Ensuring that any Hospital Information System (HIS) renewal decisions are consistent with HIS Renewal Advisory Panel clustering recommendations and reflect a commitment to reduce the overall number of HIS instances in the province. ○ Implementing or expanding existing virtual models of care or digital self-care models that are consistent with existing provincial initiatives. ○ Supporting the delivery of digital solutions to improve patient access and navigation as well as referrals to specialists, and further expand online consultation between primary care providers and specialists. Over the past year a number of inter-related Digital Health initiatives that support patient care were achieved. Health care decisions are complex and information is expansive. Digital Health solutions can improve: communication and timely access to information across systems, physicians and providers; and the patient experience. Minor delays can compromise patient safety, care and outcomes. An aggregated, real-time picture of the patient's journey improves patient flow, diagnosis, treatment and reduces duplicate tests. It is not unusual for patients and their families living in the HNHB LHIN to see multiple health professionals across multiple sub-regions: • ClinicalConnect is a regional electronic health record that allows a patient's record and investigations to be accessed by their family physician and consultants, allowing timelier decision-making and diagnosis as well as preventing the requirement to duplicate various investigations. • Currently, ClinicalConnect integrates data from 67 acute care hospitals, four legacy CCACs and Cancer Centres in the South Western Ontario (SWO) Digital Health Cluster (HNHB, Erie St. Clair, South West and WW LHINs), and from the Ontario Laboratories Information System (OLIS), the Southwestern Ontario Diagnostic Imaging Network (SWODIN), the Digital Health Drug Repository (DHDR), and the Diagnostic Imaging Common Service (DI-CS). Over 39,000 physicians, clinicians and provider support staff are now authorized to use ClinicalConnect as of December 31, 2016. (In the HNHB LHIN specifically, there are 16,884 registered users, 21 hospital sites, legacy HNHB CCAC, 1,142 primary/secondary care organizations (includes CHCs and LTC), 133 CSS, two Public Health Units (PHUs)). • Currently, Hamilton Health Sciences Corporation (HHSC) has expanded access and is able to review patients' Diagnostic Imaging (DI) reports provincially (beyond the SWO Digital Health cluster). Further rollout for all hospitals inside HNHB LHIN to receive these external diagnostic tests is planned for Q3 2017-18 as organizations sign agreements with eHealth Ontario. • Community laboratory services are a convenient option for patients who require blood work. This community lab data is now available to all health care providers with access to ClinicalConnect. Once again, this prevents duplication of testing and faster access for family physicians and consultants to receive these results.

- Working with the ministry, the HNHB LHIN is currently piloting the ministry's electronic Coordinated Care Tool in three of our Health Link communities (Brant Six Nations, Hamilton East and Hamilton West).
- Having the care tools available electronically will improve access for health care providers.
- Examples of initiatives to improve care delivery include: eNotifications: This will secure electronic communication to family physicians and the LHIN's Home and Community Care (legacy CCAC) when one of their patients has received care within one of the HNHB hospitals. Patients can be reassured that their health care providers have this information and can follow up with the patient and their family as appropriate.

Strategies to Support *Patients First Act*, 2016:

- ClinicalConnect, as described, provides a more complete and accurate view of a patient's health care journey. For example, with ClinicalConnect patients who arrive at the ED can be assured that the health professionals assisting them will have access to their most current medical records. Once the patient leaves the ED, their family physician and the LHIN's Home and Community Care will have access to this new information, so the patient does not have to repeat their story.
- Planning has been completed to leverage the existing ClinicalConnect integration to support a patient portal, where patients will have access to their health data, request appointments, have secure bi-directional messaging with providers and access educational information. This will better engage patients in their own health care and the implementation of this patient portal will begin in Fiscal Year 2017-18.
- Other Digital Health initiatives improving the patient experience include eConsult, eVisits, Tele-home and eShift:
- eConsult enables family physicians and specialists to consult with one another across the province so you get the best care possible without always having to travel to see a specialist. Advice from the specialist can be sent electronically to the family physician, either to start a particular treatment pathway, or suggest changes to current treatment or refer for further investigation.
- eVisit (Physician/Clinician to Patient): For many patients, traveling to specialty appointments is difficult. Using electronic technology, the use of Personal Computer Video Conferencing (PCVC) provides patients a "virtual" visit without physically going to an office.
- Telehomecare: remote patient monitoring model that is part of St. Joseph's Healthcare Hamilton's (SJHH's) Integrated Coordinated Care (ICC) Program for COPD or Congestive Heart Failure (CHF) patients. This allows patients to connect directly with their Case Manager.
- eShift: enables Registered Nurses in the community to care for multiple patients at the same time by assessing, monitoring, and directing interventions to Personal Support Workers (PSW) at the patient's side or arrange for a nurse to attend when needed.

Key issues for Digital Health Implementation:

- Increasing complexities, escalating demands, and competing priorities, are some of the key issues affecting Digital Health implementation.
- Many complex agreements from provincial agencies that require considerable review/negotiation and planning for operationalization.
- Challenges to successfully implement best practices around change management and adoption.

PART 2: GOALS and ACTION PLANS

Goal(s):

- Work with local partners to leverage and support update of digital solutions to improve access and referrals to specialists.
- Improve access to health information across the health care continuum.
- Improve patient engagement in their health care.
- 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:							
- Digital Health will allow/secure private exchange of patient information. - The ministry priority is to improve health care access and Digital Health is a critical success factor. - Alignment with the ministry directions and standards.							
Action Plans/Interventions:							
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.					
		2017-18		2018-19		2019-20	
Examples:		Status	%	Status	%	Status	%
eConsult – HNHB pilot rollout		In progress	75%	Completed	25%		
eNotifications - phase 1 targeted for completion May 2017. Phase 2 targeted for completion by end of Summer 2017.		Completed Phase 1 and 2	50%				
eVisits – OTN PCVC - Initial adoption psychiatry.		In progress	25%	In progress	25%	In progress	25%
Increase ClinicalConnect adoption.		In progress	20%	In progress	20%	In progress	20%
Health Links – support Care Coordination pilot Health Links.		Completed	25%				
Pilot secure messaging using ClinicalConnect. (Pilot group includes Primary Care, Hospital, Health Links, HNHB LHIN Home and Community Care).		Completed	25%				
Telehomecare/Telemedicine – complete review of early adopter implementations and plan for expansion.		In progress	25%	In progress	25%	In progress	25%
Complete integration of hospitals to Hospital Report Manager (HRM) and collaborate with OntarioMD® on the expansion and onboarding of physicians to HRM in HNHB LHIN and transition from Electronic Medical Record (EMR) Download.		In progress	25%	Completed	25%		
Canada Health Infoway Patient portal funding project -implementation – beginning fiscal 2017-18.		In progress	25%	In progress	25%	In progress	25%
eReferral - Acute to LHIN Home and Community Care eReferral via ClinicalConnect.		Completed	50%				
How will we measure success?							
- Some examples of success will include wait time data for specialists as well as lab and DI utilization. - Increase use of eConsults by primary care and specialists by 25%. - Increase use of telemedicine for the provision of clinical care i.e. OTN, PCVC. - All LHIN hospitals have implemented eNotification.							

What are the risks/barriers to successful implementation?
• Turnaround time for provincial privacy and security requirements/assessments/agreements/costs. • Expansion of Digital Health projects and competing priorities outpacing capacity. • Multiple and competing patient care priorities. • Data Sharing Agreements/Privacy Legislative changes/Consent Model processes.
For each risk/barrier, describe the plan to mitigate the risk?
Mitigating Strategies: • Development of an implementation plan geared to resource availability. • Collaboration with partners. • Re-prioritize work pending ministry/Digital Health Ontario (eDHO) directions or readiness. • Further partnering/collaboration (e.g., Mohawk College, McMaster University, secondments from partners, dovetail with other synergistic initiatives). • Continue to adjust, evolve and mature Digital Health program and establish new roles. • Engage other expert resources (e.g. Legal) and leverage/model other provincially available agreements.
What are some of the key enablers that would allow us to achieve our goal?
• Effective and efficient collaboration amongst the growing number of Digital Health stakeholders.
Additional Comments (i.e. additional information that supports the implementation/success of the goal).
n/a

4.2. Health and Wellness of the Population

PART 1: IDENTIFICATION OF PRIORITY
Priority:
HEALTH & WELLNESS OF THE POPULATION
Priority Description:
The provision of quality care and equitable access to programs and services requires an understanding of the individuals and communities being served. Variations in health outcomes across sub-populations may be driven by race, social, income and ethnic factors. Respecting the diversity of communities and a consideration of the broader social determinants of health will allow the LHIN to better explore and address challenges in health system navigation, as well as, structural and client service barriers that impede access to services and affect the provision of quality care. The <i>Patients First Act, 2016</i> enables the HNHB LHIN to promote health equity and reduce disparities and inequities through: • The implementation of LHIN sub-regions, which respects the diversity of local communities in the planning, design, delivery and evaluation of services. • Establishment of formal linkages with local PHUs through the Medical Directors of Health, thereby facilitating the integration of a population health approach into local planning and service delivery across the continuum of care. PHUs will assist the LHIN to uncover the unique needs of each community, identify disparities and develop solutions to improve population health and health equity. • Strengthen engagement with Francophone, and Indigenous communities as well as those HSPs that serve the populations in the planning and delivery of health services.

Current Status:

The HNHB LHIN continues its commitment to improve health equity in the health care system and has embedded a health equity lens to all business processes and program planning.

Through ongoing collaboration with planning tables addressing health service inequities for marginalized and vulnerable populations, the LHIN will build on its expanded mandate to include other high risk populations as identified in collaboration with local PHUs and other community partners. This will lead to the development and implementation of targeted interventions to improve access to appropriate and culturally sensitive care at the sub-region level.

An example of a population where the LHIN applied a health equity lens was the Migrant Agricultural Worker (MAW) population that works for the most part in Norfolk, Haldimand and Niagara. In 2015-16 the LHIN funded two CHCs (Grand River and Quest) to provide primary care services for this population. Funding was used for the implementation and expansion of MAW health clinics in the communities of Virgil, Vineland, Simcoe, Delhi, Beamsville and Brantford.

The Nurse Practitioner primary care-based model is supported by a team of professionals including a Registered Nurse, an outreach worker, a translator, and volunteers. In 2016-17 these programs served a total of 850 individuals and they continue to demonstrate success by exceeding performance areas measured.

To assist in identifying populations and inequities in programs and services, the HNHB LHIN has incorporated the HEIA tool into program planning and development processes. Implementation of the HEIA will assist HSPs and the LHIN to integrate health equity considerations into planning and decision-making. This will assist in identifying unintended impacts of any new or proposed service or program change.

In the HNHB LHIN, completion of the HEIA tool is required for Voluntary Integration submissions and Stage 1 Capital Proposals. In addition, the LHIN may request an HSP complete the HEIA tool when submitting Business Case Proposals, Service Delivery Change Forms (SDCFs), Capital Submissions, and formal evaluations of new programs, services and initiatives. The HEIA completed by HSPs will assist the LHIN and LHIN sub-regions in identifying other marginalized or vulnerable populations that require a health equity focus during planning and program development.

In response to the *Patients First Act, 2016*, the HNHB LHIN established the LHIN/Public Health Steering Committee, comprised of representatives from each of the five PHUs and LHIN Leadership.

PART 2: GOALS AND ACTION PLANS

Goal (s):

The HNHB LHIN will establish more formal linkages with Public Health, through the LHIN/Public Health Steering Committee. The Steering Committee will identify collaborative efforts to support local health planning and decision-making and specific objectives through the development of an integrated work plan. The plan will be shared between the LHIN and the five PHUs and may include:

- Agreeing on and communicating common definitions and principles for population health and health equity.
- Developing joint epidemiology/data management and common indicators in support of population health.
- Other specific initiatives or projects aimed at improving the health and wellness of populations across the HNHB LHIN.

Public Health expertise will also be used to assist in planning for the newcomer population. The LHIN will leverage learnings from the work of the Hamilton Mayor's Advisory Committee for Syrian Newcomers (Health Working Group) and the Hamilton Primary Care Table to improve access to health care services and system navigation for newcomers across LHIN sub-regions.

The HNHB LHIN will align with the provincial priorities of HQO and the ministry's Health Equity Branch. In 2016-17, HQO developed a Health Equity Plan and incorporated health equity into their QIPs to assist in the advancement of an equitable health care system. The HNHB LHIN will continue to work with HQO and the ministry as health equity indicators, outcome measures, and a health equity training strategy are still in development.

Consistency with Government Priorities:

The above noted goals and action plans are consistent with the provincial government and LHIN priorities as reflected in:

- *Patients First Act, 2016*
- Patients First: Action Plan for Healthcare, 2015
- *The Excellent Care for All (ECFAA) Act, 2010*
- *FLSA*
- Ontario's First Nations Health Action Plan
- The Journey Together: Ontario's Commitment to Reconciliation with Indigenous Peoples
- Ontario's Poverty Reduction Strategy
- Open Minds, Healthy Minds Ontario's Comprehensive Mental Health and Addictions Strategy
- Ontario's Long-Term Affordable Housing Strategy

Action Plans/Interventions:

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.					
	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
Design and develop the health equity action plan for the HNHB LHIN—with identified priorities.	Completed	100%				
Apply a health equity lens to sub-region planning and develop and initiate a plan to address inequities and service gaps at the sub-region level through analysis of population data and completed HEIAs.	In progress	50%	Completed	50%		
Conduct a current state analysis of LHIN-funded health resources at the sub-region level to inform and assist newcomers in health system navigation.	Completed	100%				
Complete an environmental scan of LHIN-funded HSPs to identify existing health equity focused policies, practices and activities.	Completed	100%				
Work with local PHUs to identify areas for coordination and collaboration in strategic planning to improve population health and wellness in HNHB LHIN.	In progress	25%	In progress	25%	In progress	25%

How will the LHIN measure success?

- Increased ability and confidence of the HNHB LHIN and HSPs to apply a health equity lens and population health approach to planning (e.g., use of the HEIA tool).
- Improved knowledge base of LHIN communities, health-related programs, and Human Health Resources (HHR) to inform funding decisions based on current and predicted need and trends in vulnerable populations.
- Improved health system performance monitoring through the establishment of health equity indicators, identification of and focus on outcome measures, and enhance performance review and risk assessment processes.
- Improved linkages between disease prevention, health promotion and care.
- Improved integration between public health and health service delivery to better address population health needs.

