Hamilton Niagara Haldimand Brant **LHIN**

Annual Business Plan 2018-19

Ontario
Local Health Integration Network

The HNHB LHIN would like to acknowledge that the regions of Hamilton, Niagara, Haldimand-Norfolk, Brant, and Burlington are situated upon traditional territory of the Haudenosaunee and Anishinabek.

This territory is mutually covered by the *Dish With One Spoon Wampum Belt Covenant*, an agreement between the Iroquois Confederacy, the Ojibway and other allied nations to peaceably share and care for the land and resources around the Great Lakes.

Today, these remain home to many Indigenous Peoples and we are grateful for the opportunity to work with communities across this territory including Six Nations of the Grand River and Mississaugas of the New Credit First Nations.

With gratitude we also acknowledge that the settler population has been able to benefit from this beautiful land.

Hamilton Niagara Haldimand Brant
Local Health Integration Network
Annual Business Plan 2018-19

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March 1, 2018

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
2018-19 Annual Business Plan

I am pleased to provide you with a copy of the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network's (LHIN) 2018-19 Annual Business Plan (ABP). The ABP was tabled and approved by the HNHB LHIN Board of Directors at their February 28, 2018 meeting.

The ABP is a key component of the accountability framework between the HNHB LHIN and the Ministry of Health and Long-Term Care (ministry). The ABP operationalizes the LHINs' 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 2018-19 ABP represents the third year of the LHIN's 2016-19 IHSP.

The HNHB LHIN aligned the priorities outlined in its 2016-19 IHSP with the four key goals of the *Patients First: Action Plan for Health Care*: *Access, Connect, Inform and Protect*. These continue to be reflected in the HNHB LHIN's 2018-19 ABP which details the priorities, goals and action plans for achieving transformational change that are consistent with *Patients First: Action Plan for Health Care* and the Minister's 2018-19 mandate letter to the LHIN.

.../2

Mr. Tim Hadwen

Through this transformation, the HNHB LHIN in collaboration with heath care leaders will focus on:

- Ensuring that health care planning and service delivery reflects the patient voice and is responsive to patients' needs, values and preferences with the goal of improving the patient experience.
- Identifying and addressing the root causes of health inequities and the social determinants of health.
- Reducing the burden of disease and chronic illness and advance health promotion.
- Creating healthy communities by improving access to primary care and reducing wait times for specialist care and health care services such as mental health and addictions services, home and community care and acute care, thereby reducing variation across the LHIN.
- Eliminating barriers to seamless care by breaking down silos between health care sectors and providers and ensuring providers work together in collaboration with patients to deliver the best possible care.
- Supporting and advancing new innovative models of care and digital solutions that improve patients' access to care and are more efficient for providers.

The HNHB LHIN's 2018-19 ABP follows the guidelines provided by the ministry including:

- The HNHB LHIN context for population health planning at the LHIN and sub-region level.
- Inclusion of the patient and caregiver voice in identifying local priorities.
- Involvement of Indigenous Peoples and the Francophone population.
- Identification of goals and action plans for key priorities including LHIN management and delivery of Home and Community Care services.
- Summary of key performance metrics, risks and mitigation strategies.
- Summary of LHIN operations.
- Communications and community engagement.

We are inspired and excited by the opportunities that the LHIN will have as a partner and a leader in driving and enabling transformational change at the local health system level.

Sincerely,

Janine van den Heuvel
Board Chair

c: Donna Cripps, Chief Executive Officer, HNHB LHIN

1.2. Mandate and Strategic Directions

The Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network's (LHIN's) mandate in 2006 was to plan, fund and integrate the local health system. The passage and royal assent of the ***Patients First Act, 2016 (PFA),*** expanded the LHIN's mandate to include the management and delivery of home and community care services. The LHIN's current mandate is to plan, fund and integrate the local health system and deliver and manage home and community care services. The LHIN's legislative authority to manage the local health system is given through the ***Local Health System Integration Act, 2006 (LHSIA***).[1]

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. The ABP operationalizes the HNHB LHIN 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 the 2018-19 ABP represents the final year of the LHIN's 2016-19 IHSP.

The HNHB LHIN, in accordance with the Agencies and Appointments Directive receives an annual letter from the Minister of Health and Long-Term Care (Minister) that sets out the Minister's expectations for the LHIN. The Minister's 2018-19 mandate letter informed the LHIN of the ministry's collective overarching key priorities and outlines specific priorities for this fiscal year.

The February 2015 release of *Patients First: Action Plan for Health Care* by the Minister, exemplifies the government's commitment to putting people and patients first by improving their health care experiences and outcomes through focusing on four goals:

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

The government's strong commitment to putting people first by improving their health care experiences and health outcomes resonates with the HNHB LHIN, as these goals are reflected in the HNHB LHIN's five-year Strategic Health System Plan (SHSP) and 2016-19 IHSP.

[1] MOHLTC Legislation Local Health System Integration Act, 2006. Website accessed November 19, 2017 http://www.health.gov.on.ca/en/common/legislation/lhins/default.aspx

The HNHB LHIN aligned the priorities outlined in its 2016-19 IHSP with the four key goals of the Patients First Action Plan. Those priorities continue to be reflected in the 2018-19 ABP which details priorities, goals and action plans for achieving transformation that are consistent with the *Patients First: Action Plan for Health Care* and the Minister's 2018-19 mandate letter to the LHIN.

Through this transformation, the HNHB LHIN's focus in working with health care leaders will be on:

- Ensuring that health care planning and service delivery reflects the patient voice and is responsive to patients' needs, values and preferences with the goal of improving the patient experience.
- Identifying and addressing the root causes of health inequities and the social determinants of health.
- Reducing the burden of disease and chronic illness and investing in health promotion.
- Creating healthy communities by improving access to primary care and reducing wait times for specialist care and health care services such as Mental Health and Addictions (MHA) services, home and community care and acute care, thereby reducing variation across the LHIN.
- Eliminating barriers to seamless care by breaking down silos between health care sectors and providers and ensuring providers work together in collaboration with patients to deliver the best possible care.
- Supporting and advancing new innovative models of care and digital solutions that improve patients' access to care and are more efficient for providers.

1.3. Alignment with the Priorities of the Minister's Mandate Letter

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
Transparency and Public Accountability	• Effectively manage all operational, strategic, and financial risks encountered by the LHIN while ensuring alignment with government priorities and achievement of business objectives. • Collaborate with Health Shared Services Ontario (HSSOntario) to complete an enterprise-wide review of the LHIN that identifies opportunities for improving efficiency and effectiveness and opportunities for savings that can be reinvested into patient care. • Collaborate with the ministry to develop performance targets that measure success of transformational activities. Be accountable for outcomes and report on progress toward achieving health system performance targets to the ministry and publically.
Improve the Patient Experience	• Develop in partnership with the HNHB Patient and Family Advisory Committee (PFAC), a work plan where patients and families are involved in setting local health care priorities and decision making. • Implement the Caregiver Distress Index (CDI) as a standard tool used by Home and Community Care (HCC) Care Coordinators to identify caregivers at high risk of adverse outcomes and coordinate their access to respite support. • Improve transitions across the health care continuum specifically from hospital to community by focused rehabilitation in hospital to optimize functional status and through identification of alternative discharge options.
Build Healthy Communities Informed by Population Health Planning	• Advance a coordinated and integrated system of care by aligning and integrating health and social services and programs through local leadership at the sub-region level. • Develop a common work plan for the LHIN/Public Health Steering Committee to guide initiatives focused on improving health equity. • Spread and scale the Health Links model of care with input from primary care providers. • Undertake LHIN level planning for key strategies, for example dementia.

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
Equity, Quality Improvement, Consistency and Outcomes-Based Delivery	• Spread the adoption of Health Quality Ontario (HQO) standards and best practice guidelines across the sub-regions. • Establish culturally safe environments for receiving care or requesting to be connected with culturally-appropriate services. • In collaboration with local Indigenous Peoples, develop and initiate a plan to deliver equitable access to high quality care and support for First Nations, Inuit and Métis Peoples living on and off reserve in both urban and rural areas. • Engage designated Francophone Health Service Providers (HSPs) and the French Language Health Planning Entity (FLHPE) to advance opportunities to meet the requirements of the *French Language Services Act (FLSA*).
Primary Care	• Implement innovative approaches to improve equitable primary care access in all sub-regions. • Embed Care Coordination and System Navigation into select primary care practices beginning with LHIN-funded community health centres (CHCs) and family health teams (FHTs).
Hospitals and Partners	• Expand the capacity of the HNHB Transitional Care Program. • Implement an integrated discharge planning framework, in partnership with hospitals through the Home First philosophy that will support shared accountability and work as one system in patient care transitions. • Expand and integrate Home and Community infrastructure and services with Integrated Funding Models (IFMs) for episodic care throughout the HNHB LHIN in partnership with participating hospitals.
Specialist Care	• Increase the usage of eHealth and telemedicine to provide improved access to specialty care. • Improve access to specialty care by building capacity for musculoskeletal (MSK) centralized intake and assessment in the HNHB LHIN with input from providers.
Home and Community Care	• Implement the Levels of Care Framework to improve public understanding and expectations related to access and delivery of home and community care. • Work with service providers and community support services (CSS) to build capacity through testing new models of service delivery that explore realignment of resources within care communities across the sub-regions. • Develop and initiate a model for palliative/end-of-life home and community services that is integrated and coordinated with outreach specialists and primary care.
MHA	• Map access by sub-region to structured psychotherapy and establish referral networks with primary care providers. • Develop a pathway/process that will facilitate seamless transitions for children and youth to adult MHA services. • Complete a current state capacity assessment of HNHB LHIN-wide supportive housing.
Innovation, Health Technologies and Digital Health	• Advance telehomecare using Ontario Telemedicine Network's (OTN's) services, specifically in areas such as tele-wound care, diabetes and mental health. • Improve patient access to personal health information through enabling digital self-care models that are consistent with existing provincial initiatives.

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

The HNHB LHIN has accountability for allocating nearly $3 billion annually to HSPs across the continuum of care including hospitals, community services and long-term care homes (LTCHs). 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 SAAs covering hospital corporations, LTCHs and community services.

In addition, under its expanded mandate, the HNHB LHIN has accountability for the delivery of home and community care services across the LHIN. The HNHB LHIN allocates approximately $240 million, of the $3 billion, through agreements with 11 service provider organizations (SPOs) for the provision of home and community care services.

The HNHB LHIN and its HSPs and SPOs are guided by the Minister's annual mandate letter, as well as the LHIN's SHSP, IHSP and ABP.

The *PFA, 2016* is a key component of the *Patients First: Action Plan for Health Care*, in that it provides LHINs with an expanded role that is embedded in legislation, enabling transformational change and opportunities for achieving greater quality, integration and value across the health care system. As the LHIN continues to work towards transformation, it will seek opportunities that will enable the drive towards integration which will transform local service delivery across the continuum, to provide a more seamless patient experience in alignment with the LHIN's three strategic directions.

The HNHB LHIN's ABP outlines the service areas that will be a focus in 2018-19. A number of priorities cross all service areas: quality improvement, health equity, integrated health care system, and transparency and public accountability. The LHIN's approach to addressing these priorities is detailed below within the LHIN's three strategic directions.

Quality
Quality reflects the HNHB LHIN's commitment to foster and sustain a strong culture of quality, and continuously working in collaboration with HSPs towards improving performance, experience, and health outcomes for the people we serve. The HNHB LHIN supports the development and delivery of consistent, high quality services and programs, monitors system level outcomes, and manages performance. Within the expanded mandate, the HNHB LHIN is focused on delivering high quality, excellent home and community care. The HNHB LHIN reviews adverse events and complaints as learning opportunities, and in response makes improvements in patient care, processes, and policies. The HNHB LHIN will work with local clinicians at a community level to support implementation of completed quality standards.

Health Equity
Health equity is one of HQO's six dimensions of a quality system and is a priority area of focus in the HNHB LHIN. It is the LHIN's expectation that an assessment of health equity is a standard component of all LHIN activities including: planning, program development, integrations, capital projects, business cases and funding decisions. Understanding local populations at the sub-region level, through a health equity lens to identify high-risk populations, will be a priority and a requirement for sub-region tables. Approaches used, and learnings on the demographics of populations within

each sub-region, will inform LHIN-level planning. Engagement with Indigenous Peoples and Francophone Ontarians will occur at the sub-region and LHIN level.

Integration
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 - from the patient's perspective, the care is seamless. Integration refers to a spectrum of activities that describe how different people, programs, and organizations can work together towards a common vision. Integrations can range from collaborations and partnerships to full organizational mergers. Integrations can expand access to services, enhance service capacity and sustainability, meet emerging or unmet needs, improve quality of services based on best practice, and improve outcomes and patient and caregiver experience. Areas of focus in 2018-19 will be on integrated models/activities that will support transitions from acute care to community, increase access to mental health and addictions services, and support seniors.

