Hamilton Niagara Haldimand Brant
Local Health Integration Network

Minutes of the Business Meeting of the Board of Directors February 24, 2016

A meeting of the Board of Directors of the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) was held on February 24, 2016, at the Boardroom, Hamilton Niagara Haldimand Brant Local Health Integration Network, 264 Main Street East, Grimsby, Ontario, and beginning at 4:00 p.m.

Present: Michael P. Shea, Board Chair
Laurie Ryan-Hill, Member
Mervin Witter, Member
Helen Mulligan, Member
Bill Thompson, Member
Dominic Ventresca, Member

Regrets: Ruby Jacobs, Vice Chair

HNHB LHIN Staff in Attendance: Donna Cripps, CEO
Helen Rickard, Corporate Coordinator, Recording Secretary
Steve Isaak, Director, Health System Transformation
Derek Bodden, Director, Finance
Rosalind Tarrant, Director, Access to Care
Linda Hunter, Director, Health Links and Strategic Initiatives
Trish Nelson, Director, Communications, Community Engagement and Corporate Services

A. Convening the Meeting

A.1 Call to Order

A quorum was present.

A.2 Approval of the Agenda

MOVED: Bill Thompson
SECOND: Dominic Ventresca

That the agenda of February 24, 2016, be adopted, as circulated.

CARRIED

A.3 Declaration of Conflicts

No conflicts were identified at this time.

B. Education Session

B.1 HNHB LHIN Discussion Paper Feedback Update

(**Appendix 1** appended to original set of minutes)
Presenter: Trish Nelson, Director, Communications, Community Engagement and Corporate Services, HNHB LHIN

Key Points of Discussion:

- A summary was provided on the HNHB LHIN consultation activities and feedback received regarding the MOHLTC Discussion Paper released on December 17, 2016.
- The HNHB LHIN discussion paper engagement sessions included webinars, face to face consultations with health service providers, health links consultation meetings, questionnaires, and additional meetings with stakeholders.
- The HNHB LHIN has also received written submissions from stakeholders.
- The total number of participants through all engagement consultations is currently at 1235 people of which 56% are physicians.
- The presentation highlighted consistent themes from the consultation feedback provided.

C. Minutes of the Last Meeting

C.1 Approval of the Minutes of January 27, 2016

MOVED: Mervin Witter
SECOND: Bill Thompson

That the minutes of the Board Meeting – Business of January 27, 2016, be adopted as circulated.

CARRIED

D. Consent Agenda

Consent Agenda of February 24, 2016
MOVED: Dominic Ventresca
SECOND: Helen Mulligan

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network adopts the consent agenda of February 24, 2016, consisting of:

i. 2016-17 French Language Joint Annual Action Plan

CARRIED

E. Reports

E.1 Report of the CEO

MOVED: Michael Shea
SECOND: Laurie Ryan-Hill

That the Report of the Chief Executive Officer (CEO) be received and filed.

CARRIED

Key Points of Discussion:

- The CEO reviewed the report as circulated.
- It was noted that the Provincial Budget will be released on Thursday, February 25, 2016.

E.2 Report of the Chair

MOVED: Mervin Witter
SECOND: Bill Thompson

That the Report of the Chair be received and filed.

CARRIED

Key Points of Discussion:

- The Chair reviewed the report as circulated.
- Details of the meeting of Feb. 3, 2015 with Brain Injury Community Re-Entry Niagara and Brain Injury Services Hamilton were provided.

E.3 Report of the Audit Committee Chair

MOVED: Michael Shea
SECOND: Bill Thompson

That the Report of the Audit Committee Chair be received and filed.

CARRIED

- The Audit Committee held a meeting on February 24, 2016. The minutes of the Audit Committee meeting of January 27, 2016, were approved by the Audit Committee for receipt by the Board of Directors.

MOVED: Laurie Ryan-Hill
SECOND: Bill Thompson

That the minutes of the Audit Committee meeting of January 27, 2016, be received and filed.