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 HSPs' 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 provincial strategies to build will and engage stakeholders. - Offer training and education to enhance the health equity knowledge of HSPs. - Collaborate with HQO, LHINs and PHUs to develop a common dataset.
What are some of the key enablers that would allow us to achieve our goal?
- Leveraging HQOs 2016 Health Equity Plan for health equity system development. - Leveraging the work of the IHN and the French Language Services Provincial Network. - Continued open and timely communication with the ministry's Health Equity Branch, HQO, local PHUs 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

4.3. Health Links

PART 1: IDENTIFICATION OF PRIORITY
Priority:
HEALTH LINKS
Priority Description:
The government's Patients First: Ontario's Action Plan for Health Care plans focus on the commitment to put people and patients first by improving the health care experience, reducing gaps in care and strengthening patient-centred care. Integrated service delivery means the system will focus on patient-centred care. This includes supporting the advancement of Health Links, a 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 Patients First: Ontario's Action Plan for Health Care, and it's the foundation for the HNHB LHIN sub-regions along with Primary Care, and Home and Community Care reforms. The care coordination, service delivery and integration activities that are central to the Health Links model are foundational to the Patients First strategy. Many of the Health Links' model of care attributes and processes, when expanded across sub-regions will support the needs of our population as a whole. This includes better communication, single point of contact, multi-disciplinary team approach to coordinated care and determining what matters to the patient including addressing their social needs. Health Links has been a mechanism to forge partnerships across a broad range of providers including within health and social services to address the social determinants of health. These partnerships have led to complex case resolution, better patient care and experience. The model respects local variations and needs, but abides by a core set of principles including:

- Patient-centred 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 model of care will continue to include collaboration with the LHIN's Indigenous and Francophone populations.

Current Status:

The LHIN has in place 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 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-centred 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 MHA, frailty and those that are palliative.
 - 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 Links model of care:

- Provide patient-centred 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 in 2012 as a key commitment in the ministry's Patients First: Action Plan for Health Care and were intended to transform the health care system through increasing access to integrated, quality service to the patient population living with complex conditions.

Action Plans/Interventions:**Action Plans****“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 e.g., if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.

	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
Continue to advance the implementation and standardization of the Health Links model of care based on a patient-centered model of care and best practices.	In-progress	25%	In-progress	25%	In-progress	25%
Develop Sustainability Plan for scale and spread of Health Links in each sub-region.	Completed	100%				

How will we measure success?

The HNHB LHIN will monitor the implementation of Health Links by tracking the following indicators:

1. Number of patients with complex chronic conditions with a coordinated care plan.
2. Reduce the number of 30 day readmissions to hospital.
3. Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere.
4. Reduce unnecessary admissions to hospitals.
5. Enhance the health system experience for patients with the greatest health care needs.

What are the risks/barriers to successful implementation?

- Real-time identification of patients that would benefit from the Health Links model of care.
- Primary Care physician engagement varies within the sub-regions.
- Capacity of the providers to universally change to a more patient-centred integrated model of care and adoption of the Health Links model of care.
- Information Technology (IT) solutions are required to address the sharing of health information across HSPs.

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, in order to identify patients with complex medical needs, high utilization or trending toward high utilization of health care resources, as well as those who would benefit from a coordinated approach to care planning.
- Health Links will work directly with primary care physicians on communicating the benefits of Health Links for their patients, and building sustainable relationships.
- Identify the need to transform the system to create a new way of working together that's patient-centred through various planning and operational mechanisms (e.g. committees), performance plans, and new business plans.
- Implement the ministry's solution for documenting the coordinated care plan across the HSPs.

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

- More integrated IT and funding resources.
- Advancement of the *Patients First Act, 2016*.
- Integrated service between health and social organizations.
- Effective interdisciplinary teamwork.
- Specially trained care coordinators to support the scale and spread of the Health Links model of care.

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

Coordinated patient-centred care with meaningful patient engagement 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 with smooth transitions.

Major transformation of the health care system needs to more easily link, if not incorporate, several domains including management, service delivery (health and social) and funding. The HNHB LHIN will continue to work with the ministry to ensure the necessary transformation is in place.

4.4. Home and Community Care

PART 1: IDENTIFICATION OF PRIORITY**Priority:****HOME AND COMMUNITY CARE****Priority Description:**

The premise of home and community care, which is well supported by scientific evidence and expert panels alike¹⁹, is that the preference of many individuals (and Ontarians) of all ages is to remain independent and in their own homes for as long as they can. This is only possible when appropriate supports are available, including one or more of the following: nursing care, physiotherapy, occupational therapy, speech language therapy, PSS, respite care, homemaking services, home healthcare supplies and healthy eating. Access to home and community care supports shorter hospital stays, and delays or avoids the need for admission to an institutionalized setting (such as a hospital or LTC). Home and community care is necessary for our health system to deliver on the promise of right care, right time and right place.

Current Status:

The *Patients First Act, 2016*, significantly change how home and community care services are delivered in Ontario. In 2017-18, all home care services previously provided by the HNHB CCAC transitioned to the HNHB LHIN.

To prepare for this transition, leadership from both organizations worked together to understand the current state and design the future for home and community care under the new mandate. A total of 18 Functional Integration Teams (FITs) were established to explore specific functions of the two organizations ranging from finance to clinical care and case management. Each FIT shared information and discussed processes, procedures and practices and, if appropriate, made recommendations to ensure operational readiness for transition.

The HNHB LHIN continues to lead the implementation of a model of care that integrates the legacy CCAC and CSS agencies providing in-home PSS. This “One Sector” model is directly aligned with system priorities of integration, consistency, capacity, quality and value outlined in the ministry’s Patients First strategy.

Major milestones achieved in 2016-17 include:

- Increased capacity in the CSS sector to maintain equitable access to PSS throughout the LHIN.
- Implementation of electronic referral solution, improving the flow of information between the legacy CCAC and CSS agencies enabling faster and more efficient coordination of individuals requiring in-home PSS.

¹⁹ Bringing Care Home. (2015). Report of the Expert Group on Home and Community Care to the Minister of Health and Long-Term Care: Ontario.

- A waitlist management strategy which prioritizes clients based on level of care need, as measured by standardized assessment.
- Standardized processes, such as communication materials, and policies for complaints management and phone escalation.

This work has strengthened relationships between sectors, standardized and improved consistency in the quality and amount of care provided to individuals at home and in the community, enhanced the capacity of CSS agencies to provide PSS, and improved integration across all sectors including primary and acute care.

Lessons learned will enable flexibility to adapt to pending initiatives from the ministry regarding Patients First: A Roadmap to Strengthen Home and Community Care (the 'roadmap').

In 2016-17 the LHIN allocated approximately \$16M in new base funding to allow the legacy CCAC to increase home care services and of this, \$2M was directed to support caregiver respite.

The HNHB LHIN funds a variety of services to support caregivers including adult day programs (ADPs), companion support, educational "self-care" programs, and in-home and overnight respite. Respite providers are working together to coordinate access to these various programs and this work will continue in 2017-18.

The HNHB LHIN is an early adopter in implementing one of the strategies outlined in the roadmap known as bundled care. Called the Integrated Comprehensive Care Program (ICCP), this model of care strengthens the integration of health care service between hospitals and home and community care. The ICCP was implemented across all acute hospitals in the HNHB LHIN in 2016-17, and initially targeted individuals hospitalized with COPD and/or CHF. Between April and December 2016, 1,020 individuals were enrolled in this program, and preliminary results demonstrated a one day in-hospital reduced length of stay (LOS), a 9% decrease in all cause readmissions within 30 days and a 13% decrease in all cause readmissions within 60 days compared to baseline.²⁰ A provincial evaluation is underway and may result in expansion of this program model to include other care pathways.

Finally, 2016-17 marked the third year of the PSS Wage Enhancement initiative. Now completed, this province-wide initiative enhanced the wages of PSWs in LHIN-funded community organizations throughout the HNHB LHIN, allowing stability and improving the ability of HSPs to recruit individuals to join this valued workforce.

PART 2: GOALS AND ACTION PLANS

Goal (s):

The transition of home care services from the HNHB CCAC to the HNHB LHIN will enable many new opportunities for planning, integration and funding of home care services. There will be a concerted effort to transform the home and community care system, initially by focusing on the initiatives outlined in the roadmap. Principles guiding the transformation of home and community care include building a system where people:

- Who need care most have better access to the right care (using sub-regions as a context for capacity planning and resource allocation).
- Receive more consistent care.
- Better understand what services are available (transparency).
- Receive more caregiver support.

²⁰ HNHB Integrated Decision Support Accessed February 17, 2017

In 2017-18, and using this planning framework, the HNHB LHIN has set the following home and community care goals:

- Ensure the continuity of home care service delivery (post-CCAC transition):
 - Patient care will be continuous. There will be no interruption of service and no decrease in experience, quality or safety.
 - Care delivery and related services (e.g., placement, resource matching and referrals) will remain as core activities.
 - Confidence and trust of community, patients and stakeholders is maintained and ideally improved.
- Move the coordination of care closer to the patient:
 - Strengthen the integration of primary care and home and community care by exploring options to embed care coordinators and system navigators in primary care practices. The HNHB LHIN will develop and test an integration model in 2017-18 in select primary care offices.
 - Conduct a comprehensive review of all system navigation and care coordination resources and models in the community.
 - Improve public understanding and expectations related to accessing home and community care.
 - Improve coordination and consistency in caregiver access to respite services according to level of need.
- Improve transitions in care that are supported by home care:
 - Expand the implementation of Integrated Funding Models (IFMs) for episodic care utilizing the expertise of the ICCP leadership and as directed by the ministry.
 - Participate in provincial evaluation of IFMs to monitor outcomes of the ICCP.
- Ensure geographic alignment of home care service providers with sub-regions:
 - Conduct capacity planning for home and community care in each sub-region, identifying discrepancies in access and availability of services and planning for equity across the LHIN.
 - Work with Francophone and Indigenous populations to further understand home and community care needs and ensure equitable access to services.

Consistency with Government Priorities:

The *Patients First Act, 2016*, transformed the role of the LHIN in relation to home and community care and brought new opportunities for planning, integration and funding of services. As outlined in the Patients First strategy, including the roadmap, Ontario's health system will prioritize 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.
- Improving client and care giver experience.
- Driving greater quality, consistency and transparency.
- Planning for expanded capacity.
- Modernizing delivery.
- Identifying the unique needs of Indigenous and Francophone populations.

Action Plans/Interventions:

Action Plans “We will deliver the following:	<i>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 e.g., if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.</i>					
	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
Work with CCAC to ensure continuous patient care through transition.	Completed	100%				
Develop and test an integrated model for care coordination in select primary care settings.	In progress	50%	Completed	50%		

Review system navigation and care coordination resources and models in the community.	Completed	100%				
Work with patients and families to understand expectations for home and community care and develop communications strategy as appropriate.	In progress	50%	Completed	50%		
In alignment with the ministry's strategic direction, including the Levels of Care Framework, improve public understanding and expectations related to accessing home and community care.	Completed	100%				
Implement standardized method for assessing caregiver distress and use to coordinate access to respite.	In progress	50%	In progress	25%	Completed	25%
Participate in provincial evaluation of IFMs to monitor outcomes of the ICCP.	Completed	100%				
Expand IFMs for episodic care throughout the HNHB LHIN.	In progress	50%	Completed	50%		
Develop a capacity plan for ensuring equitable access to home and community care in each sub-region.	In progress	50%	Completed	50%		
Work with Francophone and Indigenous populations to develop specific plans for improving access.	In progress	25%	In progress	50%	Completed	25%

How will the LHIN measure success?

- Overall satisfaction and confidence of patients, families and caregivers, HSPs, and other stakeholders with health care in the community.
- Improved performance on MLAA indicators:
 - 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 services.
 - Percentage of home care clients with complex needs who received their first nursing visit within five days of the date they were authorized for nursing care.
 - 90th percentile wait time from community for CCAC in-home services, application to first service.
- 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?

- Inconsistent access to home and community care based on assessed level of need across Ontario.
- Demand for home and community care services for both care recipients and caregivers 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?

- Work with the ministry, LHIN colleagues and HSPs to ensure consistency in the level of care that should be provided to care recipients and their caregivers relative to their assessed level of need.

• 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-region. Capacity planning should include adult day and respite programs, as families may benefit from coordinated access to a variety of home and community care services rather than separate access to each. • 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?
• Roadmap deliverables, including the Statement of Home and Community Care values, Levels of Care Framework, findings from self-directed funding projects, online resource for caregiver supports and capacity planning framework, shared with LHINs. • Electronic patient tracking system to monitor the number of PSS hours provided to a person across various services is in place. This will ensure individuals receive the appropriate maximum hours of allocated PSS. • Ongoing leadership from the HNHB LHIN and HSPs continues. • Existing networks, such as the Home and Community Care Collaborative, Primary Care Network and Health Links tables continue. • Continued participation in the provincial IFM project and Community of Practice.
Additional Comments (i.e. additional information that supports the implementation/success of the goal)
n/a

4.5. Mental Health and Addictions

PART 1: IDENTIFICATION OF PRIORITY
Priority:
MENTAL HEALTH AND ADDICTIONS
Priority Description:
The Patients First: Action Plan for Health Care, 2015, exemplifies a commitment to ensure people are at the centre of the health care system by focusing on putting the needs of the person first. It outlines the need to provide faster access to the right care for MHA programs and services including expanding MHA prevention programs, improving access to community care, reducing wait times for services, and integrating other supports such as housing and employment. The ministry also identifies plans to inform individuals by expanding mental health programs in schools and workplaces that promote well-being and prevent addictions. The provincial Mental Health and Addictions Leadership Advisory Council, established in 2014, was provided with a three year mandate to advise the Minister on the implementation of the <i>Open Minds Healthy Minds</i> Strategy. The strategy also outlines four overarching goals: • Improve mental health and well-being for all Ontarians. • Create healthy, resilient, inclusive communities. • Identify MHA problems early and intervene. • Provide timely, high-quality, integrated, person-directed health and other human services.

Current Status:

The complexity of the MHA system presents a challenge for persons needing access to MHA services, their families, primary care providers and the HSPs supporting the person. While the HNHB LHIN funds 38 HSPs to provide specific MHA services, there are also numerous other providers, agencies and organizations (funded by the LHIN and others, including other ministries and Health Canada) that support persons with mental health issues and/or addictions.

In 2016-17, the HNHB's MHA Advisory Group identified ten priority areas (split between continuing and new) for focused action and/or investments.

Continuing Priorities:

- Develop an Early Intervention (EI) service delivery model.
- Develop a concurrent disorders capacity building strategy.
- Enhance crisis outreach and support services.
- Complete a review of the Schedule 1 bed long stay population.
- Improve the transitions of children and youth to adult MHA services.