Value
The HNHB LHIN is committed to stewardship and public accountability. As health system commissioners, the HNHB LHIN Board of Directors (Board) makes health system decisions based on evidence, equity, performance and risks with the needs of patients and communities being the focus of all decision-making. The LHIN reports on its progress towards achieving local health performance targets and works with HSPs to identify opportunities to improve performance. This requires strong internal business processes and effective management of all operational, strategic and financial risks encountered by the LHIN, while ensuring alignment with government priorities and achievement of business objectives. In 2018-19, the HNHB LHIN will work with HSSOntario to complete an enterprise-wide review of LHINs that identifies opportunities for improving efficiency and effectiveness and opportunities for saving that can be reinvested into patient care.

In September 2017, the HNHB LHIN introduced a new vision for change*, **Imagine what we can achieve together…when we care, listen and act.*** The vision speaks to the opportunities for transformation that exist within our organization and our region following the passage of the *PFA, 2016*. The vision encourages creativity, innovation and thinking in new ways and focuses on achievement of outcomes and goals. Finally, it compels HNHB LHIN staff and providers to always care and listen to patients, communities, and partners, and to be responsive and committed to action. In 2018-19, the HNHB LHIN will continue to implement this vision and realize its intent.

1.5. Environmental Scan

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 km^2, including both urban and rural areas. There are approximately 1.46 million people in the HNHB LHIN, representing about 10.4% of the population of Ontario. The HNHB LHIN's population is projected to grow by 10.5% over the next ten years. [2,3]

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

- The LHIN's population is aging. More than 270,000 people aged 65 or older live in the LHIN and this number is projected to increase by a third, to approximately 380,000 people, within the next ten years.[4] Among seniors, the

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

largest growth will be among those 75 years and older – greater than 45%. The LHIN currently has the second largest population of older adults, 75 years and older, in Ontario.[5]

- The LHIN has a diverse population - for 17% of its residents, neither English nor French is their first language.[6]
- Francophone, First Nations, Inuit, Métis, and urban Indigenous Peoples are recognized populations in the LHIN. Compared to other areas of Ontario, the HNHB LHIN has a lower percentage of immigrants (20%) and visible minorities (10%).[6,7]
- About 2% of the LHIN population is defined as Francophone.[6] Almost 80% of the LHIN's Francophone population resides in Hamilton and Niagara. Niagara's Welland, Port Colborne, and Wainfleet communities have the highest percentage of Francophone population compared to other communities within the LHIN.[6]
- There are two First Nation reserves in the 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). As of October 2017, SNGR band membership includes 27,223 individuals with approximately half living on reserve, representing a similar population distribution to that of First Nations Peoples across Canada.[8,9] MNCFN has a registered population of 2,490 people of whom 60% live off reserve.[9] In the HNHB LHIN, 36,710 people self-identified as "Aboriginal" on the 2016 Census, although this value is likely an underestimate due to incomplete enumeration.[6]
- While the LHIN has a similar population proportion of low income families as Ontario (13.5 % versus 14.4%), the rates of individuals living in poverty within Hamilton's urban core (37%) are approximately 2.5 times greater than the provincial average.[6] Compared to the Ontario average, the LHIN also has a higher percentage of lone-parent families and a lower percentage of adults with high school and post-secondary education. [6,7]

Socio-Demographic Characteristics

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

Health Status

Health can be measured using 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 HNHB LHIN residents rate their health as 'fair' or 'poor'.[10]

In addition, 35% of HNHB LHIN residents say they are limited in their activities, sometimes or often because of a physical or mental condition or health problem, and 18% report having pain or discomfort that prevents them from engaging in activities.[10]

Illness, Disease and Death

In terms of chronic conditions, approximately 24% of HNHB LHIN residents have been diagnosed with arthritis, 19% with high blood pressure, 8% with diabetes, 9% with asthma, and 5% with Chronic Obstructive Pulmonary Disease (COPD).[10] Increasing trends in the prevalence of diabetes, high blood pressure, and mood disorders, have been reported since 2005.[11]

[5] Population Estimates, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHealth Ontario.
[6] 2016 Census of Canada, Statistics Canada.
[7] 2011 Census of Canada, Statistics Canada.
[8] Six Nations of the Grand River, Indigenous and Northern Affairs Canada, 2017.
[9] Mississaugas of the New Credit, Indigenous and Northern Affairs Canada, 2017.
[10] Statistics Canada, Canadian Community Health Survey, 2014.
[11] Statistics Canada, Canadian Community Health Survey, 2005-2014.

Death rates reflect the overall health of the population. Ischemic heart diseases, lung cancer, and cerebrovascular diseases have been the leading causes of death in the HNHB LHIN.[12] The age-standardized mortality rate is higher in the HNHB LHIN when compared to the province.[13] Rates of potential years of life lost are useful for measuring the number of years of life "lost" from deaths that occur "prematurely" (i.e., before age 75). The rates of potential years of life lost within the HNHB LHIN are higher than the provincial rates.[14]

Healthy Practices

Poor health practices such as physical inactivity or poor dietary habits, may increase the risk of chronic disease, disability, and death. The smoking rate is 18% in the HNHB LHIN compared to 17% in the province.[14] There is a significant degree of variation in smoking rates within the HNHB LHIN, with rates ranging from 12% to 29%.[14] Overall, more than half (55%) of the population in the HNHB LHIN reports being physically active during leisure-time, which is comparable to the province.[14] In terms of fruit and vegetable consumption, 41% of HNHB LHIN residents report having five or more servings per day, similar to the provincial rate.[14]

It is important to acknowledge the impact that the social determinants of health such as income, social status, employment and social and physical environments have on one's capacity to engage in positive personal health practices. The ability to perform healthy behaviors such as healthy eating is influenced by an individual's social circumstances (for example, access to affordable, healthy food). For example, in Ontario, individuals with the lowest income are more likely to smoke than individuals with the highest income (22.1% compared with 14.4%).[15]

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 care provider. In the HNHB LHIN, 95.3% of adults had a primary care provider compared to 94.5% for Ontario.[16]

2) Health System Oversight and Management

2.1. Patient Experience

PART 1: IDENTIFICATION OF PRIORITY
Priority
Improve the Patient Experience
Priority Description
The HNHB LHIN's Strategic Aim is to "dramatically improve the patient experience through Quality, Integration and Value". To understand the patient and caregiver experience with the health care system, it is essential to listen and engage with patients and their caregivers. The 2015 expert report *Bringing Care Home* reported that Ontario residents want a home care system that provides client and family-centred care. The report also spoke to the caregiver's urgent need for supports and information on how to access a range of services.

[12] Mortality and Potential Years of Life Lost, by Selected Causes of Death, Statistics Canada, 2010-2012.
[13] Premature and Potentially Avoidable Mortality Tables, Statistics Canada, 2011-2013.
[14] Statistics Canada, Canadian Community Health Survey, 2014.
[15] Income and Health. Health Quality Ontario, 2016.
[16] Health Care Experience Survey, Health Analytics Branch, MOHLTC, 2017.

The LHIN is committed to listening to the patient and caregiver voice and being responsive to patients' needs, values and preferences. The LHIN will partner with patients, families, and providers in health care planning and system design as well as the delivery of home and community care.

Current Status

The HNHB LHIN aims to enhance the patient experience at the systemic, sectoral, organizational, and individual care provider levels. The LHIN has created a framework of patient experience that focuses on commitment, understanding, collaboration, and improvement.

Patient experience within the HNHB LHIN is measured in multiple ways:

- HSPs are obligated in their SAAs to measure and report data related to patients' overall satisfaction with care, and patients' involvement in decision making.
- Home and Community Care patients are randomly selected and invited to participate in the Client and Caregiver Experience Evaluation Survey.
- The Health Care Experience Survey is a telephone-based survey undertaken across Ontario. LHIN-level results are received on an annual basis.
- Patient complaints are investigated and a response provided to the patient or family as appropriate.
- Complaints are also tracked and reviewed for trends to identify areas for improvement.

The *PFA, 2016* requires each LHIN to strengthen the patient voice in health care planning by creating one or more Patient and Family Advisory Committees (PFACs). The PFAC ensures that patients and caregivers are involved in processes to identify local population health needs, address gaps and improve access to appropriate and culturally sensitive care.

On September 14, 2017, the HNHB LHIN held its inaugural PFAC meeting. While the committee will consist of 15 patients, family members and caregivers with a range of health care experiences, as of December 2017 the committee consisted of 13 members (appropriate participation from the Francophone and Indigenous communities was still being sought). Members were selected based on their experience with the health care system and a combination of considerations to reflect the diversity of the people and communities across the LHIN.

The PFAC aims to assist in shaping the LHIN's programs, services and initiatives designed to improve care in the LHIN. As outlined in the committee's Terms of Reference, its mandate is to:

- Identify and advise on opportunities to incorporate the patient's perspective in initiatives to better integrate care across the region and across the health care system.
- Support effective patient engagement within the LHIN.
- Provide advice on recommendations about health care access or service delivery improvements from the patient and/or family caregiver perspective.
- Provide input on LHIN policies and standards guiding LHIN initiatives, particularly regarding patient care and patient engagement.
- Recommend strategies and practical ideas for improving patient care, and caregiver recognition and support.

The committee will identify priority areas and develop a committee work plan in alignment with local and provincial priorities.

The HNHB LHIN, through its Mental Health and Addictions Advisory Committee, has also established a Mental Health and Addictions Peer and Family Advisory Committee (MHA PFAC). As of December 2017, nine members with diverse lived experience with MHA had been recruited for the MHA PFAC and the committee had held an inaugural meeting.

The HNHB LHIN funds a variety of services to support caregivers including adult day programs, companion support, educational "self-care" programs, and in-home and overnight respite. In 2017-18, HNHB LHIN HCC expanded the use of an evidence informed approach to identify Caregiver Distress and develop care plans to support patients and their families. This work was done in partnership with the University of Waterloo and focused on utilizing the CDI as a tool to assess caregiver burden to identify those who are at high risk of adverse outcomes and who could benefit from respite support. The CDI screener is now administered to all long-stay HCC community patients as part of the assessment process; the results help to inform the service allocation for respite personal support hours for patients and their caregivers.

In addition to the introduction of the CDI screener, HNHB introduced a flexible model of care that allowed patients and caregivers to "bundle" all available hours to meet their needs. This caregiver-centred approach allowed care coordinators to develop care plans that considered the strengths and needs of patients and their caregivers. A marked 51% increase in caregiver support hours was realized as of September 2017 with 30% more patients and caregivers served since 2016-17.[17] Reducing caregiver distress will continue to be a focus for home and community care in 2018-19, which will support people to remain in their own homes for as long as possible.

PART 2: GOALS AND ACTION PLANS

Goal (s)

In 2018-19, to gain greater insight and understanding into the factors that impact patient experience and to continue to support caregivers, the HNHB LHIN will complete the following activities:

- The LHIN's PFAC will develop a work plan in alignment with local and provincial priorities.
- The PFAC will provide regular updates and report annually at minimum on its work plans, activities and progress to the LHIN's Board through the LHIN Chief Executive Officer (CEO).
- The MHA PFAC will provide input and/or advice to the HNHB LHIN MHA Advisory Committee on matters related to mental health and addictions and will connect with the LHIN's PFAC as needed.
- The LHIN's patient relations process will be further developed to effectively manage and learn from patient complaints and compliments.
- The HNHB LHIN-delivered HCC will improve public understanding and expectations related to accessing home and community care supports and continue to improve the coordination and consistency in accessing caregiver respite services to reduce caregiver burden and support people in their own homes for as long as possible (refer to Section 3 - HCC).

Government Priorities:

This priority advances the ministry's *Patients First: Action Plan for Health Care*, the Minister's *Patients First: A Roadmap to Strengthen Home and Community Care*, and the Minister's 2018-19 mandate letter by:

- Engaging with patients and families to ensure they are involved in health care priority setting and decision making.
- Working towards improving transitions for patients between different health sectors and providers so that patients receive seamless, coordinated care and only need to tell their story once.
- Supporting patients and families by implementing initiatives that reduce caregiver distress.

This priority is also supported by legislation in the *PFA, 2016.*

[17] HNHB LHIN. Email November 27, 2017

Action Plans/Interventions		
Action Plans		
	Expected Status (as of March 31, 2019)	**Expected Completion Date**
The LHIN's PFAC will develop a work plan in alignment with local and provincial priorities.	Completed	March 31, 2019
Implement adoption of the CDI by all care coordinators to assess caregiver burden, identify those caregivers at high risk of adverse outcomes and coordinate their access to respite support.	Completed	March 31, 2019
Refine patient relations processes ensuring that HNHB LHIN meets the expectations of our patients and community and is fully compliant with HQO recommendations regarding patient relations measurement.	In progress	Ongoing

2.2. Building Healthy Communities Informed by Population Health Planning

PART 1: IDENTIFICATION OF PRIORITY
Priority
Building Healthy Communities Informed by Population Health Planning
Priority Description
The transformation agenda enabled by the *PFA 2016* includes changing and strengthening the way health and social service providers work together to build healthy communities. A healthy community is the product of individual experiences that are maximized when each person is holistically supported to reach their fullest potential. One core element of support is adequate access to quality health care services, but all social determinants of health must be considered. A population health approach aims to improve the health and wellness of an entire population by addressing the social determinants of health, taking a population rather than individual orientation, embracing committed collaborative action with stakeholders other than the health sector that could influence health and partnerships, addressing health equity, and understanding needs and solutions through community outreach.[18] Population Health can refer to a population within a geographic region, a patient population or a population sharing certain common characteristics.[19] Population health planning requires working collaboratively with citizens and service providers at a community level to develop a shared vision and improvement framework. A key component of the *PFA, 2016* is the effective integration of services and greater equity with communities and sub-regions as the focal point for integrated service planning and delivery. A sub-region is a geographic area within a LHIN that will enable health and social service planners and providers to better identify and respond to the needs of local communities, and ensure people are able to access the care they need, when and where they need it. This includes strengthening the role of patients and families in the planning for their own health care needs and an increased focus on cultural sensitivity in the delivery of health care services to Indigenous Peoples,

[18] Canadian Institute for Health Information. 2014. Population Health and Health Care. Exploring a population health approach in health system planning and decision-making.