CARRIED

Consent Agenda of February 24, 2016

MOVED: Laurie Ryan-Hill
SECOND: Helen Mulligan

That the Audit Committee reviewed the consent agenda of February 24, 2016 consisting of:

i. HNHB – Hospital Cash Advances

That the consent agenda of February 24, 2016 be received and filed.

CARRIED

Hamilton Urban Core Manager of Clinical Services Funding
The Manager of Clinical Services was funded on a one-time basis for six months in 2014-15 and for the fiscal year 2015-16 as an operation position that will assist Hamilton Urban Core Community Health Centre improve the efficiency and effectiveness of the clinical team to better meet the health care needs of their clients.

Funding is available for permanent allocation in current fiscal year.

From a trending perspective, access to primary care/panel size has improved year over year since the implementation of the Manager of Clinical Services.

MOVED: Laurie Ryan-Hill
SECOND: Helen Mulligan

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve funding for the Manager of Clinical Services ($101,745) at Hamilton Urban Core as base funding beginning in 2016-17.

CARRIED

Multiple Sclerosis Clinic
The Hamilton Health Sciences Corporation Multiple Sclerosis Clinic is one of seven MS Clinics in Ontario. The HHSC MS Clinic serves a large geographic area inclusive of all parts of the HNHB LHIN. Within the HNHB LHIN, patients from across the LHIN have clinic access for new referrals, active support, and acute management.

The MS Society reduced its funding support for all MS Clinics by 50% as of April 1, 2014, and eliminated clinic funding as of April 1, 2015. HNHB LHIN one-time funding has been recommended in prior years in anticipation of a potential provincial funding solution with the Ministry of Health and Long-Term Care, but this was not realized.

The HHSC MS Clinic proposal was reviewed by the HNHB LHIN staff using the LHIN Decision Making Criteria. The proposal received a score of 83% which indicates very good fit with the Decision Making Framework criteria.

MOVED: Bill Thompson
SECOND: Dominic Ventresca

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve base funding commencing fiscal year 2016-17 in the amount of $150,000 to Hamilton Health Sciences Corporation in order to maintain the specialized medical services provided through the Multiple Sclerosis Clinic for people affected by Multiple Sclerosis.

CARRIED

Key Points of Discussion:

- Explanation was provided on the definitions of one-time funding and recurring one-time funding.

Home and Community Care Collaborative

A Collaborative Care Model was developed in February 2015, which outlines a framework for Assisted Living / Supportive Housing community support service agencies to care for individuals with lower to moderate care needs while allowing the CCAC to accommodate increased referrals from hospitals and community for persons needing higher levels of care and case management.

The $1,000,000 approved on a one-time basis in 2015-16 is required in 2016-17 to support 30,175 hours of care that are currently being provided and provide capacity to accommodate new admissions.

MOVED: Laurie Ryan-Hill
SECOND: Helen Mulligan

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve up to $1,000,000 one-time recurring funding in 2016-17 to support the Home and Community Collaborative to the health service providers identified in Appendix A. These services were supported with one-time funding in 2015-16.

Appendix A - Home and Collaborative Care Collaboration – Funding Allocations

Agency	Geography Served	2015-16 Funding	Hours of Care
AbleLiving	Hamilton, Burlington	$150,917	4,554
Capability	Hamilton, Burlington, Dunnville	$199,513	6,020
The Good Shepherd Centre	Hamilton	$42,699	1,288
March of Dimes Hamilton	Hamilton, Burlington	$113,872	3,436
March of Dimes Niagara	Niagara, Haldimand, Norfolk	$372,641	11,244
Participation House	Brant	$71,649	2,162
St. Joseph's Homecare	Hamilton	$48,709	1,470
		$1,000,000	30,175

Note: Funding will be reallocated across providers by LHIN-based demand

CARRIED

Key Points of Discussion:

- It was confirmed that this funding is one-time recurring due to the newness of this program and may change to base funding once the program has evolved and assessment has taken place.