New Priorities:

- Identify core MHA services needed at the local, sub-region, and LHIN levels.
- Develop and implement an anti-stigma strategy for HSPs.
- Improve access to Schedule 1 beds (paediatric and adult).
- Identify and address factors that result in repeat ED visits for MHA and improve coordination of care for individuals.
- Improve access to supportive housing for persons with MHAs.

To implement the LHIN's MHA Action Plan the MHA Advisory Committee (Committee) was reestablished with a new mandate and included a broader membership with representation from Ministry of Child and Youth Services (MCYS), MCYS Lead Agencies, HSPs serving Indigenous Peoples, community MHA providers, caregivers and persons with lived experience. The Committee will recommend actions and activities to develop and strengthen a comprehensive integrated MHA system that is:

- Aligned with provincial directions and LHIN priorities.
- Centred on patient/person outcomes and experience.
- Based on a foundation of involved and supported primary care.
- Provide leadership to advance standardization, education, coordination and continuous quality improvement based on best practices across all sectors within the HNHB LHIN.

In 2016-17, the HNHB LHIN, with the support of the Committee, worked with HSPs to achieve the following from the 2016-18 Action Plan:

- Developed an EI service delivery model that incorporated the implementation of the Global Appraisal of Individual Need (GAIN) Short Screener to measure clinical outcomes (i.e., effectiveness of the interventions), and the Ontario Perception of Care tool to monitor perception of clients and their families at SJHH Youth Wellness Centre (with other programs to follow). These standardized measures will help to ensure that outcomes of services provided and experience of clients and their families are measured.
- Expanded EI Programs to Burlington, Brant, Haldimand-Norfolk, and Niagara to support equitable access across the sub-regions.
- Improved the transitions of children and youth to adult MHA services:
 - The development and implementation of a transition protocol and resources, including coordination functions, for youth transitioning from inpatient mental health services at McMaster Children's Hospital (MCH) to adult services at SJHH was completed. This will enable smooth transition for individuals in inpatient MH services from paediatric to adult services.
- Improved access to Schedule 1 beds:
 - Developed a new pathway for community hospitals in the Haldimand-Norfolk and Brant sub-regions to enable direct referral and transfer of high risk children and youth to MCH Paediatric ED. This new pathway reduced the number of handoffs, transitions, and time to access the right level of service.

- Reviewed Schedule 1 Bed Long Stay population:
 - Established a definition of long inpatient MHA stays (>90 days in acute beds and >365 days in tertiary beds) and gathered data across Schedule 1 hospital sites. Individuals with LOS meeting this criteria were reviewed with community partners. This enabled important discussions about the potential for transition for individuals back to the community.
- Developed a Concurrent Disorders Capacity Building Strategy:
 - An online Concurrent Disorders Foundations module was developed and over 295 MHA HSP staff participated and received certificates of completion.
 - Ten change projects implemented across the HNHB LHIN aligned within a Triple Aim framework of population health improvements for individuals with Concurrent Disorders. These included: targeted capacity building projects with MHA HSPs in Burlington and Niagara, the implementation of Concurrent Disorder group programming for individuals and their families in Hamilton and Brantford and Care Collaboration projects in Haldimand and Norfolk.
- Enhanced Crisis Outreach and Support Services:
 - Expanded the Mobile Crisis Rapid Response Team (MCRRT) model to Haldimand and expanded hours of coverage in Niagara. This partnership model between justice and health pairs a police officer with a MH worker as first responders to a 911 call involving a person experiencing a mental health or addiction crisis. This program model which expanded in 2015 to Brant, Halton, Niagara and Norfolk reported, as of September 2016, ED diversion rates of 70-87% and that 68-82% of individuals who were in contact with the MCRRT were connected to alternate services in the community.²¹

PART 2: GOALS and ACTION PLANS

Goal (s)

The expanded mandate provided to LHINs through the *Patients First Act, 2016* provides the LHIN with the support of the Mental Health and Addictions Advisory Committee in collaboration with HSPs and relevant partners to advance system integration, standardized care and cross sector collaboration in the planning and delivery of MHA services at the LHIN and sub-region levels while advancing provincial MHA priorities.

Access to MHA Services/Supports:

- Explore opportunities and recommend a solution to LHIN leadership for a MHA Common Intake/Centralized Intake tool/technology.
- Support the development of the provincial opioid strategy and provide local support to connect patients with addiction treatment services by mapping the current state of LHIN-funded addictions services by sub-region in order to identify opportunities to improve access and/or identify service gaps. The identified opportunities will be used to inform sub-region service planning.
- Map and expand access to structured, evidence-based psychotherapy with guidance from the ministry.
- Identify the core MHA services that should be available to all individuals as needed at the local, sub-region, or LHIN-level to support sub-region planning.
- Complete a current state capacity assessment of HNHB LHIN-wide supportive housing and identify opportunities to:
 - Collaborate and leverage existing resources in order to increase capacity of and access to supportive housing, in alignment with provincial direction.
 - Identify and implement innovative supportive housing models to provide best practice care and improve sector capacity.
- Continue to improve access to Schedule 1 beds for children, youth, and adults by implementing LHIN-wide pathways to ensure timely and equitable access to emergency and inpatient MH services.
- Address factors that result in repeat emergency visits by spreading and scaling local initiatives that have reduced inappropriate repeat use of EDs for MH and or substance use.
- Enhance crisis outreach and support services through:

²¹ HNHB LHIN Board Meeting – December 7, 2016 Mobile Crisis Rapid Response Briefing Note

- Establishing standards for Crisis Outreach and Support Teams (COAST) and MCRRTs within the LHIN. This is building on the ministry's Crisis Response Service Standards of 2005 to ensure individuals' equitable access to standardized, high quality services across the LHIN. Assess current state versus standards, and develop a plan for sustainability and spread to local communities, leveraging existing resources in collaboration with community partners.
- Develop and implement an anti-stigma strategy for HSPs to ensure individuals living with mental health and addiction issues who are accessing the health care system do not have stigmatizing experiences.
- Identify opportunities in collaboration with the LHIN's Physician Lead/Primary Care Physician to:
 - improve access to specialists for individuals suffering from mood disorders.
 - establish referral networks with primary care providers for persons with MHAs
 - develop a process to review three HQO MHA standards and develop an implementation strategy.

Children and Youth:

- Continue to develop a LHIN-wide EI service delivery model through developing service standards to ensure individuals have equitable access to standardized, high quality services in EI programs across the HNHB LHIN. Implement the GAIN Short Screener to measure clinical outcomes, the Ontario Perception of Care tool to measure client and family experience of care, and the SJHH Youth Wellness Centre Youth Engagement Tool to ensure engagement of youth in program development in line with best practices across all LHIN-funded EI Programs.
- Develop and implement a pathway/process that will facilitate seamless transitions for children and youth to adult MHA services through the implementation of local improvement initiatives in each of the six sub-regions to avoid gaps in service.

Consistency with Government Priorities:

The LHIN's 2016-18 MHA Action Plan was developed by the LHIN in partnership with the HNHB LHIN Mental Health and Addictions Advisory Committee to align with the goals of:

- *Open Minds Healthy Minds*, the Provincial Mental Health and Addictions strategy
- *Better Mental Health means Better Health*, the first annual report of the Provincial Mental Health and Addictions Leadership Advisory Council.
- Patients First: Action Plan for Health Care, 2015
- *Patients First Act 2016*

Additionally, this priority is aligned with the following government priorities:

- FLSA
- Ontario's First Nations Health Action Plan
- LHSIA
- IHN priorities

Action Plans/Interventions:

Action Plans "We will deliver the following":	<i>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 e.g., if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.</i>					
	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
Mental Health and Addictions						
Complete a current state capacity assessment of HNHB LHIN-wide supportive housing and identify opportunities to: • Collaborate and leverage existing resources in order to increase capacity of and access to supportive housing, in alignment with provincial direction.	In progress	25%	In progress	25%	In progress	25%

Implement innovative supportive housing models to provide best practice care and improve sector capacity.						
Implementation of a LHIN-wide EI service delivery model.	In progress	50%	Completed	50%		
Complete a current and future state mapping of LHIN-funded addiction services by sub-region to identify opportunities to improve access and/or identify service gaps that will be used to inform sub-region service planning.	Completed	100%				
Identify the core MHA services that should be available to all individuals as needed at the local, sub-region, or LHIN level.	Completed	100%				
Establish standards for COAST and MCRRTs within the LHIN and assess against current state. Develop a plan for sustainability and spread to local communities, leveraging existing resources in collaboration with community partners.	In progress	50%	Completed	50%		
Explore opportunities and recommend a solution the LHIN Leadership for a MHA Common Intake/Centralized Intake tool/technology.	Completed	100%				
Develop and implement a pathway/process that will facilitate seamless transitions for children and youth to adult MHA services through the implementation of local improvement initiatives in each of the six sub-regions to avoid gaps in services.	In progress	25%	Completed	50%		
Identify and address factors that result in repeat visits for MHA and improve coordination of care for repeat visitors to EDs.	In progress	75%	Completed	50%		
Improve access to Schedule 1 beds for children, youth, and adults.	In progress	50%	Completed	50%		
- Identify opportunities in collaboration with the LHIN's Physician Lead/Primary Care Physician to: - improve access to specialists for individuals suffering from mood disorders. - establish referral networks with primary care providers for persons with MHAs - develop a process to review three HQO MHA standards and develop an implementation strategy.	Not started	25%	In progress	25%	In progress	25%
How will the LHIN measure success?						
The HNHB LHIN will leverage the ten system-level indicators recommended to the ministry by the Provincial Mental Health and Addictions Leadership Advisory Council in their 2016 report "Moving Forward" to measure success: - Overall rating of services received by clients (Community-based and hospital services indicator) - Use of physical restraints (hospitals indicator) - Years of life lost due to MHA (population indicator) - Rate of death by suicide (population indicator) - Wait times from referral to service initiation (Community-based services indicator) - First contact in the ED for MHA						

7. Repeat unscheduled emergency visits within 30 days (System indicator) 8. Doctor visit within seven days of leaving hospital after treatment for MH and/or addictions (System indicator) 9. Rate of inpatient readmission within 30 days of discharge (System indicator) 10. Alternate level of care (ALC) (System indicator)
What are the risks/barriers to successful implementation?
- Capacity planning may identify discrepancies in supply and demand of particular services within sub-regions. - Barriers in access to and delivery of education programs (e.g., cost of programs, backfilling of staff, access to specific education programs, availability of human resources to coordinate and deliver education programs). - Readiness to change practices and processes.
For each risk/barrier, describe the plan to mitigate the risk?
- Encourage voluntary integrations across the LHIN. - Consider innovative approaches to access scarce resources (i.e., Digital Health solutions, etc.). - LHIN-wide monitoring of planning between service delivery areas. - Factor in staffing, timing and location issues when determining regional funding proposals and education plans. - Utilize technology to mitigate barriers of time and distance, and leverage local academic expertise when possible. - Engage Primary care and frontline staff in education related to best practice. - Monitor projects closely to ensure progress is manageable, reasonable, and achievable. - 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 HNHB LHIN HSPs to share successes of integrated services. - Utilize academic backing (e.g. journal publication) to document and promote initiatives where possible.
What are some of the key enablers that would allow us to achieve our goal?
- Sub-regions as the focus for planning with committed partnership and continued collaboration between HSPs, primary care, and other community stakeholders. - Continued and strengthened relationships with other Ministries (e.g. MCYS on EI and Child and Youth Transition work). - Guidance of the HNHB LHIN Mental Health and Addictions Client and Family Advisory Committee. - Support of the HNHB LHIN Mental Health and Addictions Advisory Committee. - Guidance of the Provincial Mental Health and Addictions Leadership Advisory Council and the ministry. - HQO MH standards. - Change management within provider organizations.
Additional Comments (i.e. additional information that supports the implementation/success of the goal)
n/a

4.6. Hospice Palliative Care

PART 1: IDENTIFICATION OF PRIORITY
Priority:
HOSPICE PALLIATIVE CARE
Priority Description:
Hospice palliative care, often referred to as “palliative care”, is a philosophy of care that aims to relieve suffering and improve the quality of living and dying. It aims to help individuals and families:²² • Address physical, psychological, social, spiritual and practical issues and their associated expectations, needs hopes and fears. • Prepare for and manage self-determined EOL and the dying process. • Cope with loss and grief during the illness and bereavement. • Treat all active issues and prevent new issues from occurring. • Promote opportunities for meaningful and valuable experiences, personal and spiritual growth and self-actualization. In surveys of patients and caregivers in Ontario, most people say they would prefer to die at home.^{23,24} Research demonstrates that more people would be able to die at home when services such as high-quality home care and home visits from doctors who provide palliative care are available. However, most patients in Ontario still die in hospital, even among those who received palliative care.²⁵ Changes to the quality, availability and integrated delivery of palliative care services in HNHB communities will lead to improvements in the patient and caregiver experience while working to create a sustainable and efficient health care system for future generations.
Current Status:
Patients First: A Roadmap to Strengthen Home and Community Care established goals and set out the following priorities for palliative and EOL care: • Support greater patient choice for palliative and EOL care. • Expand access and equity in the palliative system. • Establish clear oversight and accountability. • Introduce new supports for caregivers. • Support enhanced public education on the issue of advanced care planning. In March 2016, the ministry announced the establishment of the Ontario Palliative Care Network (OPCN). Accountable to the ministry, the OPCN is an organized partnership of community stakeholders, HSPs and health system planners responsible for the development of a coordinated, standardized approach to the delivery of hospice palliative care services in the province.²⁶ The provincial palliative structure included the development of Regional Palliative Care Networks (RPCN) under the joint accountability of the LHIN CEO and Regional Cancer Centre Vice President (RVP).

²² Quality Hospice Palliative Care Coalition of Ontario. (2011). Advancing high quality, high value palliative care in Ontario: A Declaration of partnership and commitment to action. Available at: http://health.gov.on.ca/en/public/programs/ltc/docs/palliative%20care_report.pdf

²³ Brazil K, Howell D, Bedard M, Krueger P, Heidebrecht C. Preferences for place of care and place of death among informal caregivers of the terminally ill. *Palliative Medicine*. 2005;19(6):492-9.

²⁴ Bainbridge D, Hsien S, Sussman J, Pond G. Factors associated with acute care use among nursing home residents dying of cancer: a population-based study. *International Journal of Palliative Nursing*. 2015;21(7):349-56 8p.

²⁵ Brumley R, Enguidanos S, Jamison P, Seitz R, Morgenstern N, Saito S, et al. Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care. *Journal of the American Geriatrics Society*. 2007;55(7):993-1000 8p.