[19] Government of Canada Website Public Health Agency of Canada: What is the Population Health Approach? Accessed December 16, 2017. https://www.canada.ca/en/public-health/services/health-promotion/population-health/population-health-approach.html

French-speaking people, newcomers and other marginalized populations.

Although population health planning at the sub-region level will identify system gaps and duplications, identify opportunities for integration and ensure programs and services are meeting the unique needs of each community, there is still a need for LHIN-wide population health planning that is guided by provincial priorities as outlined in the Minister's 2018-19 mandate letter and LHIN-wide planning entities such as the HNHB MHA Advisory Committee.

Current Status

Population health planning will continue to occur at the LHIN and the sub-region level. Local planning will be informed by both LHIN-level planning and the needs of the local community. To support the *PFA, 2016* and the Minister's 2017-18 mandate letter, the HNHB LHIN has focused on the following:

Sub-Regions
The HNHB LHIN is organized into six sub-regions: Brant, Burlington, Haldimand-Norfolk, Hamilton, Niagara and Niagara North West. Each sub-region is supported by a Director of Sub-Region Planning and Integration, a Clinical Lead and a Director of Patient Care.

A sub-region planning document and framework was developed in 2017-18 to guide the development of sub-regions as the focal point for population health based planning, service alignment, integration, performance/quality improvement and the implementation of sub-region and LHIN-wide priorities. Anchor Tables were established in each sub-region as the structure for working with communities and providers to plan, coordinate, integrate, fund and drive performance improvement. Anchor Table representation is intersectoral - the tables include stakeholders from outside of health care that could influence health (i.e., housing and patient/family advisors). Each Anchor Table has identified priorities related to the scale and spread of the Health Links model of care and MHA. Applying the sub-region framework to these priorities will result in the effective integration of services, greater equity, and improve the ability for people to receive care that is accessible, integrated, consistent, and of high quality.

Health equity is a key focus for population health planning at both the LHIN-wide and sub-region levels. Recognizing the inequity experienced by Indigenous Peoples, Francophone Ontarians and other marginalized populations, the LHIN strengthened relationships and planning structures throughout 2017-18 in order to achieve improved outcomes related to health equity in 2018-19. Specific activities related to these populations are described below:

- Indigenous Peoples:
    - Throughout 2017-18, planning and decision-making across all sub-regions was informed by the HNHB Indigenous Health Network (IHN) and local First Nations community health service providers.
    - The LHIN developed and implemented an inclusion strategy whereby Indigenous representative(s) nominated by the IHN and local First Nations are participating on sub-region tables. These members have a leadership role in helping to identify priorities across all areas of sub-region planning, and particularly with respect to Indigenous Peoples health and wellness. These individuals are supported by and accountable to the IHN on a bi-monthly basis.
    - To ensure communication and connections across all sub-regions, the IHN, local First Nations and the LHIN come together quarterly to discuss progress in each sub-region, share overarching priorities, identify gaps, barriers, and new opportunities, with the goal of supporting all partners to move forward together.
- Francophone Population:
    - Francophone service providers and community members are participating on Anchor Tables or as members of action-oriented teams for achieving the priorities set by the Anchor Table.

Public Health
Public Health is an essential partner in population health planning. In 2017-18 the LHIN strengthened its relationship with the LHIN's five public health units through the establishment of a HNHB/Public Health Steering Committee to advance ongoing collaboration between the LHIN and public health. This steering committee includes representation from all five public health units within the HNHB LHIN and a set of common definitions to guide collaboration going

forward has been established.

LHIN-Wide Planning

At a LHIN-wide level, activities in 2017-18 related to building healthy communities through focusing on the needs of specific population groups. These included:

- Musculoskeletal (MSK) – The HNHB LHIN completes one of the largest volumes of hip and knee procedures (Total Joint Replacement (TJR), knee arthroscopies and hip fracture repairs – 10,269 procedures annually). For the period April 1 to September 30, 2017 approximately half of the HNHB LHIN's patients who had a TJR went through centralized intake and assessment.
- Dementia:
    - The HNHB LHIN's Behavioural Supports Ontario (BSO) Strategy crosses the continuum to support persons who exhibit, or are prone to exhibiting, responsive behaviours in the community, hospital or in LTCHs, with a focus on quality of care and quality of life. New funding, announced in late summer 2017 as part of the ministry's Dementia Strategy, supported expansion of the LHIN's BSO Mobile LTC team. For the period April 1 to September 30, 2017, 5,116 patients and 2,045 family members/informal care partners were supported by BSO.[20] Of note, during this period BSO Hospital Clinical Leads diverted nine patients from behavioural assessment units or LTCHs to a lesser resourced level of care and 21.3% of patients discharged from the BSO Clinical Leads returned to their home in the community or retirement home.[20]
    - Self-Care for the Caregiver is a practical program that brings caregivers together to learn about the value of honest self-examination, quieting their minds and nurturing their inner self. For the period April 1 to September 20, 2017, 145 unique individuals attended this program.[21]
- Diabetes – The HNHB LHIN has developed and implemented a coordinated access model to standardize and improve access to Diabetes Education Programs (DEPs). This includes a standardized referral form, a toolkit to provide resources related to bariatric treatments, quarterly professional education sessions related to best practices, implementation of an e-Visit application such as Personal Computer Videoconferencing (PCVC), and guidelines to improve access to timely paediatric consultations.
- LTCH redevelopment – the HNHB has 86 LTCHs with approximately 10,500 beds. Of these, a total of 3,883 beds across 42 LTCHs have been identified for redevelopment. The LHIN is engaging with ministry staff and LTCHs to discuss specific home redevelopment plans. The LHIN also provides information to the ministry under the *Long Term Care Homes Act, 2007* Section 96.

PART 2: GOALS AND ACTION PLANS

Goal (s)

In 2018-19, sub-region Anchor Tables will build on the priorities they have each identified in 2017-18 and focus on developing and delivering on action plans for each sub-region priority. Within the context of the sub-region framework, goals for 2018-19 include:

- Population Based Planning: Work collaboratively with partners and patients to have an in-depth understanding of local health needs, service capacity gaps and opportunities, and ongoing monitoring of emerging population health and social service needs within each sub-region.
- Service Alignment and Integration: Spread and scale the Health Links model of care by end of fiscal year 2019-20, with input from primary care providers; and establish culturally safe environments for receiving care or requesting to be connected with culturally-appropriate services (including Indigenous, Francophone, newcomer, and/or other marginalized or minority populations).

[20] HNHB LHIN BSO 2017-18 Q2 Report

[21] Alzheimer Society of Brant, Haldimand Norfolk, Hamilton, Halton. Email correspondence December 17, 2017.

- Performance/Quality Improvement: Develop sub-region dashboards for measuring performance and progress towards goals identified in work plans.
- Implementation of sub-region and LHIN priorities: Implement work plans established by Action Tables and coordinate and implement LHIN-wide initiatives as required.

In 2018-19, the LHIN will focus on the following LHIN-level goals:

- Determine the strategy, objectives, and a common work plan for the LHIN/Public Health Steering Committee to guide collaborative efforts towards improving health equity through initiatives that address the social determinants of health.
- Complete a Dementia Capacity Plan for community services.
- Enhance support within sub-regions for long-term care home residents with responsive behaviours.
- Identify the LTC needs of LHIN residents by sub-region to inform LTC redevelopment in the HNHB LHIN.
- Develop a plan to expand the use of an e-visit application such as PCVC as well as other methods of electronic communication in three DEPs to improve access to specialist and allied health care professionals.

Government Priorities:

The priority of Building Healthy Communities Informed by Population Health Planning advances and aligns with:

- Patients First: Action Plan for Health Care
- Minister's 2018-19 Mandate Letter
- *Excellent Care For All Act (ECFAA)*
- *FLSA Ontario, 1986*
- IHN Priorities
- Developing Ontario's Dementia Strategy: A Discussion Paper (September 2016)
- Aging with Confidence: Ontario's Action Plan for Seniors (2017)
- Ontario's First Nations Health Action Plan

Action Plans/Interventions

Action Plans	Expected Status (as of March 31, 2019)	Expected Completion Date
Identify local initiatives that will demonstrate the benefit of coordinated and integrated care across a continuum at the patient, family and system level that builds on the Health Links model of care.	In progress	March 31, 2020
Use a health equity lens to identify high-risk populations and include health equity impact assessment as a standard component of sub-region planning, program development, integrations, capital projects and business cases.	Completed	March 31, 2019
Spread and scale the Health Links model of care, with input from primary care, to reach model maturity.	In progress	March 31, 2020
Fully operationalize centralized intake and assessment for, at a minimum, the MSK conditions that include hip, knee and low back.	Completed	March 31, 2019
Develop a common work plan for the LHIN/Public Health Steering Committee to guide initiatives focused on improving health equity.	Completed	March 31, 2019
Complete a capacity plan for dementia services at the community level in the HNHB LHIN.	Completed	March 31, 2019

	Explore opportunities to integrate BSO within the sub-regions to increase support and access to LTCHs.	Completed	March 31, 2019
	Identify the LTC needs of LHIN residents by sub-region to inform LTC redevelopment.	In progress	March 31, 2020
	Expand the use of an e-Visit application such as PCVC as well as other methods of electronic communication in three adult DEPs to improve access to specialist and allied health professionals.	Completed	March 31, 2019

2.3. Transitions – Hospitals and Partners

PART 1: IDENTIFICATION OF PRIORITY
Priority
Transitions - Hospitals and Partners
Priority Description
The *Patients First: Action Plan for Health Care* speaks of a health care system where people can access the right level of care when they need it and that services are connected and integrated so that people can move easily from one part of the system to another. Acute hospital services are a critical component of the continuum of health care services. People need and expect to receive acute care that is timely with their transition through the hospital being coordinated and seamless. While the majority of people admitted to hospital return home when their care is completed, some people experience barriers when transitioning from hospital to the community. Home care services have an essential role in supporting transition from hospital to home especially for those who are older with frailty and complex care needs. Barriers to accessing reliable and integrated home care services, whether perceived or actual, can impede timely discharge. Opportunities to improve home care services include coordination of services, transparency as to the level of care that can be provided and variability in access to services, and accountability for outcomes.[22] Hospital patients can also experience challenges in accessing another care setting such as specialized rehabilitation or alternate discharge destinations, such as LTC or supportive housing environments. Patients waiting in hospital to access another care setting are identified as waiting for an "alternate level of care" (ALC).[23] Barriers to discharge can also expand beyond the health care system which emphasize the need for a population health approach to planning to improve transitions. These barriers can include: financial resources, social support networks, physical environment, availability and access to subsidized and/or stable housing. While hospitals may seem like a safe and supportive environment to wait for an alternate discharge destination, it is not beneficial for the person nor the system to spend unnecessary time in the hospital awaiting for an appropriate discharge destination. A person's recovery is more likely to be delayed or their condition could deteriorate while waiting.[23] It also means that people coming to the emergency department (ED) who need to be admitted to hospital may need to wait longer in the ED to access a hospital bed.

[22] Ministry of Health and Long-Term Care: Bring Care Home Report 2015.

[23] CIHI. Health Care in Canada, 2011. A focus on Seniors and Aging.