Falls Prevention and Exercise

Adult Recreation Therapy Centre currently provides Falls Prevention and Exercise classes for seniors at seven sites in the Brantford area. These classes effectively combines best practice physical exercise and Falls Prevention education to create a fun and social atmosphere designed to help seniors remain healthy, active, and independent.

Request for funding for an additional four Falls Prevention and two Exercise classes is the result of an increase in referrals and number of clients attending classes; safety concerns at existing sites operating beyond room capacity; and expansion of group Falls Prevention and Exercise classes to new site in the Brantford area.

MOVED: Laurie Ryan-Hill
SECOND: Mervin Witter

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve up to $23,184 base funding ($20,160 Direct and $3,024 Indirect) to Adult Recreation Therapy Centre to support four (4) Falls Prevention and two (2) Exercise classes.

CARRIED

F. New/Other Business

F.1 Brant Community Healthcare System Pre-Capital Submission

MOVED: Michael Shea
SECOND: Mervin Witter

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network endorse the program and services component (Part A) of the Brant Community Healthcare System Pre-Capital submission for the proposed Emergency Department Redevelopment Project.

CARRIED

Key Points of Discussion:

- It was noted that the Six Nations Reserve does not have an Urgent Care Clinic.
- This expansion will increase the Emergency Department from 13,115 sq. ft. to approximately 20,000 sq. ft.

F.2 HSAA Amending Agreement

MOVED: Mervin Witter
SECOND: Dominic Ventresca

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve the proposed Hospital Service Accountability Agreement (HSAA) Amending Agreement to be made as of April 1, 2016, and amending the 2008-16 HSAA by extending its term to March 31, 2017 and by replacing the 2015-16 Schedules with 2016-17 Schedules. If a new provincial HSAA is reached prior to April 1, 2017, this extension will expire and be replaced by the new HSAA. Also to authorize the HNHB LHIN Board Chair and HNHB LHIN CEO to sign on behalf of the HNHB LHIN Board of Directors.

CARRIED

Key Points of Discussion:

- An overview was provided of the HSAA Amending Agreement noting the extension of the terms to March 31, 2017.

F.3 Draft Annual Business Plan

MOVED: Michael Shea
SECOND: Dominic Ventresca

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve the 2016-17 Draft Annual Business Plan for review by the Ministry of Health and Long-Term Care.

CARRIED

Key Points of Discussion:

- Staff presented an overview of the Draft Annual Business Plan. (**Appendix 2** appended to original set of minutes)
- The Draft Annual Business Plan will be submitted to the Ministry by February 28, 2015. The Ministry will provide feedback on the Draft Annual Business Plan and the Final Plan will be presented to the HNHB LHIN Board in June 2016 for consideration.
- The presentation highlighted key priority area's including Primary Care, Home and Community Care, Health Links, Health and Wellness of the Population, LHIN-wide Integrated Clinical programs, and LHIN-wide Population-Based strategies.
- It was noted that the Annual Business Plan will be closely monitored and may be adjusted based on changing priorities that may arise.
- A suggestion was made to include examples of barriers that exist as noted in the Draft Annual Business Plan on Page 11 in the section titled Current Status.

G. Closed Session

MOVED: Michael Shea
SECOND: Helen Mulligan

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network move to a closed session at 5:46 p.m. to review/approve the closed minutes of January 27, 2016, to discuss a matter of personal and public interest.

CARRIED

G.1 Report of the Chair on the Closed Session

During the closed session, the Board discussed a matter of personal and public interest.

MOVED: Michael Shea
SECOND: Laurie Ryan-Hill

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network moved to a closed session at 5:46 p.m. to review/approve the closed minutes of January 27, 2016, to discuss a matter of personal and public interest and returned to an open session at 6:36 pm.

CARRIED

H. Adjournment

The Board of Directors – Business meeting be adjourned at 6:36 p.m.