²⁶ OPCN Backgrounder and Key Messages July 2016

These local networks will provide the leadership and structure to facilitate the development of a comprehensive, integrated and coordinated system of hospice palliative care for LHINs.

Across the HNHB LHIN there are a number of palliative care services available in the community, hospital settings, residential hospices and LTCHs, including:

- Five residential hospices across the LHIN with a total of 46 beds.
- Good Shepherd Centre, Emmanuel House - a ten bed assisted living program that provides palliative EOL care.
- Interdisciplinary Palliative Outreach Teams.
- Palliative Pain and Symptom Management Consultant Program.
- Palliative Care Volunteer Visiting programs.
- 100 complex care beds for persons at EOL who require pain and symptom management and skilled interventions delivered by an inter-professional team.²⁷

In 2016-17 the HNHB LHIN, in partnership with the RVP, worked with stakeholders to transition the LHIN's existing Regional Palliative Care Council to the new RPCN governance model. During this transition the RPCN continued to advance the 2015-18 work plan:

- Three Family Health Teams (FHTs) were recruited to pilot the Early Identification and Prognostic Indicator Guide. The project was implemented in Hamilton, Niagara and Niagara-on-the-Lake in September 2016 with 20 primary care physicians.
- Developed a Regional Palliative Care Education Plan through the RPCN Education Working Group.
- Developed and implemented a five week education strategy attended by approximately 240 learners, including CCAC Care Coordinators, SNGR Home Care Coordinators and physicians providing palliative and EOL care.
- Implemented collaborative and consultative models that leveraged specialist teams to work with and support generalist team members to deliver palliative care (i.e., Palliative Care Outreach Teams and Community Palliative (Physician) On-Call).
- Expanded access to Residential Hospices by adding four new residential hospice beds at Stedman Community Hospice in Brantford. Planning is underway for one new bed at Carpenter Hospice in Burlington and a new six bed residential hospice at St. Joseph's Villa in Dundas (scheduled to open by April 2019).

PART 2: GOALS and ACTION PLANS

Goal (s):

Patients First: A Roadmap to Strengthen Home and Community Care provided direction for these HNHB LHIN actions to improve palliative / EOL care over the next two years (2017-19):

- Support patients (adult and paediatric) to have greater choice for palliative/EOL care by increasing access to coordinated integrated services that meet the needs of patients and caregivers.
- Development of an evidence-based capacity plan for palliative/EOL care including an assessment of demand (reflecting paediatric and homeless population groups), current supply, duplication and service gaps. The plan is to include an assessment of the system's capacity to provide services in French to the LHIN's Francophone population.
- Identify and develop a scorecard of a core set of regional indicators to assess performance of the local palliative care system at the person and system level.
- Develop a plan to deliver equitable access to high quality, culturally safe palliative care and support for FNIM living both on reserve, off-reserve and in urban/rural settings.
- Evaluate the EI Guide pilot sites and, based on outcomes, develop a plan for spread and sustainability.

The HNHB RPCN will be charged with advancing the LHINs 2017-18 work plan. This plan will be revised to align with the priority areas as they are identified by the OPCN.

²⁷ HNHB LHIN. An Integrated Program for Complex Care HNHB LHIN June 29, 2010
Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN)
2017-18 Annual Business Plan

Consistency with Government Priorities:

This priority is consistent with the Patients First: Action Plan for Health Care as well as the Minister's Patients First: A Roadmap to Strengthen Home and Community Care, 2015 which identified ten steps and goals towards a higher quality, consistent and integrated home care system, including providing greater choice for palliative and EOL care.

Additionally, this priority is aligned with:

- Advancing high quality, high value palliative care in Ontario: A Declaration of partnership and commitment to action advancing Palliative Care
- OPCN Mandate and Structure
- ECFAA
- FLSA
- IHN priorities.

Action Plans/Interventions:

Action Plans “We will deliver the following”:	<i>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 e.g., if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.</i>					
	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
Hospice palliative care:						
Identify opportunities to integrate the provision of palliative care services to improve access to coordinated integrated services that meet the needs of patients and caregiver.	In progress	50%	Completed	50%		
Develop an evidence-based capacity plan for palliative/EOL care including an assessment of demand, supply, duplication and service gaps.	Completed	100%				
Identify and develop a scorecard of a core set of regional indicators to assess performance of the local palliative care system at the person and system level.	Completed	100%				
Develop a plan to deliver equitable access to high quality, culturally safe palliative care and support for FNIM Peoples living on and off reserve and in urban/rural communities.	In progress	50%	Completed	50%		
Evaluate the early identification guide pilot and based on outcomes, develop a plan for spread and sustainability.	In progress	25%	Completed	50%		

How will the LHIN measure success?

- Feedback from patients, families, caregivers and HSPs.
- Performance on provincial Palliative Care Scorecard Metrics and MLAA monitoring indicators (percent of palliative care patients discharged from hospital with home support).
- Capacity plan completed and endorsed by HNHB RPCN.
- Integration of community-based palliative services.

- Performance of HSPs related to new strategic directions: - Increase in the number of patients with a chronic condition diagnosis referred for community palliative care services. - Increased patient/caregiver satisfaction as evidenced in data collected through the 'caregiver voice'. - Increased number of referrals for home care services to community palliative support. - Increase in the percent of patients with a palliative diagnosis receiving in-home palliative care.
What are the risks/barriers to successful implementation?
- Capacity planning is currently a pan-LHIN project. This could potentially be delayed if a decision is made to implement a standardized approach. - Availability of quality data to support scorecard development. - Readiness of providers to support service integration.
For each risk/barrier, describe the plan to mitigate the risk?
- Encourage voluntary integrations across the HNHB LHIN. - Identify prior to commencing project if a standardized approach to capacity planning is required. - Identify early data that is available provincially to report on system performance. - Monitor projects closely to ensure progress is manageable, reasonable, and achievable.
What are some of the key enablers that would allow us to achieve our goal?
- Committed partnership and continued collaboration between HSPs, primary care, and other community stakeholders. - Patient engagement and advisory panels to guide program planning. - Change management within provider organizations.
Additional Comments (i.e. additional information that supports the implementation/success of the goal)
n/a

4.7. Population-Based Strategies and Clinical Program Integration

PART 1: IDENTIFICATION OF PRIORITY
Priority:
POPULATION-BASED STRATEGIES AND CLINICAL PROGRAM INTEGRATION
Priority Description:
The HNHB LHIN funds a vast and sophisticated network of health services across the continuum ranging from specialized care in hospital to community programs that focus on specific populations. In planning how these services can be better integrated to ensure that individuals have equitable access to evidence-based quality standardized care the LHIN has taken two approaches that are based on common principles: <i>LHIN-wide Integrated Clinical Programs</i> provide specialized services based on the key concept of 'one clinical program on multiple sites' and are intended to coordinate and standardize hospital-based clinical service delivery across the LHIN. <i>Population-based strategies</i> focus on specific populations with the goal of optimizing health status (wellness) while supporting health care needs through the development and implementation of standardized models of care based on best practice or expert recommendations.

Principles that apply to both population-based strategies and clinical program integration include:

- Systems and/or models designed to ensure the person is at the centre of care.
- Equitable access to evidence-based care that is timely and optimizes opportunities to provide care in the community setting (right care in the right place).
- Standardized definitions, care models and quality improvement approaches based on leading practices.
- Programs and/or services coordinated with other initiatives (not duplicated).
- Planning that sets goals and deliverables and projects future need and distribution of services.
- Transparent sharing of information with key stakeholders, physicians and patients.
- Services are coordinated, integrated and transitions across the continuum are seamless from the person's perspective.

This approach supports the HNHB LHIN's focus on planning and delivery of health care services within geographically integrated sub-regions. Strategies such as restorative care have been implemented through a standardized delivery model across LHIN sub-regions. HNHB LHIN activities in 2017-18 will focus on the following areas:

- *LHIN-wide Integrated Clinical Programs* – orthopaedics, ophthalmology and diagnostic imaging (DI).
- *Population-based strategies* – stroke, diabetes, dementia and populations that exhibit, or are at risk of, exhibiting responsive behaviours due to cognitive impairment (Behavioural Supports Ontario (BSO)).

Current Status:

LHIN-wide Integrated Clinical Programs

Orthopaedics and Total Hip and Total Knee Replacements

- While the HNHB LHIN has not yet met the provincial wait time targets for either total hip or knee replacements, wait times have improved since the introduction of the Ontario Wait Time Strategy.
- Comparing data from 2006 to April to June 2016 demonstrates that the HNHB LHIN has seen wait time decreases of 32% for knees and 38% for hips.²⁸
- The HNHB LHIN Orthopaedic Leadership Steering Committee continues to develop and implement LHIN-wide improvement strategies, with a particular focus on continuing to improve wait times and increasing the equity of access to total hip and knee replacement as well as acute hip fracture surgeries across the LHIN's sub-regions. In 2016-17, the following LHIN-wide initiatives were launched or achieved:
 - Wait time information was made publicly available to enhance patient and referring provider decision-making about where to seek orthopaedic care.
 - The *Choosing Wisely Canada* recommendations for reducing the unnecessary use of magnetic resonance imaging (MRI) and computed tomography (CT) scans for the diagnosis of suspected osteoarthritis were implemented (in partnership with primary care providers).
 - Developed standard plane film requirements/views for the workup of potential total joint replacement (TJR).
 - A Regional Joint Assessment Program (RJAP) First Available and Appropriate Surgeon Referral Policy/Process was developed and scheduled to be implemented by March 31, 2017. This policy/process will improve access to timely surgery by standardizing the offer of a first available and appropriate surgeon to patients requiring TJR.
 - Development of an RJAP Patient No Show Policy which both outlines a policy for patients who cancel two consecutive appointments and also facilitates the redistribution of cancelled clinic appointments to other patients waiting (currently under development).
 - Formalization of a bi-annual RJAP patient experience survey and site-specific improvement plans based on the survey results.
 - The effectiveness of the Hip Fracture Partnership established between small and large hospitals in 2015 was evaluated. It was found that the partnership had its intended effect (i.e., a structure for the repatriation of patients to 'home' hospital sites following surgery, and decreased LOS).

²⁸ iPort Access to Care – Accessed February 21, 2017

- Utilization of processes detailed in the LHIN Hospital Service Accountability Agreement (HSAA) to request hospitals to identify performance plans for specific indicators. This included plans to address surgeons reporting wait times substantially higher than the provincial target.

Ophthalmology

- Under the leadership of the HNHB Vision Steering Committee, emphasis continued to be placed on initiatives to improve access, quality and patient satisfaction. In 2016-17, the following was achieved:
 - Developed a model for the redistribution of cataract QBP volumes to better align with population needs to inform future years' planning.
 - Initiated the tracking of efficiency, quality and client satisfaction measures through various survey mechanisms:
 - Safe, Effective, Accessible, and Kind (SEAK) Client Satisfaction Survey Tool was introduced in 2016 and sites will report to the Steering Committee quarterly on results.
 - Surgical Efficiency Targets Program (SETP) regularly collects measures of surgical efficiency and reports to the Steering Committee.
 - Utilization of the "Cat Quest" survey at SJHH Hamilton to assess "quality of life" improvements and patient satisfaction.
 - Three of the LHIN's five ophthalmology programs met the provincial wait time target for cataracts as of December 2016.
 - Developed an on-call coverage model between Brant Community Healthcare System (BCHS) and Norfolk General Hospital (NGH) to ensure timely access to ophthalmology care.

Diagnostic Imaging

- The Diagnostic Imaging Steering Committee and the Diagnostic Imaging Directors Working Group continue to align and integrate administrative and clinical practices for DI services across all HNHB LHIN hospitals. In 2016-17, the following initiatives were achieved:
 - Formalized and strengthened the DI Steering Committee to include both administrative and physician leads.
 - Collaborated with the CCO Access to Care staff to develop an MRI allocation tool to assist in optimizing resources across the LHIN and achieving MLAA targets. The tool is ready to be piloted across HNHB LHIN hospitals (pending ministry approval).
 - Developed a standardized form for MRI and CT referrals that includes LHIN best practice as to the use of contrast. This will support centralized and coordinated access to DI services.
 - Implemented diagnostic recommendations that those patients whose hips and knees require plain film results be provided with MRI knee referrals for suspected osteoarthritis.
 - Wait time information was made publicly available to improve transparency and referral patterns and to reduce variation across the HNHB LHIN.

Population-Based Strategies

Stroke

- The HNHB LHIN continued to show improvements in stroke indicators in 2016-17. The Ontario Stroke Network (OSN) annual report card demonstrated improvements in eight indicators from the previous report card including a reduction in 30-day mortality rates, the door-to-needle time and the proportion of individuals who receive the clot busting medication- tissue plasminogen activator (tPA).
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 contribute to consistent improved access to acute stroke unit care at BCHS (from 34.3% to 85.6%). In addition, the opening of the ISU has resulted in an increased proportion of patients discharged to inpatient rehabilitation in the HNHB LHIN (from 39.1% to 49.3%).
- In 2016, Niagara Health System (NHS) launched a second ISU at its St. Catharines site and integrated acute stroke unit care from the Welland site.
- A successful and sustainable Community Stroke Rehabilitation Model (CSRM) is ongoing in Brant, Haldimand and Norfolk. The results of this model have been applied to the development of a CSRM in Hamilton.

- The HNHB LHIN has engaged with Joseph Brant Hospital (JBH) and the Central South Regional Stroke Network (CSRSN) to develop and implement an ISU model in Burlington.

Diabetes

- As of April 2015, the HNHB LHIN was home to 143,317 adults living with diabetes. This is the third largest population when compared to Ontario LHINs and represents 12.1% of the HNHB LHIN adult population.²⁹
- Health care professionals from eight HNHB LHIN Adult Diabetes Education Programs (DEP), two Indigenous DEPs, one Indigenous diabetes initiative and four paediatric DEPs work together to improve access to DEPs for LHIN residents. In 2016-17 the following was achieved:
 - Developed and implemented a coordinated access model to standardize and improve access to DEPs across the LHIN. This model includes one standardized diabetes referral form and three identified lead agencies to assist with coordinating access for individuals with or at risk of developing diabetes. This model enables people to access a DEP without a referral as well as provides a centralized access point for health care professionals. Between April and December 2016, 92 individuals directly accessed appropriate care.³⁰
 - SJHH Kidney Care Clinic opened in Brantford for people with renal insufficiency and actively connected clients with diabetes to local DEPs rather than being followed in Hamilton – an example of providing care closer to home.
 - HNHB Paediatric diabetes programs implemented a standardized referral process for DEPs and primary care practitioners for timely appointments to tertiary diabetes care for high risk youth with Type 1 diabetes.
 - Quarterly professional education sessions have been added to HNHB LHIN diabetes meetings which provide knowledge translation on current diabetes trends and best practices.
- Ensuring transition of diabetes care across the continuum from childhood/youth to adult services is vital to the wellbeing of individuals with Type 1 and Type 2 diabetes. The paediatric and adult DEPs have reviewed current practice and identified a coordinated process to safeguard patient-centred transitions from youth to adult diabetes care. Implementation of this process is a goal for 2017-18.