Current Status

In 2017-18, HNHB LHIN hospitals reported increased occupancy pressures, reporting occupancy rates exceeding 100% in their medical beds as a result of increased acuity of the population presenting to the ED requiring admission combined with a number of patients waiting in hospital for an ALC. As of September, 2017, 556 patients were waiting across HNHB hospitals for an ALC (compared to 462 in September 2015). Of the 556 patients, 386 were waiting in acute care beds.[24]

The HNHB LHIN's population is aging, and the largest growth among seniors will be in those 75 years and older.[25] Compared with other age groups, seniors are more likely to use hospital services, and more likely to stay longer than other age groups once admitted.[23]

To support the *PFA, 2016* and the Minister's 2017-18 mandate letter, in 2017-18 the HNHB LHIN has focused on the following to improve patient transitions through the acute care system:

- *Rehabilitative care programs to maintain or improve functional status*. As of September 2017, the hospital-based Seniors Mobile Assess Restore Team (SMART), reported 9,542 individuals had been seen and 86% of these individuals were discharged home from acute care.[26]
- *Standardize Definitions and Referral Process for Rehabilitative Care;* As of March 31, 2018, the HNHB LHIN completed bedded and community rehabilitative referral option tools for all HNHB sub-regions. The LHIN ensured the information regarding community and bedded rehabilitative care programs was aligned with the provincial Rehabilitative Care Alliance (RCA) standard definitions, and was publically available and accessible to referring HSPs via the website – www.hnhblhin.on.ca. Provincial standardized RCA Patient/Caregiver Letters for Bedded Levels of Rehabilitative Care were created in English and French for communication to patients and families during transitions in care.
- *Increasing Transitional Care Program (TCP) capacity.* Six additional TCP beds opened in Hamilton and another 10 beds opened in December 2017 in St. Catharines. As of September 29, 2017, there were 205 transitional care beds open across the LHIN. Program sites report 414 discharges for a total length of stay (LOS) of 25,599 days (avoided ALC days).
- *Integrated Comprehensive Care* is a bundled care model from hospital to community for persons with Congestive Heart Failure (CHF) and/or COPD. For the period April 1 - September 30, 2017, 606 people were enrolled in the program. Hospitals reported a 2.2 day reduction in length of stay compared to 2014-15 and a reduction in 30 and 60 day unscheduled ED/Urgent Care Centre revisit rate in the first quarter of 2017-18 compared to 2014-15.
- *Subsidized Seniors Supportive Housing*. Introduced a total of 51 subsidized supportive housing units for seniors and other patients waiting in hospital in Hamilton (40), Brantford (8) and SNGR (3).

PART 2: GOALS AND ACTION PLANS

Goal (s)

Improving transitions across the health care system specifically from hospital to community will be a priority goal in 2018-19. Focus will be on initiatives that maintain or improve a person's functional status, expanding access to bedded transitional care settings, and increasing access to subsidized supportive housing.

In 2018-19 activities will include:

- Implementation of the RCA provincial work plan, specifically:
  - Developing a communication plan to inform patients, families and referring HSPs on what to expect when receiving rehabilitative care.

[24] HNHB LHIN Patient Flow Steering Committee November 2017. Performance Report.

[25] Population Estimates, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHealth Ontario

[26] HNHB LHIN 2017-18 Q2 SMART reporting.

- Applying the provincial RCA evaluation framework to assess the implementation of the RCA provincial standardized definitions.
- Assisting in the development and testing of a simplified provincial approach to rehabilitative care capacity planning.

- Expanding the capacity of the HNHB Transitional Care Program (baseline 199 beds).
- Implementing a 28 bed Acquired Brain Injury (ABI) Stroke Community Transitional Program.
- Implementing and evaluating a ten bed supportive housing unit for persons with Dual Diagnosis.
- Implementing all 51 subsidized SH units for eligible persons waiting in hospital for supportive housing.

Government Priorities:

The priority of improving transitions across the continuum of care, specifically from hospital to community works to ensure residents will have timely access to the acute and specialized services provided by hospitals while protecting Ontario's health care system. This priority aligns with *Patients First: Action Plan for Health Care* and *Patients First: A Roadmap to Strengthen Home and Community Care*. Additionally, this priority is aligned with the following government priorities:

- *ECFAA*
- *FLSA*
- IHN Priorities

Action Plans/Interventions

Action Plans	Expected Status (as of March 31, 2019)	Expected Completion Date
Implement the RCA provincial work plan consistent with the identified goals.	Completed	March 31, 2019
Expand the capacity of the HNHB TCP with a minimum of two additional sites.	Completed	March 31, 2019
Implement a 28 bed ABI Stroke Community Transitional Program.	Completed	March 31, 2019
Implement and evaluate a 10 bed supportive housing unit for persons with Dual Diagnosis.	Completed	March 31, 2019
Implement all 51 subsidized supportive housing units for eligible persons waiting in hospital for supportive housing.	Completed	March 31, 2019

2.4. 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 (NPs), carry out assessments and treatments that ensure the general health and well-being of their patients. Primary care providers have a substantial role in working with patients and their families on health

education and preventative screening. Additionally, primary care providers refer to secondary and tertiary care as well as community supports. Continuing to build on the foundation created by the *Patients First* legislation, the HNHB LHIN continues to work with primary care providers, partners, patients and caregivers to improve the patient experience, equitable access to primary care and seamless transitions with other health and social services.

Current Status

To support the *PFA, 2016* and the Minister's 2017-18 mandate letter, the HNHB LHIN has completed the following:

- An initial review of primary care human resources data by sub-region.
- A proposal to increase access to allied health professionals in the Burlington sub-region, and identified opportunities to increase access to allied health within the Brant, Haldimand-Norfolk, Hamilton, Niagara and Niagara North West sub-regions.
- Increased usage of eConsult to decrease the requirement for patients to travel for specialist appointments. This includes 503 eConsults, with 256 physicians and 23 NPs registered (67 are specialists).
- Planning for education modalities in each sub-region to support the dissemination and adoption of HQO's Opioid Guidelines.
- Implementing the new recommendations to improve access for patients (February 2018).

PART 2: GOALS AND ACTION PLANS

Goal (s)

In 2018-19 the HNHB LHIN will continue to work with providers to build primary care as the foundation of the health care system and to work with health care providers to:

- Improve access to primary care providers and inter-professional health care providers in sub-regions.
- Engage primary care providers in the development and implementation of key strategic program and service priorities.
- Support the adoption of HQO Guidelines by primary care providers.
- Increase the utilization of eConsult and telemedicine to provide improved access to specialty care.

Government Priorities:

The *PFA, 2016* enables the HNHB LHIN to ensure patients are at the centre of the health care system, transforming 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 the population in sub-regions, including the unique needs of the Indigenous and Francophone populations, is further supported by:

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

Action Plans/Interventions

Action Plans	Expected Status (as of March 31, 2019)	Expected Completion Date
Implement innovative approaches to improve equitable primary care access in all HNHB sub-regions.	Completed	March 31, 2019
Incorporate primary care input into HNHB LHIN plans. This includes: MSK Centralized	In-progress	March 31, 2020

	Intake and Assessment, transitions between primary care and other health and social services, Health Links, care coordination and system navigation.		
	Spread the adoption of best practice guidelines across the sub-regions (for example, wound care and/or opioids) in partnership with stakeholders.	Completed	March 31, 2019
	Increase the utilization of eConsult and telemedicine to provide access to specialty care.	1000 referrals from primary care to specialists utilizing eConsults..	March 31, 2020

2.5. Mental Health and Addictions

PART 1: IDENTIFICATION OF PRIORITY

Priority

Mental Health and Addictions

Priority Description

The Centre for Addiction and Mental Health reports that in any given year, one in five Canadians experiences a mental health and/or addictions issue and by age 40, one in two Canadians have, or have experienced, a mental illness.[27]
It is further reported that one third of Ontarians who identified themselves as needing MHA services did not receive help, or only had their needs partially met. Barriers identified to accessing services included fear of social stigma, inability to pay for services, and not knowing where to access help.[28]

The *Patients First: Action Plan for Health Care* identified the need to provide faster access to MHA services. This commitment was reinforced by the ministry's establishment of the Ontario Mental Health and Addiction Leadership Advisory Council, and the ongoing commitment identifying MHA as a priority in the Minister's 2018-19 mandate letter.

Current Status

In the first quarter of 2017-18 (April 1 to June 30, 2017), nearly 6,000 HNHB LHIN residents presented at an ED with a MHA issue. Over a seven month period in 2017 (April 1 to October 31), residents of the HNHB LHIN had the highest number of ED visits for opioid overdose compared to all other LHINs.[29]

The complexity of the MHA system can act as a barrier to persons needing timely access to services. The HNHB LHIN funds 38 organizations 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 MH conditions and/or addictions.

To support the *PFA, 2016* and the Minister's 2017-18 mandate letter, Ontario's Opioid Strategy, the HNHB Mental Health and Addictions Advisory Committee, in partnership with HSPs and other key stakeholders, has completed the following achievements:

- Addictions Sector Value Stream Mapping (VSM) across five sub-regions (Burlington elected not to participate as they were already developing a plan with partnering stakeholders). The VSM sessions mapped the current and ideal state

[27] Centre for Addictions and Mental Health Website accessed December 4, 2017
[28] Ontario sample of the 2012 Canadian Community Health Survey Mental Health, provided by the Institute for Clinical Evaluative Sciences.
[29] MOHLTC Emergency Department Visits for Opioid Overdose. LHIN Report Oct 2017.

and identified three local priority areas. Each sub-region's addiction agencies were then invited to submit collaborative proposals for funding taking into consideration the priority areas identified through the VSM in alignment with provincial and LHIN priorities.

- A Concurrent Disorders Capacity Building Strategy was shared with HNHB LHIN-funded MHA agencies, requesting that they undertake a Concurrent Disorders Capacity assessment within their organization, identify a priority, and report to the LHIN on the associated actions based on that priority during 2017-18. LHIN follow up with agencies was planned in the fourth quarter of 2017-18.
- Standard service delivery models for Crisis Outreach and Support Teams and Mobile Crisis Rapid Response Teams were identified.
- A review of the Schedule 1 Long Stay Population resulted in the development and implementation of a community-based supportive housing program for persons with Dual Diagnosis in partnership with Wesley Urban Ministries, the Ministry of Community and Social Services and St. Joseph's Healthcare Hamilton.
- A transition pathway for youth from Non-Schedule 1 hospitals to Hamilton Health Sciences Corporation McMaster Children's Hospital site was developed.
- The development of an allocation methodology in collaboration with LHIN-funded MHA agencies and ministry-funded Housing Service Managers (i.e., municipalities and district social services administration boards designated under the *Social Housing Reform Act, 2000*, to manage social housing programs across the province) to allocate 104 supportive housing units for individuals with MH and/or addictions concerns. This included designating a set allocation of housing units for Indigenous Peoples that would be managed through Six Nations of the Grand River.
- In 2017-18, the MHA Advisory Committee, based on a number of factors, including the outcomes of the VSM sessions across HNHB LHIN sub-regions, identified addiction services as a priority area for investment.
- In October 2017, the HNHB LHIN Board approved more than $1.9 million in new funding to support Ontario's Opioid Strategy and $1.3 million to increase access to MHA services.

PART 2: GOALS AND ACTION PLANS

Goal (s)

In 2018-19, the HNHB LHIN, with the support of the HNHB Mental Health and Addictions Advisory Committee, and MHA PFAC will:

- From a person and system perspective, evaluate the impact of MHA programs supported with new funding in 2017-18 on outcomes related to opioid use at the sub-region and LHIN level.
- Engage sub-region Anchor Tables and public health on planning addiction services.
- Address factors that may contribute to repeat emergency visits by spreading and scaling local initiatives that reduce repeat use of EDs for MH and substance use.
- Map access to structured psychotherapy by sub-region and establish referral networks with primary care providers.
- Support the ongoing development of the provincial opioid strategy and the implementation of the new and/or expanded programs funded with 2017-18 Community Investment Funding and/or Opioid Strategy Funding.
- 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 directions; and,
  - 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.
- Develop and implement an anti-stigma strategy for HSPs to ensure individuals living with MHA who are accessing the health care system do not have stigmatizing experiences.

- Develop a pathway/process that will facilitate seamless transitions for children and youth to adult MHA services.
- Conduct an environmental scan of MHA services accessed by Indigenous community members to identify where they access services to inform capacity, sub-regional gaps and areas of opportunity.
- Develop and implement a standardized approach to self-identification across LHIN-funded MHA HSPs.

Government Priorities:

The HNHB LHIN's Mental Health and Addictions Action Plans were developed by the LHIN in partnership with the HNHB LHIN Mental Health and Addictions Advisory Committee to align with the goals of:

- *PFA, 2016,*
- Open Minds Healthy Minds, the Provincial Mental Health and Addictions Strategy

The Action Plans also align with the recommendations of the Provincial Mental Health and Addictions Leadership Advisory Council.

Action Plans/Interventions

Action Plans	Expected Status (as of March 31, 2019)	Expected Completion Date
From a person and system perspective, evaluate the impact of MHA programs supported with new funding in 2017-18 on outcomes related to opioid use at the sub-region and LHIN level.	Completed	March 31, 2019
Complete a current state capacity assessment of HNHB LHIN-wide supportive housing.	Completed	March 31, 2019
Develop and implement an anti-stigma strategy for HSPs.	Completed	March 31, 2019
Develop a pathway that will stream 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.	Completed	March 31, 2019
Develop a pathway/process that will facilitate seamless transitions for children and youth to adult MHA services.	Completed	March 31, 2019
Address factors that may contribute to repeat emergency visits by spreading and scaling local initiatives that reduce repeat use of EDs for MH and substance use.	Completed	March 31, 2019
Map access to structured psychotherapy by sub-region and establish referral networks with primary care providers.	Completed	March 31, 2019
Conduct an environmental scan of MHA services accessed by Indigenous community members to identify where they access services to inform capacity, sub-regional gaps and areas of opportunity.	Completed	March 31, 2019
Develop and implement a standardized approach to self-identification across LHIN-funded MHA health service providers.	In Progress	September, 2019

2.6. Innovation Health Technologies and Digital Health

PART 1: IDENTIFICATION OF PRIORITY

Priority

Innovation, Health Technologies and Digital Health

Priority Description

Health care decisions are complex and information is expansive. Digital (electronic) solutions are enablers that are critical in improving patient care, access and navigation of the health care system. Digital Health solutions can improve communication between physicians and providers and increasingly between patients and their care team; timely access to a broad range of clinical information across systems to support effective clinical decision making; the ability to establish and maintain effective clinical workflows; and patient safety by reducing medical errors and duplication of diagnostic and laboratory tests.

Current Status

To support the *PFA, 2016* and the Minister's 2017-18 mandate letter, the HNHB LHIN, in collaboration with the Health Information Technology Services Electronic Health Care (eHealth) Office at Hamilton Health Sciences, has made significant progress with respect to adoption of digital health tools amongst providers in the LHIN.

During 2017-18, several interrelated digital health milestones that improve patient care were achieved, and aligned with provincial level work. Key achievements were:

- Expanded patient access to their personal health information by deploying a portal through MyChart (an electronic mechanism for patients to access and update their health information) for South West Ontario, based on direct engagement with patients to gain input and insights.
- Increased access to clinical information on medications (to Digital Health Drug Repository) through ClinicalConnect (ePlatform across the HNHB LHIN) for authorized users.
- In addition, advancements in other areas include immunization data, and drugs/allergies entered by patients into their Personal Health Record (PHR), a component of MyChart, is underway.
- Improved digital solutions to support health system integration and communication between acute care hospitals and community-based providers (via Health Report Manager and eNotifications) is underway.
- Increased access to specialist through eConsult to support on-line consultation between primary care providers and specialists.

PART 2: GOALS AND ACTION PLANS

Goal (s)

To support the *PFA, 2016* and the Minister's 2018-19 mandate letter, the HNHB LHIN will continue to implement and advance the uptake of digital health solutions. This will include the following:

- Support the delivery of digital solutions to improve patient access (e.g. specialists) and navigation.
- Improve patient access to personal health information through enabling digital self-care models that are consistent with existing provincial initiatives.
- Improve patient engagement in their health care via electronic access to their health information.
- Improve the ability of health professionals to access information to make informed decisions.
- Demonstrate alignment with, and action on, the ministry's 10-Point Digital Health Action Plan.

Government Priorities:
The Digital Health priorities are aligned with: • Patients First: Action Plan for Health Care • Minister's 2018-19 Mandate Letter • Ministry's Digital Health Strategy and 10-Point Digital Health Action Plan • *ECFAA*

Action Plans/Interventions

Action Plans	Expected Status (as of March 31, 2019)	Expected Completion Date
Complete implementation of eNotification.	Completed	March 31, 2019
Implement Client Health Related Information System as the electronic solution for Coordinated Care Plans for patients living with complex chronic conditions using the Health Links model of care.	Completed	March 31, 2019
Advance the spread of digital self-care models.	In progress	Ongoing
Integrate data from ClinicalConnect with MyChart, then deploy MyChart to patients at early adopter organizations.	Minimum 65,000 patients registered by end of 2019, so they can access their hospital and LHIN-HCC data using MyChart	Ongoing
Complete integration of data from multiple sources in ClinicalConnect, e.g., Primary Care; Diagnostic Imaging; Immunization Repository	Completed	March 31, 2019
Advance Telehomecare using OTN's services, specifically in areas such as Tele-wound care, diabetes and MH.	Completed	March 31, 2019

3) LHIN-Delivered Home and Community Care

PART 1: IDENTIFICATION OF PRIORITY
Priority
Home and Community Care
Priority Description
The premise of HCC is to support people of all ages, in the communities in which they live, to remain independent and cared for in their own homes for as long as possible. This is achieved when appropriate supports are available and accessible, including one or more of the following services: nursing care, physiotherapy, occupational therapy, speech language therapy, personal support services, respite supports for caregivers, and home health care supplies. Strengthening HCC also requires better integration of the health care services that patients receive from providers across the continuum of care to achieve a more seamless approach to service delivery and better patient outcomes. Patient navigation to assist in accessing these services, through system partnerships and collaboration, supports shorter hospital

stays, and delays or avoids the need for admission to an institutionalized setting (such as a hospital or LTCH). HCC is necessary for the health system to deliver on the promise of right care, right time, and right place.

HNHB LHIN-delivered HCC services are also a key component in the health care continuum, connecting with many partners to provide health care services and supports to residents across the HNHB LHIN. An example of this is the role HCC has in advancing and supporting the HNHB Regional Palliative Care Network's (RPCN's) mandate.

Hospice palliative care is a philosophy of care that aims to relieve suffering and improve the quality of living and dying by helping individuals and families. The *Patients First: A Roadmap to Strengthen Home and Community Care* established goals and set out the following Palliative and End of Life (EOL) care priorities:

- 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.

Current Status

The *PFA, 2016,* significantly changed how HCC services would be delivered in Ontario. In 2017-18, all home care services previously provided by the HNHB Community Care Access Centre, successfully transitioned to the HNHB LHIN.

The HNHB LHIN continues to lead the implementation of a transformation agenda that integrates HCC with other key service providers across the system, including primary care, hospitals and CSS agencies. 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.

As part of the foundational transformation work post-transition, the LHIN changed its structure across the Patient Services operational leadership team to align with the sub-region leadership structure. This alignment facilitated a partnership between the teams to strengthen relationships between HCC with other sectors, including MHA, social services, and primary care, within the six sub-regions in an effort to standardize and improve consistency, access and quality of care provided to individuals at home and in the community.

A restructuring of the Patient Services hospital leadership operations portfolio was completed to set the foundation for new hospital partnerships to improve transitions in care across the continuum and build a more seamless, and integrated experience for patients when moving from hospital to community. A LHIN-wide Director of Patient Flow role was established along with the development of a framework for Integrated Manager positions across hospital corporations. This new structure set the foundation for bringing hospital discharge planning teams and home care teams together, working as one system under the Home First Philosophy, through formalized shared accountability structures to ensure the right care is delivered in the right place.

In 2017-18, the RPCN continued to evolve the network's structure to align with that identified by the Ontario Palliative Care Network (OPCN). The RPCN is accountable to the ministry through the LHIN CEO and Regional Cancer Centre Vice President to advance the provincial direction for hospice palliative care.

In 2017-18, under the leadership of the HNHB RPCN, the following activities were completed:

- An environment scan of education resources/programs available with the LHIN for submission to the OPCN.
- A gap analysis for Palliative Care Outreach Team (PCOT) services across the HNHB LHIN.
- In collaboration with palliative care providers, primary care and specialized palliative care physicians, an integrated PCOT model for Niagara, Haldimand-Norfolk and Brant was mapped.
- A scorecard which included a core set of indicators to assess performance.

- In partnership with the HNHB LHIN, the IHN hosted a community engagement gathering in November 2017, focused on sharing experiences of palliative care from the perspective of Indigenous communities, families and individuals. The gathering was attended by approximately 100 individuals, including both community members and health care providers, coming together to listen, learn and share their stories. This information continues to inform the HNHB LHIN's plan to deliver equitable access to high quality hospice palliative care and support for First Nation and urban Indigenous Peoples.

PART 2: GOALS AND ACTION PLANS

Goal (s)

Transforming the HCC system will focus on the initiatives outlined in *Patients First: A Roadmap to Strengthen Home and Community Care*. Principles guiding the transformation of HCC include building a system where people:

- Who need care most, have better access to the right care, through service delivery that is aligned with care communities, using sub-regions as a context for capacity planning and resource allocation.
- Receive more consistent care and supports.
- Experience seamless transitions in care from hospital to community and through primary care.
- Better understand what services are available.
- Receive more caregiver support (refer to Patient Experience section).

In 2018-19 the HNHB LHIN has set the following goals for HCC:

- Move the coordination of care closer to the patient by putting primary care at the centre of care planning and care coordination:
  - The HNHB LHIN will embed care coordination and system navigation into select primary care practices, beginning with LHIN-funded CHCs and FHTs.
  - Improve the care of patients with MH issues by testing a MH step down model of care coordination and support within HCC, in collaboration with MH service providers and hospitals, to better support primary care in the management of these patients.
- Improve public understanding and expectations related to accessing home and community care supports:
  - Reduce wait times and improve coordination and consistency of access to services and care provision across the LHIN so patients and caregivers know what to expect.
- Improve transitions in care that are supported by HCC to support the right service, at the right time, in the right place:
  - Expand and integrate the implementation of Integrated Funding Models (IFMs) for episodic care in partnership with the Integrated Comprehensive Care Project leadership and hospital partners across the HNHB LHIN.
- Implement an integrated discharge planning framework, in partnership with hospitals, through the Home First philosophy that will support shared accountability and work as one system in patient care transitions.
- Modernize and build service provider capacity, through the alignment of services within health care communities, by exploring opportunities for geographic re-alignment of home care service providers and CSS within sub-regions.
  - Conduct capacity planning for HCC in each sub-region, identifying discrepancies in access and availability of services and planning for equity in access and more efficient and patient-centred service delivery models within care communities across the LHIN.

Goals specific to advancing the LHIN's HNHB RPCN and OPCN 2017-20 Action Plans include:

- Support patients (adult and paediatric) and caregivers to have greater choice for palliative/EOL care by improving access to transparent, coordinated and integrated palliative home care services that meet the needs of patients and caregivers.
- Complete an evidence-based capacity plan for palliative/EOL care, including an assessment of demand (reflecting paediatric and homeless population groups), identifying current resources and areas of duplication and service gaps.

The plan will include an assessment of the system's capacity to provide services in French to the LHIN's Francophone population.

- In collaboration with Indigenous Peoples, develop and initiate a plan to deliver equitable access to high quality care and support for First Nations, Inuit and Métis people living on an off reserve, in urban and rural areas.

Government Priorities:

The *PFA, 2016*, transformed the role of the LHIN in relation to HCC, and brought new opportunities for planning, integration, funding and implementation of services across the sub-regions. 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 patients and caregivers first.
- Improving patient and caregiver experience.
- Driving greater quality, consistency and transparency.
- Planning for expanded capacity.
- Modernizing home and community service delivery and care.
- Identifying the unique needs of Indigenous and Francophone populations.

These priorities align with:

- Patients First: Action Plan for Health Care
- Patients First: A Roadmap to Strengthen Home and Community Care
- OPCN 2017-20 Action Plan
- Advancing high quality, high value palliative care in Ontario
- A Declaration of partnership and commitment to action advancing palliative care
- *ECFAA, FLSA*, and IHN priorities

Action Plans/Interventions

Action Plans	**Expected Status (as of March 31, 2019)**	**Expected Completion Date**
Implement an integrated model of System Navigation and Care Coordination in primary care through models tailored to select primary care settings such as CHCs and FHTs. Develop and test a model for embedding care coordination in other primary care settings such as solo practices.	In progress	June 30, 2019
Implement the Levels of Care Framework to improve public understanding and expectations related to access and delivery of home and community care.	Completed	March 31, 2019
Expand and Integrate HCC infrastructure and services with IFMs for episodic care throughout the HNHB LHIN in partnership with participating LHIN-wide hospitals.	Completed	March 31, 2019
Implement an integrated accountability framework between hospital and home care discharge planning teams in alignment with the Home First Philosophy - reducing the number of people waiting in hospital for the right level of care.	Completed	March 31, 2019

	Test a step down model of care for patients with MH issues that will promote a seamless and improved transition from hospital to community; and from intense MH sector services to HCC while supporting primary care in the management of their patients with MH issues.	Completed	March 31, 2019
	Work with service providers and CSS to build capacity through testing new models of service delivery that explore realignment of resources within care communities across the sub-regions.	Completed	March 31, 2019
	Develop and implement a model for palliative/EOL home and community services that is integrated and coordinated with outreach specialists and primary care.	In progress	March 31, 2020
	Complete an evidence-based capacity plan for palliative/EOL care, including an assessment of demand (reflecting paediatric and homeless population groups).	Completed	March 31, 2019
	Develop and initiate a plan to deliver equitable access to high quality palliative/ EOL care and support for First Nations, Inuit and Métis people living on and of reserve, in urban and rural areas.	In progress	March 31, 2020

4) French Language Services

PART 1: IDENTIFICATION OF PRIORITY
Priority
French Language Services
Priority Description
The *FLSA* guarantees the right to communicate and receive services in French from government and Crown agencies within designated areas. *LHSIA* established the mandate and powers of LHINs to plan, fund and integrate and respect the requirements of the *FLSA* in serving Ontario's French-speaking community. The *PFA, 2016* reinforced the expectation to respect the requirements of the *FLSA* in the planning, design, delivery and evaluation of services.
Francophone Engagement and Inclusion in Health Care Planning
In 2018-19, the LHIN will continue to work with the FLHPE and local Francophone communities to inform planning and identify priorities. The LHIN will also engage designated French language HSPs to participate on LHIN-wide committees such the HNHB RPCN and in local planning through participation on sub-region Anchor tables.