Dementia

The Patients First: Ontario's Action Plan for Health Care identified improving dementia support as one of the key areas for providing faster access to the right care. Dementia is a group of conditions that affect the brain and cause problems with memory, thinking, speaking or performing familiar tasks. It is not a normal part of aging and effects people differently. Numerous reports speak to the burden of dementia on the person, their caregiver and the system.

The Alzheimer's Society projects that one in ten people over the age of 65 are living with Alzheimer's or other dementias.³¹ In the HNHB LHIN, approximately 265,000 people are over the age of 65, which would mean that potentially 26,500 people are living with dementia.

In 2016, Ontario released *Developing Ontario's Dementia Strategy: A Discussion Paper* as a means to assess:

- Existing best practices across the province.
- Improving service delivery.
- Where investments are needed to better support people living with dementia and their care partners.³²

The LHIN funds a number of programs to support individuals diagnosed with dementia and their caregivers. In 2016-17 the LHIN-funded a Self-Care for the Caregiver Program which consists of a 16-week course for caregivers of persons living with dementia and aims to strengthen and expand caregiver coping strategies, and increase the level of resilience in caregivers. Initial results comparing caregiver burden pre and post-completion of this program demonstrated an average reduction in burden of 24%. Empowering caregivers allows them to care for their loved ones longer at home and in the community.

²⁹ Diabetes System Indicators 2016 HNHB LHIN website February 19, 2017

³⁰ 2016-17 HSP Q3 Reports

³¹ Alzheimer Society of Ontario. Dementia Evidence Brief: HNHB LHIN 2012. HNHN LHIN Presentation on Dementia to MOHLTC September 11, 2015.

³² Government of Ontario, "Developing Ontario's Dementia Strategy: A Discussion Paper," September 2016, 6.

Behavioural Supports Ontario (BSO)

- The BSO Strategy provides enhanced services for older adults with a cognitive impairment who exhibit responsive behaviours wherever they live with a focus on quality of care and quality of life. The HNHB LHIN's BSO Strategy crosses the continuum to support persons who exhibit or are at risk of exhibiting responsive behaviours in the community, hospital or in LTCHs.
- In summer 2016, the ministry approved over \$1M in new funding for enhancements to the HNHB BSO program. In consultation with key system stakeholders, the BSO program expanded to incorporate new specialized staff to support successful transitions into long-term care, increased BSO staffing resources for hospitals and the community sector (one additional Hospital Clinical Lead position, one additional Community Outreach Team [COT] position and one new Responsive Behaviour Specialist serving retirement homes).
- In 2016-17, funding was utilized on a one-time basis to provide enhanced education and training to LTCH staff, as well as hospital and community staff on topics related to responsive behaviours.
- In 2016-17, the HNHB's BSO Strategy continued to make significant achievements in the enhancement of the behavioural support system for older Ontarians presenting with responsive behaviours.³³
 - Total number of new clients referred to BSO service models: 4973.
 - Total number of transitions supported by BSO service models: 1285.
 - Total number of patients supported across all sectors: 5214.
 - Total number of family members/informal care partners supported across the sectors: 2465.
 - BSO Connect served 1243 callers and connected 100% of them to an Integrated Community Lead Agency. It's important to note that 691 of those individuals (55.6%) had no services prior to calling.
- In year two of BSO Hospital Clinical Leads program, the average ALC LOS/patient with behaviours continued to decrease over Year 1 from 27.3 days to 20.7 days.³⁴
 - From Q1 to Q3, BSO Hospital Clinical Leads diverted 16 patients from behavioural assessment units or LTCHs to a lesser resourced level of care.
 - 14.4 % of patients discharged from BSO Hospital Clinical Leads returned to their community home or retirement home (not including Transitional Care Bed units).
- BSO population initiatives resulted in 743 formal education sessions, reaching 6436 attendees.³⁵

PART 2: GOALS and ACTION PLANS

Goal (s):

LHIN-wide Integrated Clinical Programs:

Orthopaedics and Total Hip and Total Knee Replacements

- The ministry's Access to Specialists and Specialty Care Strategy, which is aligned with the *Patients First Act, 2016* includes building capacity for musculoskeletal (MSK) intake and assessment as a priority area in 2017-18 and 2018-19, making it mandatory for all hip and knee referrals to go through a Central Intake and Assessment Centre (CIAC). In 2007-08 the HNHB LHIN established a Regional Joint Assessment Centre model of care. The expertise, processes and resources that support the LHIN's RJAP positions the HNHB LHIN well to transition this model to a more formalized CIAC model where all referrals for TJR surgery and other key orthopaedic procedures are required to go through the CIAC. The evolution of a CIAC model within the LHIN will also advance the first strategic goal of the LHIN's Orthopaedic Leadership Steering Committee.
- The HNHB LHIN Orthopaedic Leadership Steering Committee identified four overarching strategic goals for further improvement in the next two years (2017-18 and 2018-19):
 - Achieve equitable, timely access to orthopaedic services.

³³ BSO Provincial Activity Tracker, 2016-17

³⁴ Integrated Decision Support Database, Alternate Level of Care – Specialized Care Needs – Behavioural (Year 1 = April 2015-16; Year 2 = April 1, 2016 to December 31, 2016).

³⁵ BSO Provincial Activity Tracker, HNHB LHIN, 2016-17

- Ensure evidence-based standardized orthopaedic care that will result in quality patient and system outcomes.
- Identify the orthopaedic services required to meet the needs of the patients requiring TJR surgery in each of the sub-regions.
- Incorporate a population health management approach across orthopaedic services.
- In order to achieve these strategic goals, the objectives for 2017-18 are:
 - Identify and implement a CIAC model with an initial focus on expanding RJAP to include all referrals for TJR.
 - Formalize the partnerships between small and large hospitals for the management of hip fractures. This will include the development and HNHB LHIN Hospital CEO endorsement of a LHIN-wide person-centred acute hip fracture QBP volume management methodology in which the QBP volumes 'follow' the patients (i.e., are allocated to those sites which accept surgical patients from small hospitals).
- Assist in the implementation of the Inter-professional Spine Assessment and Education Centre (ISAEC) Clinic in Niagara.

Ophthalmology

The HNHB LHIN Vision Steering Committee has identified the following three overarching strategic goals for further improvement in the next two years:

- Improve the patient experience.
- Improve integration of emergency ophthalmic care.
- Improve access to ophthalmic care for populations at risk.

In order to achieve these strategic goals, the objectives for 2017-18 are:

- LHIN-wide implementation of the "Cat Quest" quality tool to collect data related to patient satisfaction and outcomes.
- Examination and development of a plan to address ocular referral patterns from EDs.
- Identification and planning for populations requiring additional ophthalmic outreach and care.

Diagnostic Imaging

- Decrease MRI utilization for chronic low back pain by increasing registration for referral privileges to the ISAEC Clinics by a minimum of 50 primary care physicians.
- Monitor and evaluate the implementation of diagnostic recommendation for hips and knees to assess appropriateness of referrals.
- Implement a Common Referral Form for MRI/CT across the HNHB LHIN.

Population-Based Strategies

Stroke

- Identify a plan with providers to further integrate stroke services at HHSC and SJHH.
- Develop and implement an ISU model in Burlington in collaboration with senior leaders at JBH and the CSRSN.

Diabetes

- Implement a coordinated process to support patient-centered and timely transition for youth diagnosed with Type 1 and Type 2 diabetes to adult care services.
- Implement an e-Visit application such as PCVC and other methods of electronic communication in three Adult DEPs to improve access to specialists and allied health care professionals for individuals who have difficulty accessing transportation or are unable to attend appointments (university students living away).
- Establish a process where HNHB LHIN paediatric and adult DEPs can provide information and readily available resources for individuals diagnosed with diabetes and their primary care providers who are seeking medical or surgical bariatric options.
- Develop partnerships with the regional bariatric program to support expert diabetes care for individuals at risk of Type 2 Diabetes.

Dementia

- In 2017-18 the HNHB LHIN is collaborating with HSPs to identify a local strategy for dementia and seniors' MH ensuring alignment with the provincial plan. This will entail a review and capacity assessment of HNHB dementia and seniors' MH services, leveraging existing tools such as HQO dementia quality standard, and ensuring the sustainability of key LHIN initiatives supporting those who care for persons with dementia.
- Explore new models of residential care support for persons with dementia.

Behavioural Supports Ontario

- Implementation of the LTC BSO Transitional Lead model for clients at high risk of responsive behaviours on transition. Key goals related to the program expansion include:
 - Identification of behavioural lead "champions" across all HNHB LTCHs to act as liaisons with BSO, as well as receive additional training and education with respect to responsive behaviours.
 - Implementation and operationalization of the Transitional Lead Program model.
 - Improved support and uptake with respect to the BSO Mobile Team model.
- Reduce ALC days for individuals transitioning to Behavioural Health Transition Units (BHTU) through:
 - BSO Clinical Leads ability to divert clients.
 - Successfully transitioning clients from hospital to community (including LTC).
 - Improved flow through the BHTUs.

Consistency with Government Priorities:

In conjunction with our HSPs and physicians, the HNHB LHIN drives 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 and the *Patients First Act, 2016*. Examples of how the LHIN's priority of specialized services and specific populations 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.
- 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.

Additionally, this priority is aligned with the following government priorities:

- Developing Ontario's Dementia Strategy: A Discussion Paper (September 2016)
- Ontario's Action Plan for Seniors (2013)
- ECFAA
- FLSA
- IHN Priorities

Action Plans/Interventions:						
Action Plans “We will deliver the following:	<i>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 e.g., if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.</i>					
	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
Orthopaedics and Total Hip and Total Knee Replacements:						
Identify and implement a CIAC model with an initial focus on expanding RJAP to include all referrals for TJR.	In progress	50%	Completed	100		
Expand the MSK CIAC model to include referrals in Niagara to ISAEC for low back pain.	In progress	50%	Completed	100%		
Formalize the partnerships between small and large hospitals for the management of hip fractures, including the development and CEO endorsement of a LHIN-wide person-centred Acute Hip Fracture QBP volume management methodology.	Completed	100%				
Ophthalmology:						
LHIN-wide implementation of the “Cat Quest” quality tool.	In progress	50%	Completed	50%		
Examination and Development of a plan to address ocular referral patterns from EDs.	In progress	25%	In progress	50%	Completed	25%
Identification and Planning for populations requiring additional ophthalmic outreach and care.	In progress	25%	In progress	50%	Completed	25%
Diagnostic Imaging (MCI/CT):						
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 QIPs.	In progress	25%	In progress	50%	Completed	25%
Identify opportunities to reduce unnecessary MRI and CT referrals.	In progress	50%	Completed	50%		
Decrease MRI utilization for chronic low back pain by increasing registration for referral privileges to the ISAEC Clinics by a minimum of 50 primary care physicians.	Complete	100%				
Implement a Common Referral Form for MRI/CT across the LHIN.	In progress	50%	Completed	50%		
Stroke						
Identify a plan with health service providers to integrate stroke services at HHSC and SJHH.	In progress	50%	Completed	50%		
Develop and implement an ISU model in Burlington in collaboration with Senior Leaders at JBH and the CSRSN.	In progress	30%	In progress	30%	Completed	40%

Diabetes						
Implement a coordinated process to support patient-centered and timely transition for youth diagnosed with Type 1 and Type 2 diabetes to adult care services.	In progress	50%	In progress	25%	Completed	25%
Implement an e-Visit application such as PCVC and other methods of electronic communication in three Adult DEPs to improve access to specialists and allied health care professionals for individuals who have difficulty accessing transportation or are unable to attend appointments (university students living away).	In progress	50%	In progress	25%	Completed	25%
Establish a process where HSPs in HNHB LHIN paediatric and adult DEPs can provide information and readily available resources for diabetes individuals and their primary care providers who are seeking medical or surgical bariatric options.	In progress	25%	In progress	50%	Completed	25%
Develop partnerships with the regional bariatric program to support expert diabetes care for individuals at risk of Type 2 Diabetes.	Completed	100%				
Dementia						
Identify a local plan for dementia and seniors' MH ensuring alignment with the provincial	In progress	50%	Completed	50%		
Complete a review and capacity assessment of HNHB dementia and seniors' MH services, leveraging existing tools.	In progress	50%	Completed	50%		
Explore new models of residential care support for persons with dementia.	In progress	50%	Completed	50%		
Behavioural Supports Ontario:						
Identification of behavioural lead champions in at least 80% of HNHB LTCHs.	Completed	100%				
Implementation and operationalization of the BSO transitional lead model.	In progress	50%	Completed	50%		
Decreasing ALC days to Behavioural Health Transition Units through implementation of Clinical Leads and exploring opportunities to access services remotely.	In progress	50%	Completed	50%		

How will the LHIN measure success?