PART 2: GOALS AND ACTION PLANS
Goal (s)
The Minister's 2018-19 mandate letter requires the LHIN to assess the existing capacity of French Language Services (FLS) and plan to enhance services in French.

The following key directions are foundational to improving access to FLS across the HNHB LHIN:

- Engagement and planning with the FLHPE and Francophone communities: As per the funding and accountability agreement, the HNHB LHIN in collaboration with the local FLHPE, developed a Joint Annual Action Plan that sets out the key deliverables and the associated work plan including the community engagement plan.
- Addressing the needs and concerns of the local French speaking community: The 2016 census identified less than 30,000 French speaking people within the HNHB LHIN down from the previous census. Sub-region planning will reflect the variation in the density of the French speaking population. The priorities will focus on populations in which the impact of the language barrier is more severe (e.g. seniors living in isolation, new immigrants and patients with mental health issues). The new provincial tool will be used to assess current capacity HSPs. This tool will also support designated, identified agencies and SPOs in their planning process for FLS. Provincial FLS provider indicators, categorized in different measurement domains such as demand, capacity, access and active offer, will streamline the role and activities of the HNHB LHIN regarding services in French.
- Compliance with the *FLSA*: The LHIN has developed, and is implementing, a multi-year comprehensive plan to address its obligation to be compliant with the *FLSA*, including services directly provided to the public by HCC.
- Active offer implementation: The active offer is the clear and proactive offer of services in French to individuals, from the first point of contact, without placing the responsibility of requesting services in French on the individual. The FLS plan for the HNHB LHIN incorporates elements of active offer and is being implemented in the following domains:
  - Communication
  - Information and referral

Government Priorities

This priority aligns with the following:

- *FLSA*
- Patient's First: Ontario Action Plan for Health Care

Action Plans/Interventions

Action Plans	Expected Status (as of March 31, 2019)	Expected Completion Date
Implement the deployment of the Ozi data collection tool with the goal of gathering essential baseline data on FLS capacity of HSPs to support FLS planning in the HNHB LHIN.	In progress	March 31, 2019
Implement the HNHB LHIN's plan to address compliance with the *FLSA* as a crown agency of the government in the services it provides including home and community care with a focus on active offer.	In progress	March 31, 2020
Continue to work with the FLHPE in the engagement of the Francophone community to inform the HNHB LHIN key priorities and ongoing planning.	In progress	March 31, 2020

5) Indigenous Peoples Health and Wellness

PART 1: IDENTIFICATION OF PRIORITY

Priority

Indigenous Peoples Health and Wellness

Priority Description

To reduce the health disparities experienced by Indigenous Peoples as a result of the legacies of colonization, the LHIN remains committed to listening and learning from local communities to inform the design, delivery and evaluation of health care services accessed by Indigenous Peoples. To achieve improved health outcomes, the local health care system must provide Indigenous Peoples with culturally appropriate care delivered in culturally safe settings, where Indigenous and mainstream providers work together with a shared knowledge and appreciation of the unique needs of Indigenous Peoples.

Through knowledge building and education, system navigation, respectful partnerships, and engaging communities, the LHIN supports health partners to deliver more equitable access to health care services that reflect Indigenous ways of doing, being, and healing.

Indigenous Engagement and Inclusion in Health Care Planning

During 2017-18 the LHIN continued to advance existing action plans and initiatives, while also identifying new areas of priority through the inclusion of First Nation communities and Indigenous health care providers in planning activities as well as broader engagement with Indigenous community members. Key priorities arising from engagement and inclusion activities are strengthened by provincial commitments to advance the work of reconciliation towards improving health outcomes for Indigenous Peoples.

Throughout 2017-18, the LHIN focused on developing community driven approaches to leverage the implementation of sub-region planning as a platform for system-level change that would positively impact the interactions, transitions, and experiences of Indigenous Peoples accessing the health care system.

The LHIN collaborates regularly with various local Indigenous health and social service organizations, which includes two First Nation communities (SNGR and MNCFN), De dwa da dehs nye>s Aboriginal Health Access Centre (DAHC), three Friendship Centres, Indigenous Diabetes Health Circle, two Native Women's Chapters, as well as several Indigenous housing organizations. Together these organizations and communities form the HNHB LHIN IHN which meets bi-monthly to strengthen the voice of Indigenous communities and provides essential advice and direction on local health care priorities, planning and service delivery.

The LHIN acknowledges and recognizes the unique health care experience of First Nations Peoples living on reserve and continues to work alongside local First Nations to identify where the LHIN can build strong relationships and be a partner in supporting equitable access to health services within and surrounding these communities.

Delivering Health Care Services In Partnership with Indigenous Communities

The LHIN currently supports Indigenous health programs and services through funding to four Indigenous health service providers: DAHC, Native Horizons Treatment Centre and two First Nation communities; SNGR and MNCFN. These health service providers deliver community driven and culturally-based programs and services including mental health and addictions, case management, crisis intervention, palliative care, patient navigation and advocacy, traditional medicine, in home services and supports, caregiver supports, and long-term care.

In 2017-18, the LHIN and IHN continued to advance the priorities identified in the IHN's 2015-2018 Strategic Plan:

- Cultural Safety
- Traditional Healing and Wellness
- Strengthening the Family Unit
- Mental Health and Addictions
- Chronic Disease Prevention

In addition to the above listed priorities, the LHIN continued to work with SNGR to address key areas of focus which include primary care, palliative care, and Traditional medicine.

Key successes related to these priorities are:

- Between April 2017 and September 2017, the HNHB LHIN supported 431 health care workers to participate in Ontario's Indigenous Cultural Safety (ICS) Training program. In addition, the LHIN has implemented a requirement that all programs and services receiving new LHIN funding must enroll new Full-Time Equivalents (FTEs) in ICS Training.
- In November 2017, the IHN endorsed five Indigenous health care workers to complete Tolerance Scale Facilitator's Training hosted by Ontario's ICS Program. Through this training, staff will become certified to provide this training to health care organizations in the HNHB region as a supplementary learning opportunity following the online ICS training.
- With the implementation of DAHC's Niagara-based MH case manager, this program has experienced increased demand and has supported 25 individuals between April 2017 and September 2017.
- An Indigenous Addiction Services Mapping Session was completed with participation from Indigenous Addictions providers including both LHIN funded and non-LHIN funded organizations.
- Between April 2017 and September 2017, SNGR Ogwanohgwatae:' (We Have Good Medicine) Traditional Medicine Program provided 133 individuals with access to Traditional healing serviced through 542 visits and 177 ceremonial visits. A referral protocol was developed and implemented beginning with health care providers working on SNGR.
- As previously referenced, the HNHB IHN and HNHB RPCN hosted an Indigenous Community Engagement focused on gathering stories and experiences of palliative care from the perspective of Indigenous individuals, families and communities.

PART 2: GOALS AND ACTION PLANS

Goal (s)

Cultural Safety:

- Develop and implement additional resources that will support health service providers to build knowledge and understanding of Indigenous Peoples and cultural safety.
- Support 300 health care workers to participate in ICS training.
- Develop and implement a plan to deliver Indigenous Tolerance Scale Training to 100 health service provider staff.

Self-Identification:

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

Patient Navigation:

- Review and evaluate the patient navigator program to identify gaps, barriers and opportunities to improve access to culturally appropriate services.

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.

Additional goals and action plans aimed at improving the health outcomes and experiences of Indigenous Peoples can be found throughout the HNHB LHIN's ABP to emphasize the importance of incorporating the unique needs of Indigenous Peoples across all LHIN priority areas. For more details, refer to sections on MHA, Hospice Palliative Care and Building Healthy Communities Informed by Population Health Planning.

Government Priorities:

This priority aligns and supports the following:

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

- Truth and Reconciliation Commission of Canada's Final Report and Calls to Action
- Ontario's First Nations Health Action Plan
- The Journey Together: Ontario's Commitment to Reconciliation with Indigenous Peoples
- IHN Priorities

Action Plans/Interventions

Action Plans	Expected Status (as of March 31, 2019)	Expected Completion Date
Develop and implement additional resources that will support HSPs to build knowledge and understanding of Indigenous Peoples and cultural safety.	Completed	March 31, 2019
Training: • Support 300 health care workers to participate in ICS training. • Develop and implement a plan to train 100 HSP staff in Indigenous Tolerance Scale Training.	Completed	March 31, 2019
Develop a standardized Indigenous self-identification method and identify one LHIN hospital to implement this method into hospital patient registration processes.	In progress	March 31, 2020
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	March 31, 2020

6) Performance Measures

How will the LHIN measure success?

The LHIN measures success using a combination of performance, monitoring, and developmental indicators (such as Ministry-LHIN Accountability Agreement (MLAA) indicators and local indicators). In 2018-19, the HNHB LHIN will focus on indicators that are responsive, reliable, valid, and demonstrate impact aligned to priorities identified in this ABP. These measurable indicators will be utilized to assess our progress toward the overarching goals of *improving the patient experience and engagement, improving access*, and *improving quality, integration and value*. Specific process and output measures (for example, the completion of certain deliverables, and the number of patients seen) associated with each action plan included in this ABP, although not mentioned here, will also be applied to support measurement of success and progress.

Improve Patient Experience and Engagement	
Increased patient/caregiver engagement, confidence, and satisfaction with health care.	• Percentage of "Good", "Very Good" and "Excellent" responses on a 5 point scale (poor to excellent) to three Client Experience Survey (CCEE) questions: • Overall rating of LHIN home and community care services • Overall rating of management or handling of care by care coordinator • Overall rating of service provided by service provider Target: Increase results to 93% or above by March 31, 2019.

	• Percent of patients who report positively when asked "in general, how satisfied are you with care in your community" as part of telephone based survey (Health Care Experience Survey). Target: Increase results to 85% or above by March 31, 2019. • 100% of LHIN HCC Long Stay Community Care Coordinators will utilize the CDI to identify caregivers at risk of adverse outcomes to coordinate respite care by March 31, 2019.
Improved timeliness of responses to patient complaints.	• 70% of patient complaints acknowledged within 2 business days.
Increase number of patients being provided with an active offer of services in French by LHIN HCC staff.	• 10% increase in the number of patients provided with an active offer of services in French by March 31, 2019. Baseline year 2017-18.
Percent of LHIN HCC patients who are receiving palliative/EOL services through a new model integrated and coordinated with outreach specialists and primary care.	• Integrated model of care for palliative/EOL will be developed by March 31, 2019. • 100% of LHIN HCC patients receiving palliative/EOL services will have access to care through the new model of care that is integrated and coordinated with outreach specialists and primary care by March 31, 2020.
Improve Access	
Increased percentage of people who received physician home visit(s) and/or palliative home care in the last 90 days of life.	• 5% increase in the number of people receive a physician home visits and/or palliative home care in the last 90 days of life as a proportion of all community decedents by March 31, 2020. Baseline 30% 2015 Data Source OPCN.
Decreasing trend in ED LOS for complex patients.	• 25% decrease in ED LOS for complex patients by March 31, 2019. Baseline of 16 hours November 2017 Stocktake.
Increase in the number of individuals assessed for total hip and knee replacement through a centralized intake model.	• Central intake for hip and knee total joint replacement surgical referrals and Inter-professional Spine Assessment and Education Clinic fully operational by March 31, 2019. • 100% of referrals for elective hip and knee replacement surgery will be through the MSK Central Intake by March 31, 2020.
Increased patient attachment to primary care providers in HNHB LHIN.	• A review of primary care human resources by sub-region will be completed by March 31, 2019.
Increased number of physicians, both specialists and primary care, with access to eConsult.	• Digital solution of electronic communication (eVisit) implemented in three adult DEPs by March 31, 2020. • 1000 referrals from primary care to specialists utilizing eConsults by March 31, 2019.
Decreased wait times for community service.	• Decrease in the 90th percentile wait time from community for home care services: application from community setting to first home care service (excluding case management) to 21 days by March 31, 2019.
Increase patient's access to their health information by integrating data from Clinical Connect to MyChart.	• Minimum 65,000 patients will be registered by the end of 2019 to access their hospital and LHIN-HCC date using MyChart.

Improve Quality	
Improved consistency and equity of access and levels of service across home and community care services.	• All LHIN sub-regions will have completed a health equity impact assessment by March 31, 2019. • A capacity plan for dementia services at the community level will be completed by March 31, 2019. • A framework will be in place across HNHB LHIN HCC that details criteria for palliative services and EOL care and when care is transferred to the HCC Palliative Care Team by March 31, 2019, • Access to publically funded diabetes offloading devices will be available in each sub-region by March 31, 2019.
Increase the number of coordinated care plans (CCP) for people living with complex chronic conditions and sharing of CCPs with all members of the patients care team	• 1,635 (38% increase over 2017-18) CCPs will be completed for persons living with complex chronic conditions by March 31, 2019. • 100% of the CCPs will be shared with team members by March 31, 2019.
Increased adoption of best practice guidelines (e.g. opioids, wound care) across sub-regions.	• New opioid standards will be communicated to all HNHB Primary Care providers. • A minimum of 724 patients with diabetic foot ulcers will access public funded offloading devices, a best practice for diabetic foot ulcers by March 31, 2019.
Completed San'yas Ontario ICS Training for HSP staff.	• 400 HSP staff will attend ICS training with 95% completion rate by March 31 2019.
Improve Integration	
Decrease in ALC designation in hospital and length of stay in hospital waiting for an ALC.	• Increase transitional bed capacity by two additional sites by March 31, 2019. • Implement a 28 ABI-Stroke Community Transitional Program by March 31, 2019. • 50% reduction in ALC designation to LTCH from hospital by March 31, 2019. • 100% of LHIN hospitals will have an Integrated Manager of Discharge Planning Model operational by March 31, 2019.
Decreasing trend in rate of hospital readmission within 30 days for certain chronic conditions such as CHF, COPD, mental health and addictions and diabetes.	• Percent decrease in the number of patients presenting to the ED for diabetic foot ulcer by March 31, 2020. Baseline year 2017-18, baseline data will be identified when year-end data is available in June 2018. • A RAAM clinic will be fully operational in Hamilton by March 31, 2019. • 30% reduction in repeat ED visits within 90 days for the population seen at the Hamilton RAAM clinic by March 31, 2019.
Improved access to Home Care services and system navigation for patients through embedding Care Coordinators within primary care.	• 100% of LHIN funded Community Health Centres will have care coordinators embedded into the program by March 31, 2019. • 100% of Family Health Teams will have a care coordinator embedded in their practice by March 31, 2019.
Decreased percentage of people who had one or more ED visits in the last 30 days of life.	• 5% decrease in the percent of people who have one or more unplanned ED visits (% of discharges coded Z51.5) in the last 30 days of life by March 31, 2020. Baseline year 2017-18.

Improve Value	
Increased percentage of patients with MH issues supported through Hospital to Community Mental Health Transition model.	• A Mental Health and Addiction Hospital to Community Transition Integrated Care Coordination Model will be implemented at one HNHB Schedule 1 Mental Health hospital by March 31, 2019.
Increased percentage of patients receiving short term post-hospital care through an integrated funding model or an integrated comprehensive care model.	• Two HNHB LHIN hospitals to scale the bundled ICC model to include acute and post-acute care for a range of surgical procedures by March 31, 2020. • Four HNHN LHIN hospitals will implement a bundled ICC model for hip and knee replacement surgery by March 31, 2019
Increase in the average number of days a patient requires wound care for treatment of diabetic foot ulcer when treated with diabetes offloading devices	• A decrease in the average time a LHIN HCC patient receives wound care (wound healed) for diabetic foot ulcer when a patient is treated with diabetic offloading devices comparing 2018-19 to 2017-18. Baseline year 2017-18, baseline data will be identified when year-end data is available in June 2018.

7) Risks and Mitigation Plans

Risk/Barrier	Mitigation Plan(s)
Readiness and Capacity of Providers to Plan and Implement Change: The readiness and/or capacity of an organization to change existing practices and processes to achieve a patient-centred, integrated or standardized approach, implement and adopt best practices or incorporate alternative models of care may limit the impact of transformational change.	• Leverage change-ready champions that exemplify integration successes wherever possible. • Lead transformational change with initiatives that improve patient experience and demonstrate benefit to the organization. • Support innovate approaches to change management through facilitated workshops.
System Capacity: The capacity of the system to respond to the increasing needs of an aging population living with more complex conditions and the impact of social determinants of health at a time where there are multiple and competing priorities.	• Apply a health equity lens to identify priority initiatives. • Work in collaboration with public health and social service provides to identify innovative models (i.e. housing) to support an aging population. • Engage academia and educators to identify capacity and plan further health human resource requirements. • Consider innovative approaches to access scarce resources for service delivery and training (i.e., Digital Health solutions, webinars etc.).
Limitations and Challenges of Digital Health Technology: Multiple eHealth solutions that are not integrated across the continuum, limiting timely access to health information by patients and providers.	• Evolve and move to a mature Digital Health solution that connects electronic systems across the health care continuum. • Engage expert resources to leverage existing electronic solutions to enable data sharing.
Primary Care: Limited Primary Care provider involvement across, and within sub-regions.	• Identify barriers to primary care engagement and work with the Primary Care Network, Primary Care Leads and highly engaged primary care champions in each sub-region to develop collaborative opportunities for engagement • Identify opportunities that improve patient experience and demonstrate benefit to the primary care provider.
Health Equity: • HSPs' awareness, capacity and capability to apply a health equity lens to planning activities and ensure an equitable distribution of resources based on need.	• Reinforce ministry direction on ensuring health equity. • Involve populations who may experience health inequities, in planning and setting local priorities. • Leverage existing resources to increase knowledge and understanding of health equity through facilitated workshops.

8) LHIN Operations and Staffing Tables

Table A: LHIN Spending Plan

Allocation: Home Care/LHIN Delivered Services	2017/18 Estimated Actuals	2018/19 Allocation	2019/20 Planned Expenses	2020/21 Planned Expenses
Salaries	$ 55,697,961	$ 59,178,587	$ 59,178,587	$ 59,178,587
Benefits Contributions	15,752,293	16,009,210	16,009,210	16,009,210
Med/Surgical Supplies & Drugs	14,783,535	15,613,866	15,613,866	15,613,866
Supply & Sundry Expense	1,614,726	2,021,066	2,021,066	2,021,066
Equipment Expense Patient	2,973,671	2,946,799	2,946,799	2,946,799
Equipment Expense	214,597	305,174	305,174	305,174
Amortization on Major Equip, Software License & Fees				
Contract Out Expense Services	230,226,097	222,316,918	222,316,918	222,316,918
Contract Out Expense	300,383	321,500	321,500	321,500
Building & Grounds Expense	350,792	405,000	405,000	405,000
Building Amortization				
Total: Home Care/LHIN Delivered Services	**$ 321,914,055**	**$ 319,118,120**	**$ 319,118,120**	**$ 319,118,120**

Allocation: Aggregated Operation of the LHIN	2017/18 Estimated Actuals	2018/19 Allocation	2019/20 Planned Expenses	2020/21 Planned Expenses
Salaries	$ 2,981,173	$ 3,803,047	$ 3,803,047	$ 3,803,047
Benefits Contributions	1,022,787	1,100,816	1,100,816	1,100,816
Med/Surgical Supplies & Drugs				
Supply & Sundry Expense	590,536	167,181	167,181	167,181
Equipment Expense Patient				
Equipment Expense	13,315	21,200	21,200	21,200
Amortization on Major Equip, Software License & Fees				
Contract Out Expense Services				
Contract Out Expense	558,693	686,693	686,693	686,693
Building & Grounds Expense	15,000	40,000	40,000	40,000
Building Amortization				
Total Aggregated Operation of the LHIN	**$ 5,181,504**	**$ 5,818,937**	**$ 5,818,937**	**$ 5,818,937**
Sub-total: LHIN Operations	$ 3,533,090	$ 4,513,744	$ 4,513,744	$ 4,513,744
Sub-total: LHIN Operations Initiative	$ 1,138,414	$ 1,305,193	$ 1,305,193	$ 1,305,193
Sub-total: LHIN Operations Digital Health	$ 510,000	**TBD**	**TBD**	**TBD**

Allocation: Integrated LHIN Administration/Governance	2017/18 Estimated Actuals	2018/19 Allocation	2019/20 Planned Expenses	2020/21 Planned Expenses
Salaries	$ 8,572,684	$ 9,342,018	$ 9,342,018	$ 9,342,018
Benefits Contributions	3,064,871	2,522,844	2,522,844	2,522,844
Med/Surgical Supplies & Drugs				
Supply & Sundry Expense	1,264,233	1,454,256	1,454,256	1,454,256
Equipment Expense Patient				
Equipment Expense	1,101,733	916,493	916,493	916,493
Amortization on Major Equip, Software License & Fees	166,630	125,000	125,000	125,000
Contract Out Expense Services				
Contract Out Expense	817,490	876,950	876,950	876,950
Building & Grounds Expense	3,225,579	3,008,967	3,008,967	3,008,967
Building Amortization	225,072	225,000	225,000	225,000
Total: Integrated LHIN Administration/Governance	**$ 18,438,292**	**$ 18,471,528**	**$ 18,471,528**	**$ 18,471,528**
Total: LHIN SPENDING PLAN	**$ 345,533,851**	**$ 343,408,585**	**$ 343,408,585**	**$ 343,408,585**

Notes for Table A: LHIN Spending Plan

1. Home Care/LHIN Delivered Services envelope includes direct services as defined in Schedule 7, Table 1 of the 2015-18 Ministry LHIN Accountability Agreement.

2. Aggregated Operation of the LHIN includes:

i. LHIN Operations: LHINs' mandated system operations/activities related to planning, funding and integrating.

ii. LHIN Operations Initiatives: Activities that are one-time and/or require separate reporting as per ministry funding letters. (E.g. FLS and Indigenous Engagement).

iii. LHIN Operations Digital Health: The coordinated and integrated use of electronic systems, information and communication technologies to facilitate the collection, exchange and management of personal health information in order to improve the quality, access, productivity and sustainability of the health care system.

3. Integrated LHIN Administration/Governance envelope includes indirect costs such as administration and overhead expenses of the combined organization.

Table B: LHIN Staffing Plan (Full-Time Equivalents or FTE[1])

Allocation: Home Care/LHIN Delivered Services[2]	2017/18 Estimated Actuals	2018/19 Allocation	2019/20 Planned Expenses	2020/21 Planned Expenses
Management and Operation Support (MOS) FTE	238.67	222.85	222.85	222.85
Unit Producing Personnel (UPP) FTE	465.62	487.41	487.41	487.41
Nurse Practitioner (NP) FTE	8.40	8.40	8.40	8.40
Physician FTE	0.19	-	-	-
Total Home Care/LHIN Delivered Services FTE	712.88	718.66	718.66	718.66
LHIN Operations[3]	**2017/18 Estimated Actuals**	**2018/19 Allocation**	**2019/20 Planned Expenses**	**2020/21 Planned Expenses**
MOS FTE	24.76	33.76	33.76	33.76
UPP FTE	-	-	-	-
NP FT	-	-	-	-
Physician FTE	0.49	0.49	0.49	0.49
Total LHIN Operations FTE	25.25	34.25	34.25	34.25
LHIN Operations Initiatives[4]	**2017/18 Estimated Actuals**	**2018/19 Allocation**	**2019/20 Planned Expenses**	**2020/21 Planned Expenses**
MOS FTE	1.39	1.03	1.03	1.03
UPP FTE	-	-	-	-
NP FT	-	-	-	-
Physician FTE	1.33	1.33	1.33	1.33
Total LHIN Operations Initiatiave FTE	2.72	2.36	2.36	2.36
LHIN Operations Digital Health[5]	**2017/18 Estimated Actuals**	**2018/19 Allocation**	**2019/20 Planned Expenses**	**2020/21 Planned Expenses**
MOS FTE				
UPP FTE				
NP FT				
Physician FTE				
Total LHIN Operations Digital Health	-	-	-	-
Integrated LHIN Administration/Governance[6]	**2017/18 Estimated Actuals**	**2018/19 Allocation**	**2019/20 Planned Expenses**	**2020/21 Planned Expenses**
MOS FTE	41.94	40.42	40.42	40.42
UPP FTE	55.00	58.78	58.78	58.78
NP FT	-	-	-	-
Physician FTE	0.23	0.23	0.23	0.23
Total FTE	97.17	99.43	99.43	99.43
Total FTE Summary	838.02	854.70	854.70	854.70

Notes for Table B: LHIN Staffing Plan:

1. One Full Time Equivalent equals 1950 hours per year. One FTE may be comprised of multiple staff.
2. Home Care/LHIN Delivered Services envelope includes direct services as defined in Schedule 7, Table 1 of the 2015-18 Ministry LHIN Accountability Agreement.
3. LHIN Operations includes LHINs' mandated system operations/activities related to planning, funding and integrating.
4. LHIN Operations includes activities that are one-time and/or require separate reporting as per ministry funding letters. (E.g. French Language Services and Aboriginal Engagement).
5. LHIN Operations Digital Health includes the coordinated and integrated use of electronic systems, information and communication technologies to facilitate the collection, exchange and management of personal health information in order to improve the quality, access, productivity and sustainability of the health care system.
6. Integrated LHIN Administration/Governance envelope includes indirect costs such as administration and overhead expenses of the combined organization.

9) Integrated Communications Strategy

Business Objectives

The ongoing implementation of the priorities identified in the LHIN's five year SHSP, 2016-19 IHSP and Minister's mandate letter 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 Agencies and Appointments Directive, all Board governed agencies, including LHINs, receive a mandate letter from the Minister outlining the broad service and performance expectations for the coming fiscal year.

Recognizing the continued implementation of the *Patients First Act, 2016*, the HNHB LHIN's 2018-19 Minister's mandate letter focuses on priority activities expected to be completed in the year following transition (see section 1.2).