Clinical Programs:

- Improved performance on provincial MLAA targets for Orthopaedics, Ophthalmology and DI:
 - Sustained or increased percentage of surgeries completed for priority 2-4 within wait time targets (cataract, hip and knee).
 - Sustained or increased percentage of diagnostic scans (MRI and CT) completed for priority 2-4 within wait time targets.
 - Performance of HSPs related to new strategic directions:
 - 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.
 - CIAC model is identified and an implementation plan has been developed

○ Increased proportion of total hip and knee replacement surgery closed case volumes that flow through (CIAC) RJAP. ○ Improved care pathways for patients presenting with urgent/emergent ophthalmic conditions in EDs. ○ More points of access to ophthalmic care for populations which may not otherwise be seen or treated. ● Stroke: ○ Improved access to stroke unit care as measured by the site specific report card results. ○ Integration of all stroke services in Hamilton at the Regional Stroke Center. ○ Implementation of an ISU at JBH. ● Diabetes: ○ Youth, families and HSPs report improved transitioning from youth diabetes programs to adult services. ○ Three DEPs utilize PCVC or other communication technology to increase access to services. ● Dementia and BSO: ○ Local Dementia Plan developed. ○ Behavioural leads identified in at least 80% of LTCHs. ○ Collaborate with providers of home care services to identify and refer clients for BSO transitions support based on objective and evidence-based criteria. ○ Reduced ALC days for patients awaiting transition to hospital based Behavioural Health Transition Units. ● Feedback from patients, families and caregivers and health service providers as appropriate i.e., LTCH for BSO.
What are the risks/barriers to successful implementation?
● Capacity planning may identify discrepancies in supply and demand of particular services within sub-regions (i.e. orthopaedic hip/knee surgery). ● Readiness to change practices/processes : ○ Significant change in surgical practice required to expand the centralized intake and access model in RJAP. ○ Change in physician referral patterns from individual surgeons to RJAP for total hip and knee replacement surgery. ○ Change in hospital perspective and practice related to volume allocations required in order to implement a person-centred allocation methodology for Acute Hip Fracture QBPs (i.e., from site-based to program/service-based). ● Availability of data to assess project; for example, ensuring sites actively participate in data collection with respect to “Cat-Quest” survey. ● Readiness of providers to collaborate to ensure an equitable distribution of cataract volumes based on patient need. ● LTCHs preference for an alternative model of behavioural support (e.g. an embedded model). ● HSP capacity to: ○ Accommodate the needs of youth with diabetes transitioning to adult care. ○ Integrate stroke services.
For each risk/barrier, describe the plan to mitigate the risk?
● Consider innovative approaches to access scarce resources (i.e., Digital Health solutions, etc.). ● LHIN-wide monitoring of planning among service delivery areas. ● Factor in the staffing/ timing and location issues when determining regional funding proposal and education plan. ● Engage primary care and front line staff in education related to best practice. ● Work with Primary Care Leads in each of the sub-regions to ensure engagement and participation in planning. ● Monitor projects closely to ensure progress is manageable, reasonable, and achievable. ● Work with LHIN HSPs to share successes of integrated services. ● Utilize academic backing (i.e., journal publication) to document and promote initiatives where possible (e.g. “Cat-Quest,” priority population initiatives, etc.). ● Consider lessons learned and key success factors from other LHINs that have implemented centralized intake and access models for total hip and knee replacement surgery. ● Ongoing collaboration with LTCHs to ensure BSO supports are effectively utilized and meeting the needs of LTCH residents.

Take a collaborative and quality improvement approach to initiatives in order to make participation and implementation manageable.
What are some of the key enablers that would allow us to achieve our goal?
- Committed partnership and continued collaboration between HSPs, primary care, and other community stakeholders. - Patient engagement and advisory panels to guide program planning. - Change management within provider organizations (e.g., surgical champions of centralized intake and access models to facilitate change amongst peers). - LHIN directive to implement a CIAC for orthopaedics and evolve the RJAP in order to make significant progress on reducing wait times.
Additional Comments (i.e. additional information that supports the implementation/success of the goal)
n/a

4.8. Primary Care

PART 1: IDENTIFICATION OF PRIORITY
Priority:
PRIMARY CARE
Priority Description:
Primary care is the entry point to the health care system for most Ontarians. Primary care providers, such as family doctors and nurse practitioners, carry out assessments and treatments that ensure the general health and well-being of their patients. Additionally, primary care providers can refer to secondary and tertiary care and community supports. Evidence shows that jurisdictions with a strong foundation of primary care have better health equity and overall better health system performance.³⁶ Building on the foundation created by the Patients First legislation, the HNHB LHIN will work with primary care providers, partners, patients, and caregivers to improve the patient experience and timely access to equitable primary care and seamless transitions with other health and social services.
Current Status:
To support the <i>Patients First Act, 2016</i> the HNHB LHIN has completed the following: - Received ministry approval of six sub-regions (Brant, Burlington, Haldimand-Norfolk, Hamilton, Niagara, Niagara North West), which will be the focal point for primary care planning and performance improvement. - Completed an initial review of primary care data by sub-region.

³⁶ Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly*. 2005;83(3):457-502. doi:10.1111/j.1468-0009.2005.00409.x.

- Engaged with public and HSPs, including primary care, to inform primary care and sub-region planning (November-December 2016).
- Engaged with formal and informal sub-region primary care leaders to “listen” to what was important in each sub-region regarding primary care planning, integration, and enhancements (January - June 2017).
- Recruitment of sub-region Clinical Leads (target hire dates May 1, 2017) to support sub-region and primary care planning and integration.

PART 2: GOALS AND ACTION PLANS

Goal (s):

The HNHB LHIN will continue to build primary care as the foundation of the health care system and work in partnership with primary care providers, partners, patients; and caregivers to develop sub-region plans that will:

- Ensure all patients who want a primary care provider has one.
- Improve access to primary care.
- Improve access of patients to interprofessional health care to ensure comprehensive care.
- Integrate Health Links model of care into sub-region planning.
- Improve timely access to specialists.
- Embed care coordinators/system navigators in primary care to ensure smooth transitions of care between home and community care and other health and social services.

The planning and integration of a primary care in HNHB LHIN will use a lens of health equity and will involve collaboration in order to meet the needs of the LHIN's Indigenous and Francophone populations, as well as its vulnerable populations and newcomers.

Consistency with Government Priorities:

The *Patients First Act, 2016* helps to ensure patients are at the centre of the health care system and the Act transformed the role of LHINs to implement strategies to achieve timely access to, and better integration of, primary care.

Equitable access to primary care that meets the needs of Indigenous and Francophone populations is further supported by government priorities identified in the following documents:

- Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario
- ECFAA
- FLSA
- IHN Priorities

Action Plans/Interventions:

Action Plans “We will deliver the following:	<i>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 e.g., if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.</i>					
	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
Implement Healthcare Connect guidelines.	In progress.	75%	Completed	100%		
Develop innovative approaches to improve primary care access.	In progress	50%	Completed	50%		

Increase access to specialists by increasing the number of family physicians registered to use ISAEC in Hamilton and surrounding areas by 50.	Completed	100%				
Increase e-consult usage by specialists and family physicians by 50%.	In progress	75%	Completed	25%		
Utilize ministry's Capacity Assessment Framework to plan for capacity.	In progress	25%	In progress	25%	Completed	50%
Post and recruit sub-region Clinical Leads.	Completed	100%				
Identify primary care gaps within sub-regions and create local actions plans.	In progress	25%	In progress	25%	Completed	50%

How will the LHIN measure success?

A strong foundational primary care system in HNHB will result in the following outcomes for residents:

- Improved access and attachment to primary care providers:
 - Connecting patients to primary care providers (increase use of Health Care Connect (HCC) as an option for improving attachment rates.
 - Improving access to primary care on the same day/next day, after hours, on weekends, and over holiday periods for patients who are sick (Increase "Timeliness of primary care access" to 55%).
 - Improve primary care capacity planning to meet unmet community needs by using the ministry's Capacity Assessment Framework to plan for capacity at the sub-region level.
- Timely access to specialists:
 - People can access specialist care more quickly and this is demonstrated by 100 e-consults sent and received.
 - Enhanced access to MSK service by increasing patient flow by 60% through RJAP.
- Improved access to interprofessional care:
 - Improving access to interprofessional care linked to primary care
- Effective and seamless transitions between primary care and other health and social:
 - Develop and implement a plan with input from primary care providers, patients, caregivers and partners that embeds care coordinators and system navigators in primary care

What are the risks/barriers to successful implementation?

- Highly engaged primary care providers to collaborate in system design to achieve desired outcomes for patients and caregivers.
- Recruitment of highly respected and effective Primary Care Leads to ensure desired outcomes for patients, caregivers and sub-regions.

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

- Continue to work with primary care providers around primary care planning.
- Utilize a robust recruitment strategy and panel to recruit well-respected and influential Primary Care Leads.
- Ensure a high state of readiness to support the transfer of CCAC programs.
- Work closely with the ministry, LHIN sub-region leadership, and primary care providers to obtain data.

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

- Collaboration and engagement with public, providers, ministry, and pan-LHIN colleagues.
- Effective change management and communication strategies.
- Strong physician and LHIN leadership.

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

n/a

4.9. Sub-Regions

PART 1: IDENTIFICATION OF PRIORITY

Priority:

SUB-REGIONS

Priority Description:

A sub-region is a smaller geographic planning area that will help the LHIN better understand and address patient needs at the local level. By looking at care patterns through a smaller, more local lens, the LHIN will be able to better identify and respond to community needs and ensure that patients have access to the care they need, when and where they need it. This includes the needs of Francophone Ontarians, Indigenous Peoples, newcomers and other individuals and groups within the LHIN whose health care needs are unique and who often experience challenges accessing and navigating the health care system.

Sub-regions will serve as a focal point for population-based planning, service alignment and integration, and performance improvement; which will enable patients to receive care that is accessible, integrated, consistent, high quality, and that makes a difference.

Current Status:

To support the *Patients First Act, 2016* and specifically the sub-region component the HNHB LHIN has:

- Proposed sub-regions based on population characteristics, health service use patterns, availability of core services and existing relationships and care patterns.
- Facilitated engagement sessions to gather feedback and input on various options for potential sub-region areas.
- Received Board endorsement and ministry approval for six sub-regions (Brant, Burlington, Haldimand-Norfolk, Hamilton, Niagara, and Niagara North West).
- Completed an initial review of data by sub-region to support population based planning.
- Engaged with HSPs, and broader health system partners, including primary care, to inform sub-region planning (November - December 2016).
- Engaged with formal and informal sub-region primary care leaders to “listen” to what was important in each sub-region regarding primary care planning, integration, and enhancements (January - February 2017).
- Established a partnership mechanism with the five PHUs across the HNHB LHIN to ensure sub-region development was rooted in the concepts of population health and health equity.
- Initiated recruitment of sub-region Clinical Leads and Directors, Sub-Region Planning and Integration (target hire dates – May, 2017) to support sub-region and primary care planning and integration.

While the principles and goals remain consistent across the LHIN, the way in which sub-regions develop and the initial priority activities identified will vary based on local need and opportunity. For example, the Niagara North West sub-region identified the primary care/specialist/hospital relationship as a strength and key priority for focus while the Hamilton sub-region (given its population) is looking at the opportunities presented in three distinct neighbourhoods, while exploring the implementation of *At Home/Chez Soi* (a MH/homelessness strategy) across the city.

PART 2: GOALS AND ACTION PLANS

Goal (s):

LHINs will be responsible for sub-region planning and actively working with communities and providers to plan, coordinate, integrate, fund and drive performance improvement. This involves identifying and responding to unique community needs; and organizing and coordinating a broad range of health care services.

Providers from primary care, home and community care, LTCHs, and hospitals will need to work in collaboration with other system providers to ensure that every person has timely access, and seamless links, to necessary health and related support services.

The goals of sub-region planning:

- Ensuring patients have equitable, reliable, and timely access to care.
- Improving system integration and navigation.
- Improving system performance and quality.
- Creating strong local partnerships to address community needs at the sub-region and neighbourhood levels.

A key objective of this approach is to achieve the government's goal of ensuring patients receive care that is accessible, integrated, consistent, high quality, and that makes a difference. Sub-regions will also use a lens of health equity and will involve collaboration to meet the needs of the LHIN's Indigenous and Francophone populations, as well as vulnerable populations and newcomers.

Consistency with Government Priorities:

The *Patients First Act, 2016* helps to ensure patients are at the centre of the health care system and the Act transformed the role of LHINs to implement strategies to achieve timely access to, and better integration of, primary care.

Sub-region population based health planning, integration and performance improvement activities will also align with:

- *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*
- ECFAA
- FLSA
- IHN Priorities

Action Plans/Interventions:

Action Plans "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 e.g., if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
Post and recruit Director, Sub-Region Planning and Integration (x6).	Completed	100%				
Post and recruit Sub-Region Clinical Leads (x6).	Completed	100%				
Facilitate ongoing sub-region engagement sessions.	In progress	50%	In progress	25%	In progress	25%
Confirm HNHB sub-region framework and structure.	Completed	100%				
Develop sub-region plans to address priority areas.	In progress	25%	In progress	25%	In progress	50%

How will the LHIN measure success?
Sub-regions will be the focal point for population-based planning, service alignment and integration, and performance improvement and will result in the following outcomes for patients, caregivers, and providers: • Creating strong local partnerships to address community needs at the sub-region and neighbourhood levels: ○ Population health-based planning to identify and respond to unique community needs. ○ Patients/caregivers will have an active voice in health system design and delivery. ○ Primary care providers can access community resources and better navigate and connect their patients with specialist services, community rehabilitation and MH services. • Providing patients with equitable, reliable, and timely access to care in their community: ○ A single point of access to primary care, and seamless links between primary care and other services. ○ Access to system navigation and care coordination that meets their needs. ○ Investments are focused where the need is greatest to improve the equity of health for all citizens. • Improved system integration and navigation: ○ Access to system navigation and care coordination that meets their needs. ○ Patients/caregivers will have an active role working together with providers as one care team. ○ Patient information will follow their health care journey so they only have to tell their story once. • Improved system performance: ○ Improved patient experience. ○ More efficient and coordinated use of resources.
What are the risks/barriers to successful implementation?
• Recruitment of highly respected and effective sub-region leadership (Director(s) Sub-Region Planning and Integration and Clinical Leads) to ensure desired outcomes for patients, caregivers and sub-regions. • Availability and timeliness of population planning data including demographics, health care resource utilization, prevalence of conditions, health behaviours and primary care. • Readiness of community providers to align services and integrate. • Capacity of providers to participate in sub-region planning across multiple sub-regions.
For each risk/barrier, describe the plan to mitigate the risk?
• Utilize a robust recruitment strategy and panel to recruit well-respected and influential sub-region leadership roles. • Work closely with the ministry, LHIN sub-region leadership, and primary care providers to obtain data. • Support the community partners to participate fulsomely in sub-region planning. • Continue to participate and support the work of the provincial work streams.
What are some of the key enablers that would allow us to achieve our goal?
• Collaboration, communication and engagement with public, providers, ministry, and pan-LHIN colleagues. • Effective change management and communication strategies. • Strong physician and LHIN leadership.
Additional Comments (i.e. additional information that supports the implementation/success of the goal)
n/a

4.10. System Capacity and Seamless Transition to Avoid Alternate Level of Care

PART 1: IDENTIFICATION OF PRIORITY
Priority:
System Capacity and Seamless Transition to Avoid Alternate Level of Care
Priority Description:
Patients First: Ontario's Action Plan for Health Care lists four key objectives; two of which are <i>Improving Access</i> – by providing faster access to the right care, and <i>Connecting Services</i> – by delivering better coordinated and integrated care in the community, closer to home.³⁷ 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 (known as “patient flow”) for reasons that extend beyond the health care system. Barriers to transitions from hospital to home or community can often be attributed to social determinants of health such as income, social/family support network, physical environment, or access to discharge destinations (capacity). In 2016-17, the number of people waiting for an ALC in HNHB LHIN hospitals ranged from 430 to 532.³⁸ Two areas of concern when a patient experiences long waits in hospital to access their next care destination are: • The person's recovery may be delayed or in the case of seniors may regress both physically and mentally while waiting. • Longer wait time in the ED for other people waiting to be admitted to the hospital.
Current Status:
The HNHB LHIN's population is aging. By 2025 an increase in the population over the age of 65 to 360,000 is expected – this is a 35% increase compared to today. Among seniors, the largest growth will be those 75 years and older.³⁹ Generally, seniors are more likely to require health care relative to other age groups, especially hospital EDs and inpatient services such as acute, complex continuing and rehabilitative care.⁴⁰ In 2016-17 the HNHB focused on initiatives to keep seniors well, prevent ED visits and hospitalizations when possible, and ensure smooth transitions in care across sectors when needed. These included but were not limited to: • Restorative programs to maintain or improve functional status. • ED and admission avoidance. • Improved transitions across the continuum through innovative approaches: ○ Integration of navigation for discharge planning to improve care coordination. ○ Increase community bedded capacity through a Transitional Model of Care Program. ○ BSO Hospital-Based Clinical Leads.

³⁷ MOHLTC Patients First Action Plan for Health Care. February 2015.

³⁸ HNHB LHIN Alternative Level of Care Information System (ALS IS)

³⁹ Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHealth Ontario.

⁴⁰ CIHI. Health Care in Canada, 2011. A focus on Seniors and Aging.

Restorative Programs to Maintain or Improve Functional Status:

The LHIN's approach to restorative programs takes a health and wellness approach. Programs and service models were developed with the aim to maintain functional status (falls prevention and exercise classes), prevent functional decline (seniors mobile assess and restore model), or improve functional status (assess restore, slow stream rehab, convalescent care and rehabilitation). In 2016-17:

- Approximately 8,000 individuals participated in Falls Prevention and Exercise classes delivered at 209 locations across the HNHB LHIN.
- The Seniors Mobile Assess Restore Team (SMART) model continued 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, rehabilitative care 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 2016, 6,545 individuals were seen by SMART teams and 81% of individuals were discharged home from acute care.⁴¹
- The HNHB LHIN continued to support restorative programs - Assess Restore, Slow Stream Rehab and Convalescent Care – across all regions.
- These programs, which in 2016-17 totalled 189 beds, support individuals who need access to restorative care to regain their optimal functional status following an acute illness. As of September 2016, restorative programs reported that 79% of individuals admitted to HNHB LHIN restorative programs were discharged home.⁴²
- 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. As of March 31, 2017, more than 95% of the local HNHB RCA virtual network will have adopted and implemented the provincial standard definitions for bedded and community rehabilitative care. The Niagara RCA sub-region task group applied the provincial capacity planning framework to guide planning for rehabilitative care services.

Emergency Room and Admission Avoidance

Since April 2008, overall ED visits in the HNHB LHIN have increased by 32%.⁴³ During this same time period, ED visits for patients considered complex (or higher severity of presenting signs and symptoms) based on the Canadian Triage and Acuity Scale (CTAS) increased by 67%.⁴⁴

EDs across the LHIN continue to experience a high volume of seniors accessing emergency services. Since 2008, HNHB EDs have seen a 34.1% increase in those presenting over the age of 65.⁴⁵

On average, those over the age of 65 are spending approximately 15 more hours in the ED representing the complexity and challenge with transitioning this population to the appropriate care destination. In 2016-17, HNHB LHIN hospitals reported the second highest rate of admissions in the province (12.9%) and the highest ambulance volume in the province arriving at the ED.

Of these arrivals by ambulance, the majority of individuals are over the age of 65 and experience a longer wait in the ED for a transfer to care from Emergency Medical Services (EMS) to hospital ED staff (ambulance off load delay) than any other age category.

Programs and service models have been developed in order to address ED and/or hospital avoidance, in particular for seniors who would benefit from either receiving care within their home setting or having facilitated discharge planning start at first encounter to an ED. Examples of admission avoidance strategies within the HNHB LHIN include:

⁴¹ Six hospital health service provider SMART reports (YE 2013/14, YE 2015/16, Q2 2016/17).

⁴² HNHB LHIN level data, health service provider Q2 2016 assess restore and slow stream rehabilitation reports

⁴³ HNHB LHIN level data, health service provider Q2 2016 assess restore and slow stream rehabilitation reports

⁴⁴ ER Fiscal Year Report, Access to Care

⁴⁵ Intellihealth Ontario

- Community Paramedicine (CP) programs: Located within four of the sub-regions - Hamilton, Niagara, Brant and Haldimand Norfolk - the programs target older adults and frequent users of 911 services who have complex health and social issues.
- By acting as a primary care extender in the community, community paramedics are assessing individuals in their homes and connecting seniors to primary and community care, meaning 911 and ED services are available for other people who need critical care resources.
- Nurse-Led Outreach Teams (NLOT): Registered nurses and nurse practitioners work with LTCHs to assess residents and provide episodic care and treatment in order to mitigate transfers to the ED. If transfers to the ED occur, the NLOT team works with the hospital staff to facilitate timely transitions back to the resident's LTCH.
- In-hospital admission avoidance strategies: ED sites across the LHIN utilize a variety of roles to help individuals return home and avoid hospital admission. These roles are often embedded within the ED care team and include discharge planners, social workers, pharmacists and the CCAC. Sites have also employed a variety of strategies to assist with admission avoidance such as short stay units and clinical decision units, where approaches such as medication reconciliation, home care planning, and community support arrangements are discussed before an admission is deemed necessary.
- In 2016, three HNHB LHIN hospitals received letters from the ministry recognizing outstanding ED performance in the following areas:
 - In 2015, HHSC's McMaster Children's Hospital site demonstrated the greatest improvement in the 90th percentile ED LOS for all patients within the Paediatric Hospital group compared to 2014.
 - In 2015, JBH demonstrated the greatest improvement in the 90th percentile ED LOS for all patients within the Medium-Volume Community Hospital group compared to 2014.
 - In 2015, for the third year in a row, Haldimand War Memorial Hospital (HWMH) demonstrated the lowest 90th percentile ED LOS for all patients within the Low-Volume Community Hospital group.

Transitions Across the Continuum-Innovative Approach

Improving patient flow and ensuring smooth transitions across sectors, requires a range of partners working together in new and innovative ways to establish a local health system. In 2016-17:

- Three HNHB LHIN hospital sites explored models to integrate navigation for discharge planning with the HNHB CCAC for better and more seamless care coordination. One hospital site moved forward with implementation in early 2017.
- The LHIN increased community capacity through innovation solutions such as the Transitional Model of Care Program (TCP). Located in registered retirement homes and assisted living, the TCP, which began in October 2014, improved system flow and reduced the number of individuals waiting in hospital for an ALC and has expanded to 16 sites (more than 200 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 who are unable to return home to pre-hospital living arrangements.
 - 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.
 - Since October 2014, the program has accrued 82,168 avoided hospital ALC days.
- The LHIN expanded the BSO Hospital Clinical Leads program for individuals who exhibit or are at risk of exhibiting responsive behaviours while in hospital. Having a responsive behaviour remains one of the top reported barriers to discharging patients from HNHB LHIN hospitals:
 - In year two of the BSO Hospital Clinical Leads program, the average ALC LOS for a patient with behaviours decreased from 27.3 to 20.7 days. This represented a decrease from year one of the program.
 - Between Q1 and Q3, BSO Hospital Clinical Leads diverted 16 patients from either a behavioural assessment unit or a LTCH to a more suitable level of care requiring fewer resources.
 - 14.4 % of patients discharged from BSO Hospital Clinical Leads returned to their community home or retirement home (not including Transitional Care Bed units).⁴⁶

⁴⁶ Integrated Decision Support Database, Alternate Level of Care – Specialized Care Needs – Behavioural (Year 1 = April 2015-16; Year 2 = April 1, 2016 to December 31, 2016).

- Refer to Section 4.7 Population-Based Strategies and Clinical Program Integration for further details related to BSO.

PART 2: GOALS and ACTION PLANS

Goal (s)

The passing of the *Patients First Act, 2016* expanded the role and mandate of the LHIN providing greater opportunity to implement the level of change needed to advance a patient-centered integrated health care system. In 2017-18 the HNHB LHIN will continue to build on initiatives that focus on keeping seniors well, prevent when possible ED visits and hospitalizations and improve system capacity that will advance smoother transitions across the continuum.

Restorative Programs to Maintain or Improve Functional Status:

- Identify sites where exercise and falls prevention programs are located and explore opportunities for expanded classes, new site locations and partnership with other wellness programs to increase capacity.
- Improve access to LHIN-funded restorative programs by optimizing current capacity and resources including:
 - Adapting and disseminating provincial standardized information for patients, families and referring HSPs related to the rehabilitative levels of care.
 - Developing an evaluation framework to be used to assess the implementation of the RCA definitions and aligns with the Provincial Framework.
 - Applying the provincial RCA capacity planning framework in the Hamilton sub-region.

Emergency Department and Admission Avoidance:

- Implementation of ED notification which will provide a real-time electronic message/report to providers notifying them when their patients present at the ED. This will help facilitate more timely discharges from the ED as well as support the flow of information related to ED visits to primary and home care providers.
- Ensure safe discharges from EDs for at risk patients by implementing a Safe Discharge Checklist within the HNHB LHIN.
- Avoid admissions to hospital by optimizing opportunities with the CP programs to:
 - Decrease seniors' 911 usage by connecting them to resources in the community and providing timely care within the home.
 - Screen at risk seniors in supportive housing and retirement settings for high blood pressure, diabetes, falls, and poly-pharmacy concerns.
 - Improve system partnerships, collaborations, and resource sharing among service providers.

Transitions Across the Health Care Continuum:

- Expand an integrated navigation model (discharge, navigation and care coordination roles) across hospital sites for improved and more seamless care coordination.
- Explore opportunities to enhance and expand the community-based TCP program for existing and new populations.
- Explore opportunities to increase system capacity for improved patient flow by breaking down silos between health sectors and providers to ensure seamless transitions for patients and to ensure that providers work together to provide patient-centred care i.e. a seven day a week model of care.
- Complete current state assessment of community capacity of Supportive Housing/Residential Living Environments in the HNHB LHIN by sub-region, to support individuals to remain in the community as long as possible (alternatives to LTC and hospitals) to enable capacity planning and opportunities for innovations.

Consistency with Government Priorities:

This priority is closely aligned with the objectives outlined in Patients First: Ontario's Action Plan for Health Care, 2015, especially faster access to the right care and integrating and coordinating services in the community, closer to home. It also aligns with the Patients First: A Roadmap to Strengthen Home and Community Care.

Additionally, this priority is aligned with the following government priorities:

- Patients First Act, 2016
- ECFAA
- FLSA
- IHN Priorities

Action Plans/Interventions:

Action Plans “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 e.g., if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2017/18		2018/19		2019/20	
Restorative Programs to Maintain or Improve Functional Status	Status	%	Status	%	Status	%
Identify sites where exercise and falls prevention programs are located and explore opportunities for expanded classes, new site locations and partnership with other wellness programs.	Completed	100%				
Adapt and disseminate provincial standardized information for patients, families and HSPs related to the rehabilitative levels of care.	In progress	50%	Completed	50%		
Develop an evaluation framework that will be used to assess the implementation of the RCA definitions and aligns with the Provincial Framework.	In progress	50%	Completed	50%		
The Hamilton RCA sub-region task group will apply the provincial RCA capacity planning framework in Hamilton.	In progress	50%	In progress	50%		
Hospital Avoidance						
Implementation of ED Notification - an electronic real time flagging solution.	In progress	50%	Completed	50%		
All HNHB EDs will implement a safe discharge checklist for at risk patients being discharged from the ED.	Completed	100%				
Sub-regions with CP programs will demonstrate a 10% decrease in overall 911 call volume.	Completed	100%				
Explore opportunities to scale and spread CP programs to all sub-regions.	In progress	50%	Completed	50%		
Transitions Across the Health Care Continuum						
Integrate navigation for discharge planning within three hospital sites for better and more seamless care coordination.	In progress	50%	Completed	50%		
Explore opportunities to enhance and expand the community-based TCP program for existing and new populations.	In progress	50%	In progress	25%	Completed	25%
Explore opportunities to increase system capacity for improved patient flow.	In progress	50%	In progress	25%	Completed	25%

Complete current state assessment of community capacity of Supportive Housing/Residential Living Environments in the HNHB LHIN by sub-region.	In progress	50%	Completed	50%			
How will the LHIN measure success?							
- Feedback from patients, families and caregivers: - Availability of standardized information designed for patients, families and referring partners related to the rehabilitative levels of care. - Performance on provincial evaluations: - Successful implementation of the RCA definitions frameworks as measured by the provincial RCA evaluation criteria currently under development - Performance on provincial MLAA targets: - Decreasing trend in the LHIN's ALC rate - Reduction in percentage of ALC days - Reduction in 90th percentile ED LOS for complex populations - Reduction in 90th percentile ED LOS for minor/uncomplicated patients - Performance of HSPs related to new strategic directions: - Less than 160 people waiting in hospital for a LTCH - Adoption of standardized tools and methodologies by HSPs: - Application of the standardized rehabilitative care capacity planning framework in Hamilton building on lessons learned from the application of the capacity planning framework in Niagara. - Programs will demonstrate consistent commitment to leading practice and quality standards.							
What are the risks/barriers to successful implementation?							
- Capacity planning may identify discrepancies in supply and demand of particular services within sub-regions. - Primary care engagement and access to primary care to provide services on evenings and weekends. - Ongoing increases in number of individuals (and severity of care needs) presenting and being admitted to EDs, and number of individuals designated ALC.							
For each risk/barrier, describe the plan to mitigate the risk?							
- Encourage voluntary integrations across the LHIN. - Consider innovative approaches to access scarce resources (i.e., Digital Health solutions, etc.). - LHIN-wide monitoring of planning between service delivery areas. - Work with Primary Care Leads in each of the sub-regions to ensure engagement and participation in planning. - 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. - Collaborate with all system partners to implement admission avoidance strategies that are timely and adaptable. - Take a collaborative and quality improvement approach to initiatives in order to make participation and implementation manageable.							
What are some of the key enablers that would allow us to achieve our goal?							
- Committed partnership and continued collaboration between HSPs, primary care, and other community stakeholders. - Patient engagement and advisory panels to guide program planning. - Change management within provider organizations.							
Additional Comments (i.e. additional information that supports the implementation/success of the goal)							
n/a							

5. LHIN Operations and Staffing Tables

Table A1:

LHIN Operations Spending Plan

LHIN Operations Sub-Category (\$)	2016-17 Actuals	2017-18 Allocation	2018-19 Planned Expenses	2019-20 Planned Expenses
Salaries and Wages	3,849,100	3,849,100	3,700,000	3,700,000
Employee Benefits				
HOOPP	353,700	353,700	340,000	340,000
Other Benefits	445,482	445,482	428,282	428,282
Total Employee Benefits	799,182	799,182	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	287,781	287,781	287,781	287,781
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	0	0	0	0
LHIN Collaborative	0	0	0	0
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	1,098,251	1,098,251	1,098,251	1,098,251
Supplies and Equipment				
IT Equipment	40,000	40,000	40,000	40,000
Office Supplies & 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	5,959,983	5,959,983	5,779,983	5,779,983
Annual Funding Target	5,959,983	5,959,983	5,779,983	5,779,983
Variance	0	0	0	0

Table A2:**LHIN Operations Spending Plan – including CCAC Transfer**

LHIN Operations: Total Planned Expense for 2017-18	\$5,959,983
Total CCAC Planned Expense for 2017-18 (post T-day period only)	\$282,549,686
Total LHIN and CCAC Planned Expense for 2017-18	\$288,509,669

Notes: to Table A1 and A2:

1. The Funding and Expense for LHIN Shared Service Organization (LSSO) and LHIN Collaborative (LHINC) has been removed from the LHIN Budget in 2017-18 and provided directly to the newly created Health Shared Services Ontario (HSSO). For comparative purposes, the funding and expense for this line item have been removed in 2016-17. The HSSO carve-out is \$429,164.
2. The LHIN Planned Expenses excludes FLPE initiative funding - \$411,693 and eHealth funding - \$510,000
3. The CCAC Amount represents the Community Annual Plan Submission (CAPS) and Board Approved Budget - prorated to reflect the post T-Day Period Only.
4. The CCAC amount includes HSSO carve-out (re: OACCAC services) - \$2,718,791 and excludes effects from PSS Rate Harmonization.
5. The above spending plans do not include any additional funding (ie, the new 17/18 base funding of \$8,788,400)
6. The Savings target of \$993,100 has not been incorporated in the above totals.