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:

- Support an improved patient, family and caregiver experience by increasing awareness of health care services available and how to access them.
- Engage patients, families, caregivers, providers, stakeholders and system leaders to become active participants in and ambassadors for transformation.
- 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, families, caregivers, providers, stakeholders and system leaders to become active participants in and ambassadors for transformation.
- 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.
- Guide the communications and engagement activities of the HNHB LHIN (Board and staff) and HSP partners involved in initiatives contained in the 2018-19 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.

Context

- The HNHB LHIN's 2016-2019 IHSP, the 2018-19 Minister's mandate letter and the initiatives laid out in this Annual Business Plan are strategically aligned with government direction 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.
- Each LHIN is governed by a twelve-member Board of Directors made up of individuals from the local community. The board makes decisions about health services based on what is important to the community.
- Through an agreement with the ministry, each LHIN must measure how it is performing against a detailed list of requirements that includes looking at access to care and quality of care improvements.
- LHINs work to ensure that every individual, regardless of gender, race, income or social status, has equitable access to health care.
- The benefits of LHINs are numerous and proven – they are able to build solutions around people and populations, to be flexible to allow for locally-driven solutions and to engage communities and individuals in health care design and delivery.
- The health care system has evolved to the point where LHINs are being recognized as the local system managers who play a central leadership role in driving health system transformation.

Target Audience

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

- HSPs and key stakeholders (LHIN-wide, cross-LHIN and pan-LHIN):
  - Patients and Caregivers
  - PFAC
  - Primary Care Providers including physicians
  - Professional Associations (such as Ontario Hospital Association, Ontario Medical Association and Hamilton Academy of Medicine.
  - IHN
  - FLHPE
  - Regional Quality Table
  - Sub-Region Anchor Tables
- HNHB LHIN employees
- Government – Administrative Leadership and Elected Officials:
  - Municipal
  - Regional
  - Provincial – including ministry stakeholders
- General Public
- Community Organizations
- Media:
  - Print – daily, weekly and community newspapers and publications
  - Electronic – television, radio and online
  - Social Media – Twitter, Facebook, LinkedIn, YouTube
- Other LHINs, especially neighbouring LHINs – South West, Waterloo Wellington and Mississauga Halton
- Ministry and other ministries (as appropriate and required)

Key Messages

- Ontario is increasing access to care, reducing wait times and improving the patient experience through its Patients First: Action Plan for Health Care - protecting health care today and into the future.

- 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 by improving the health care experience: increasing access, connecting services, informing patients and protecting our health care system.
- 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.
- Changes underway supported by the *PFA, 2016* have expanded the LHIN mandate and will give LHINs the tools, oversight and accountability they need to better integrate local health care services and coordinate care across the care continuum in a way that better serves patients.
    - In May and June 2017, home care services and staff transferred to LHINs. This was a structural system change that will help patients and their families get better access to a more local and integrated health care system. The process happened in carefully planned stages and was seamless for patients and home care clients. There was no disruption to care and providers remained the same.
- Once fully implemented, these changes 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 NP.
    - 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.
    - Administration of the health care system will be streamlined and reduced, with savings put back into improving patient care.
    - With PFACs in every LHIN, the voices of patients and families in their own health care planning will be strengthened.
    - There will be an increased focus on cultural sensitivity and the delivery of health care services to Indigenous Peoples and French speaking people in Ontario.
    - 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 continue to 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 along the way.

Strategic Approach

- Position the enhanced HNHB LHIN as a valued key player within the transformation of Ontario's health care system and as the lead in health system transformation in the HNHB region.
- Develop and leverage opportunities to build our reputation and establish credibility.
- Provide accurate and timely information to all audiences.
- Be transparent and accountable to our shared audiences re: timelines, outcomes and opportunity for participation/feedback.
- Foster an understanding of the need for health system transformation both internally and externally.
- Continue to build support for the health system model by focusing on the benefits of the health system. transformation that create an integrated sustainable health care system that ensures better health, better care, and better value for money.
- Demonstrate how patients/caregivers/general public can participate in improving their own health and support the development of plans to support care delivery in the six LHIN sub-regions.
- Mitigate communications risks of negative publicity by proactive planning of risk reduction.
- Provide information on performance and progress on the implementation – document successes and share it.

Tactics – high level

The Communications and Community Engagement team leverages a variety of communication vehicles tailored to various stakeholder groups including but not limited to:

- Media releases, e-newsletters, blogs and videos.
- Printed materials including brochures, information booklets; display materials for patients, families and caregivers.
- Website and social media.
- Stakeholder events.
- Outreach to local government stakeholders.
- Engagement with specific stakeholders – unions, provincial associations, community groups.

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:

- Patient satisfaction captured through a variety of mechanisms including direct feedback from patients, families and caregivers as well as reports from health service providers and service provider organizations.
- 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.
- 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.
- Analysis of media, print, broadcast and social 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.

Using feedback mechanisms and ongoing assessment, the LHIN will monitor the effectiveness of communication 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 the 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).

10) Community Engagement

In accordance with Community Engagement Guidelines (revised June 2016) and in keeping with the expectations of the *LHSIA, 2006,* all LHINs are required to develop and publish their Community Engagement plan. Plans are updated annually to reflect specific priorities and objectives in the current/upcoming year.

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

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, 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 (LHIN sub-regions) to achieve its objectives. Accordingly, a core principle of engagement in HNHB LHIN is to identify existing stakeholder groups or entities, individuals or organizations which have interest in the outcomes of the initiative/project.
  - Stakeholders are individuals, communities, political entities or organizations that have a vested interest in the outcomes of the initiative. They are either affected by, or can have an effect on, the project. Anyone whose interests may be positively or negatively impacted by an initiative or anyone that may exert influence over the initiative or its results is considered a project stakeholder. All stakeholders must be identified and managed/involved appropriately. For the purpose of stakeholder identification, "communities" can be interpreted to mean geographic locations (i.e. a municipality in the HNHB LHIN region), communities of interest or communities of practice.
  - Community of interest - 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 - is 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).

- Political Entity - For the purpose of stakeholder identification, "political entity" is an individual, organization or group with known political interests or public responsibility. This may include officials in public office, or organized labour or citizens groups.
- Anchor Tables - for the HNHB LHIN, sub-region Anchor Tables are defined as a group that has been formally constituted and/or is supported by the LHIN in order to facilitate engagement related to LHIN MLAA deliverables as well as identified sub-region priorities.
- As appropriate, the engagement of providers or persons with expertise and experience in the delivery of services from across the six sub-regions within the HNHB LHIN.

- Engagement of Indigenous Peoples:
  - The HNHB LHIN estimates that the First Nation, Métis and urban-based Indigenous peoples residing in the region represents about 1.7% of the total regional population. First Nation, Métis, Inuit and Non-Status people face a number of health issues and challenges and their health status is below that of the general population. First Nation, Métis, Inuit and Non-Status people have identified a number of barriers to receiving equitable access to health services including jurisdictional issues, lack of sensitivity to their culture, and a lack of targeted programs that focus on their particular health needs.
  - The HNHB LHIN works with Indigenous communities for improved health and wellness. The LHIN has a responsibility to learn about and respect Indigenous communities' approach to health and wellness. Respect for and inclusion of Indigenous traditional practices with non-traditional health services is essential for health solutions aligned with cultural identity, holistic health and community values.
  - SNGR Territory and MNCFN and the HNHB LHIN have established an important partnership that benefits the health, communities and the future of First Nations, Métis, Inuit and Non-Status people.
  - The HNHB LHIN's IHN provides a setting for Indigenous health and social service organizations from across our region to collaborate with the HNHB LHIN and other HSPs to understand and address the health needs and issues of the Indigenous communities. The IHN meets approximately ten times per year.
- Engagement of HNHB LHIN Francophone Community:
  - The HNHB LHIN has a French-speaking population of approximately 32,330 or 2.4% of the population. Niagara's francophone population includes a large number of seniors most of whom are Canadian born. In contrast, more than half the Francophones in the Hamilton area are younger and born outside of Canada.
  - 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 FLHPE (April 2011). FLS Entity #2 for HNHB LHIN provides advice and support to the HNHB LHIN with respect to:
    - Engaging the local Francophone community.
    - Identification and planning for health needs and priorities.
    - The needs and priorities of diverse groups within the Francophone community.
    - Health services available to the Francophone community.
    - The identification and designation of health service providers for the provision of French Language health services.
    - Strategies to improve access to, accessibility of and integration of FLS in the local health system.
    - The integration of FLS.
- Patient and Family Advisory Committee:
  - Local Health Integration Networks aspire to learn what patients, families and caregivers value most in our health care system. In order to improve health outcomes and experiences, patients and families across Ontario must be engaged and empowered to have a strong voice to shape care delivery. Local Health Integration Networks are committed to partnering and listening to patients and families to ensure that

changes in the health care system reflect the diverse needs and opinions of those it serves.

- Expanding patient engagement across the health care system is a key commitment articulated in the *PFA, 2016*. A key element of this approach was the establishment of the LHIN PFAC
- The LHIN PFAC will aim to assist in shaping LHIN's programs, services and initiatives designed to improve care for patients, families and caregivers across the HNHB LHIN. The PFAC members will apply their learning, collective experience and insights to:
  - Identify and advise on opportunities to incorporate the patient's perspective in initiatives to better integrate care across the region and across the health care system.
  - Support effective patient engagement within the HNHB LHIN.
  - Provide advice on recommendations about health care access or service delivery improvements from the patient and/or family caregiver perspective.
  - Provide input on LHIN policies and standards guiding LHIN initiatives, particularly regarding patient care and patient engagement.
  - Recommend strategies and practical ideas for improving patient care, and caregiver recognition and support.
  - Work in partnership and engage in co-design with the HNHB LHIN CEO, LHIN staff, service providers and partners.
  - Link and collaborate with other patient and family advisory groups within the HNHB LHIN and across the province as appropriate.
  - Not have a fiscal mandate to perform these duties.
- When executing its mandate, the PFAC adheres to the following principles:
  - The Committee will make every effort to provide informed advice on LHIN policy and program initiatives.
  - The Committee will take into account population health and health equity in making its recommendations.
  - The LHIN will respond to the committee's advice and final decisions will remain with HNHB LHIN staff, Board and CEO.
  - The Committee will work in alignment with best practices identified in the LHIN Community Engagement Guidelines and the provincial Patient Engagement Framework.
- The HNHB LHIN PFAC meets no less than six times per year and consists of 14 patients, family members and/or caregivers with a range of health care experiences. Members were selected based on their experience with the health care system and a combination of considerations to reflect the diversity of the people and communities within the LHIN.

11) Glossary of Acronyms

ABI	Acquired Brain Injury
ABP	Annual Business Plan
ALC	Alternate Level of Care
Board	Board of Directors
BSO	Behavioural Supports Ontario
CCP	Coordinated Care Plans
CDI	Caregiver Distress Index
CEO	Chief Executive Officer
CHC	Community Health Centres
CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
CSS	Community Support Services
DAHC	De dwa da dehs nye>s Aboriginal Health Access
DEP	Diabetes Education Program
eConsult	Electronic Consultation
eHealth	Electronic Health Care
ECFAA	*Excellent Care for All Act*
ED	Emergency Department
EOL	End of Life
FHT	Family Health Team
FLHPE	French Language Health Planning Entité
FLS	French Language Services
FLSA	*French Language Services Act*
FTE	Full-Time Equivalent
HCC	Home and Community Care
HNHB	Hamilton Niagara Haldimand Brant
HQO	Health Quality Ontario
HSSO	Health Shared Services Ontario
HSP	Health Service Provider
ICS	Indigenous Cultural Safety
IFM	Integrated Funding Model
IHN	Indigenous Health Network
IHSP	Integrated Health Service Plan
JAAP	Joint Annual Action Plan

LHIN	Local Health Integration Network
LHSIA	*Local Health System Integration Act*
LOS	Length of Stay
LTC	Long-Term Care
LTCH	Long-Term Care Homes
MH	Mental Health
MHA	Mental Health and Addictions
Minister	Minister of Health and Long-Term Care
ministry	Ministry of Health and Long-Term Care
MLAA	Ministry-LHIN Accountability Agreement
MNCFN	Mississaugas of the New Credit First Nation
MSK	Musculoskeletal
NP	Nurse Practitioner
OBSP	Ontario Breast Screening Program
ODS	Ontario Diabetes Strategy
OECD	Organization of Economic Cooperation and Development
OPCN	Ontario Palliative Care Network
OTN	Ontario Telemedicine Network
PCOT	Palliative Care Outreach Team
PFA	*Patients First Act*
PFAC	Patient and Family Advisory Committees
PCVC	Personal Computer Videoconferencing
RCA	Rehabilitative Care Alliance
RPCN	Regional Palliative Care Network
SAAs	Service Accountability Agreements
SHSP	Strategic Health System Plan
SMART	Seniors Mobile Assess Restore Team
SNGR	Six Nations of the Grand River
SPO	Service Provider Organization
TCP	Transitional Care Program
TJR	Total Joint Replacement
VSM	Value Stream Mapping

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