Table B: Funding Breakdown

Funding Breakdown	2016-17	2017-18
Operations	4,487,008	4,487,008
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	5,959,983	5,959,983

* Lead funding is shown as paid out in Consulting Fees

Note: the above does not include funding for Entité

Table C1: LHIN Staffing Plan (Full-Time Equivalents)

Position Title	2016-17 Actuals as of Mar. 31/16 FTEs	2017-18 Forecast FTEs	2018-19 Forecast FTEs	2019-20 Forecast FTEs
Chief Executive Officer	1	1	1	1
Physician Lead	1	1	1	1
Director	7	7	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
	41	41	40	40

Table C2: LHIN Staffing Plan (Full-Time Equivalents) – including CCAC Transfer

LHIN FTEs – 2017-18 Forecast	41.0
CCAC FTEs – 2017-18 Forecast	787.8
Total	828.8

NOTE:

- Please note the staffing plan above accounts for the two new positions under the LHIN's revised organizational structure: one FTE for Vice-President of Home and Community Care and the one FTE for Vice-President of Clinical.

6. Integrated Communications Strategy

Business Objectives:
The ongoing implementation of the priorities identified in the LHIN's five year SHSP and 2016-19 IHSP, as well 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. As part of the Government's new Agencies and Appointments Directive, all Board governed agencies, including LHINs, received a mandate letter from the Minister outlining the broad service and performance expectations for the coming fiscal year. Recognizing that the implementation of the <i>Patients First Act, 2016</i> will be a multi-year journey, the 2017-18 LHIN mandate letter focused on priority activities expected to be completed in the first year after transition (see page 8 for an outline of the expected priorities).
Communications Objectives:
A strong communications strategy and plan are critical to the execution of the ABP and 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. • Engage patients, caregivers, providers, stakeholders and system leaders to become active participants in and ambassadors for transformation. • Support an improved patient and caregiver experience by increasing awareness of health care services available and how to access them. • Build confidence among Ontarians that: ○ Progress is being made to improve access to health services. ○ Progress is being made to improve the patient experience. ○ The system is sustainable, being effectively managed and providing value for tax dollars. • 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 2017-18 ABP. • Ensure that all stakeholders understand the role of their 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. • Increase health literacy to enable and support Ontarians to live healthy lives and manage their illnesses better. • 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:

- 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 centre 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 OAGO 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 CCACs 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, a discussion paper outlining structural changes to the health system.
- In early 2016, the HNHB LHIN engaged numerous stakeholders on behalf of the ministry to solicit their comments and feedback related to the proposal. The feedback was shared with the ministry and further engagement and consultation with a deliberate focus on primary care providers continued through the rest of the year.
- In December 2016, the Ontario government passed Bill 41, *The Patients First Act, 2016* (initially introduced in June 2016 as Bill 210) legislation that will help patients and their families obtain better access to a more local and integrated health care system, improving the patient experience and delivering higher-quality care. Under the new law, LHINs will assume responsibility for home and community care and system integration, have greater involvement with primary care, and develop improved linkages with population health planning.
- In September 2016, following extensive consultation with stakeholders and physicians, including a series of engagement sessions held in July and August 2016, the HNHB LHIN Board endorsed the establishment of six sub-regions. The sub-regions – Burlington, Hamilton, Brant, Haldimand Norfolk, Niagara and Niagara North-West – were submitted to the Ministry and approved in January 2016.
- In May 2017, the Minister sent the 2017-18 mandate letter to LHINs. The mandate letter focuses on collective key priorities and outlines the broad service and performance expectations for LHINs in 2017-18 as LHINs take on an expanded role that includes the delivery of home and community care and oversight of primary care.
- The HNHB LHIN will continue to have a critical role to play in key provincial initiatives such as Health System Funding Reform (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 its 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.

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):
 - Patients, clients, caregivers, and residents
 - HNHB LHIN HSPs – Administrative and Governance
 - Primary Care Providers including physicians

- Professional Associations (such as Ontario Hospital Association (OHA), OMA and HAM (Hamilton Academy of Medicine).
- IHN
- FLPE
- System Strategy Council (SSC)
- Quality Guidance Council
- HNHB LHIN employees
- Government – Administrative Leadership and Elected Officials:
 - Municipal
 - Regional
 - Provincial – including ministry stakeholders
- General Public:
 - Residents and Caregivers
 - Patient and Family Advisory Council
 - Citizens' Reference Panels:
 - Broader Public
 - Indigenous Peoples
 - Francophone Populations
 - 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 – South West, Waterloo Wellington and Mississauga Halton
- Ministry and other ministries (as appropriate and required)

Key Messages:

- The LHINs have made a significant contribution to Ontario's health care system over the past ten years.
- Over the past decade, the LHINs have developed knowledge about the health and health care needs of our local communities and led change at the local and regional level.
- 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.
- The Patients First: Action Plan for Health Care is Ontario's plan to transform the health care system into one that puts the needs of patients at its centre.
- The Patients First: Action Plan for Health Care sets clear and ambitious goals for Ontario's health care system in order to put patients at the centre of our health care system by improving the health care experience: increasing access, connecting services, informing patients and protecting our health care system.
 - We have made progress in all four priority areas, but we can do more to put patients first.
- By putting patients first in everything we do, we will provide faster access to the care patients need today and make the necessary investments to ensure our health system will be there for patients for generations to come.
- On December 7, 2016, Ontario passed the *Patients First Act, 2016*, an important step forward in the Patients First: Action Plan for Health Care.
- Once fully implemented, changes supported by the *Patients First Act, 2016* will make local health care more responsive to local needs:
 - Patients will benefit from improved access to primary care, including a single number to call when they need health information or advice on where to find a new family doctor or nurse practitioner.
 - Primary care providers, inter-professional health care teams, hospitals, public health units and home and community care providers will be better able to communicate and share information, to ensure a smoother patient experience and transitions. Our goal is that patients will only have to tell their story once.
 - Administration of the health care system will be streamlined and reduced, with savings put back into improving patient care.
 - The voices of patients and families in their own health care planning will be strengthened.

- There will be an increased focus on ensuring culturally safe care for Indigenous Peoples and meeting the requirements of the *FLSA*.
- The HNHB LHIN will ensure that any changes are seamless and that they simplify and improve the patient experience.
- Strengthening the LHIN role in primary care will create a platform upon which a truly integrated health system can be built.
- The HNHB LHIN is looking forward to continuing to engage with care providers and community partners to get feedback about how to make the LHIN and our health care system more integrated, accessible and better for patients no matter where they live.
- Together with the ministry, the HNHB LHIN 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.
- Patients, caregivers and HSPs tell us that despite multiple databases and information sites, it is still difficult to access and understand what services and programs are available to meet patient needs. The HNHB LHIN will develop a strategy and related initiatives to support a “let’s see what we can do together” approach - to support navigation within the local health care system, enhance patient experience, and ensure good stewardship of health system resources.

Strategic Approach:

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

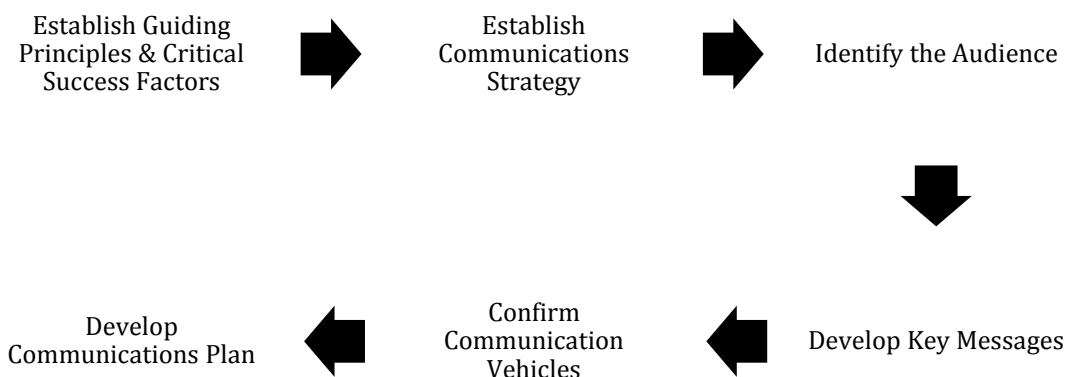
This framework will enable the HNHB LHIN to establish a clear process, and will minimize risk by identifying key stakeholders, key messages and communication vehicles up front.

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 the French- speaking population, Indigenous Peoples, and migrant workers and refugees with information/support related to strategic initiatives.

Framework: Communications Strategy and Approach



Tactics – high level:

The communication and 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
Patients/Clients/Caregivers		- Brochures/Handouts - LHIN website - Newsletters - Blog - Social Media - LHIN Annual Report - Media
HNHB LHIN Staff	Communications Lead/LHIN CEO	- Meetings - LHIN website/Intranet - Newsletters - Blog - Social Media
Citizens' Reference Panel	LHIN CEO	- Group sessions - Social Media
Patient and Family Advisory Council	Communications Lead/LHIN CEO	Group sessions
General Public (including some of same audiences listed here)	Communications Lead/LHIN CEO	- Media - LHIN website

		• Newsletters • Blog • Social Media • Voices in the Community videos
Editorial Board meetings	Communications Lead/LHIN CEO	• Meetings, social media
Physicians	LHIN CEO/Clinical Lead	• Meetings/blog • Physician Newsletter • Social Media
Francophone Community	LHIN	• Meetings, media
Indigenous Communities	LHIN	• Meetings, media
Neighbouring LHINs	LHIN CEO	• Meetings, media
Ministry – Minister's Office, Health System Accountability and Performance Division – Relations and Coordination Unit and Communications and Marketing Division	LHIN CEO/Board Chair/Communications	• Meetings • Teleconferences
Agencies with provincial/national mandate (i.e., 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.
- Patient satisfaction captured through a variety of mechanisms including direct feedback from patients, families and caregivers, as well as reports from health service providers.
- Number of positive print or broadcast media articles/coverage focused on improved access to health services and an improved patient experience.
- Audience reach and engagement measured using social media metrics 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, Social Media and the LHIN 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.).

7. Community Engagement

Community Engagement:

In accordance with LHIN Community Engagement Guidelines (June 2016) and in keeping with the expectations of the *Local Health System Integration Act (LHISA 2006)* and the *Patients First Act, 2016*, all LHINs are required to develop and publish a 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 2017-18, 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 and 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 (CoP).

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).

Patient and Family Advisory Council

Patient engagement is an important part of a high-functioning, quality health system. Patient engagement means patients, their caregivers and families actively collaborating to improve Ontario's health system. We are committed to including the insights and feedback of patients, families and members of the public in our work at the HNHB LHIN. Building on leading research led by HQO, the HNHB LHIN will be aligning with the framework for patient engagement developed by HQO.

Members of the HNHB LHIN Patient and Family Advisory Council may contribute to the work of the LHIN in many ways:

- Participating in forums to discuss key issues.
- Participating with HNHB LHIN committees.
- Sharing one-on-one feedback.
- Informing and helping to build resources and tools for patient engagement.

Engagement with Indigenous Peoples

First Nations, Métis, and Inuit Peoples represent approximately 2.5% of the total HNHB LHIN population according to the 2011 National Household Survey⁴⁷. While Indigenous Peoples experience greater health disparities stemming from the legacies of colonization, lack of culturally appropriate and safe care, and systemic racism, Indigenous communities continue to find strength and resilience through models of wellness based in culture, language and land. To support community-led approaches to wellness, the HNHB LHIN continues to build trusting relationships and respectful partnerships with Indigenous communities as a foundation for improving access and equity in health care programs and services.

First Nations communities and Indigenous health and social service providers work directly and regularly with the LHIN to advise, plan, deliver and continuously improve health care programs and services. The HNHB LHIN engages Indigenous partners through regular IHN meetings, community gatherings, local planning meetings and regional steering committees. Exploring new opportunities for meaningful and respectful engagement with Indigenous communities remains a key priority as the LHIN aims to improve health outcomes for present and future generations.

For more information about how the HNHB LHIN is engaging and partnering with Indigenous communities to plan and deliver health care services, refer to *Section 3: Indigenous Peoples* of this report.

⁴⁷ 2011 National Household Survey, Statistics Canada.

Engagement of HNHB LHIN Francophone Community

The HNHB LHIN has a French-speaking population of 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 *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 FLPE (April 2011). The FLPE 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 HSPs for the provision of FL health services; strategies to improve access to, accessibility of and integration of FL health services in the local health system; the integration of FL health services.

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