Original Signed by: March 30, 2016

Michael P. Shea, Chair **Date**

Original Signed by: March 30, 2016

Donna Cripps, Corporate Secretary **Date**

Patients First

A Proposal to Strengthen Patient-Centred Health Care in Ontario

Summary of Consultation Activities and Feedback Received

Education Session - HNHB LHIN Board of Directors

February 24, 2016 *(updated February 29, 2016)*

Presented by:
Trish Nelson – Director, Communications, Community Engagement and Corporate Services

Ontario
Local Health Integration Network

The Need for Continued Improvement

Despite the progress the Ministry of Health, LHINs and health service providers have made in the past decade, we still need to do more to ensure that the health care system is meeting the needs of Ontarians.

- Some Ontarians – particularly Indigenous peoples, Franco-Ontarians, members of cultural groups (especially newcomers), and people with mental health and addiction challenges – are not always well-served by the health care system.
- Many Ontarians have difficulty seeing their provider when they need to, especially evenings, nights or weekends – so they go to EDs and walk-in clinics.
- Some families find home and community care services inconsistent and hard to navigate, and many family caregivers are experiencing high levels of stress.
- Public health services are disconnected from the rest of the health care system and population health is not a consistent part of health system planning.
- Health services are fragmented in the way they are planned and delivered. This fragmentation can affect the patient experience and can result in poor health outcomes.

Patients First:
A Proposal to Strengthen Patient-Centred Health Care in Ontario

Discussion Paper - released December 17, 2015

Feedback directly to HNHB LHIN by
February 19, 2016
http://www.hnhblhin.on.ca/PatientsFirstProposal.aspx

Feedback directly to MOHLTC by
February 29, 2016
http://www.health.gov.on.ca/en/news/bulletin/2015/hb_20151217.aspx


now
what?
tomorrow
yesterday

The Discussion Paper's proposed changes will improve the patient experience and system performance.

EASIER ACCESS

- Making it easier to get care in your community
- Making the health care system easier to navigate
- Reducing the strain on emergency departments

MORE EQUITABLE

- Better access to care no matter where you live in the province, and improved health outcomes for under-served groups

GREATER CONSISTENCY

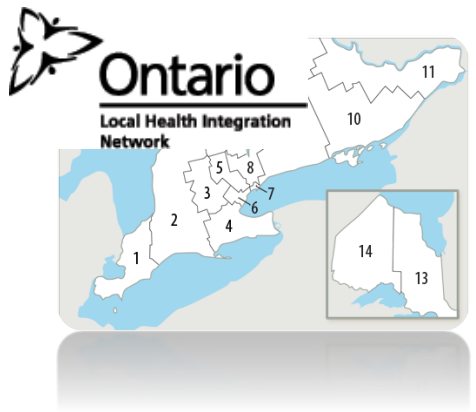
- Across home and community services
- Easier for patients and health care providers to connect
- Lower stress on caregivers

BETTER CONNECTIONS

- Between primary health care providers, hospitals and community care
- Public health and population health planning and other parts of the system

How will this be done?

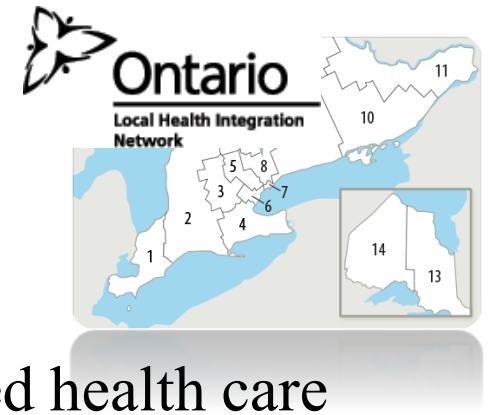
The role of the LHINs is key.



- The LHINs are closer to local/regional needs and priorities.
  - Currently, most LHINs cover large geographic areas. We know that many communities have different needs, so smaller planning areas would be created to better respond to local needs.
- Expanding their mandate to primary care and home care will give them responsibility for integrating care in their communities through better coordination of services (such as helping patients move more easily from surgery in hospital to home care as they recover).

How will this be done?

The role of the LHINs is key.



- To achieve the goal of strengthening patient-centred health care delivery, LHINs would take on more responsibilities in 4 areas:

Connecting Different Parts of the System

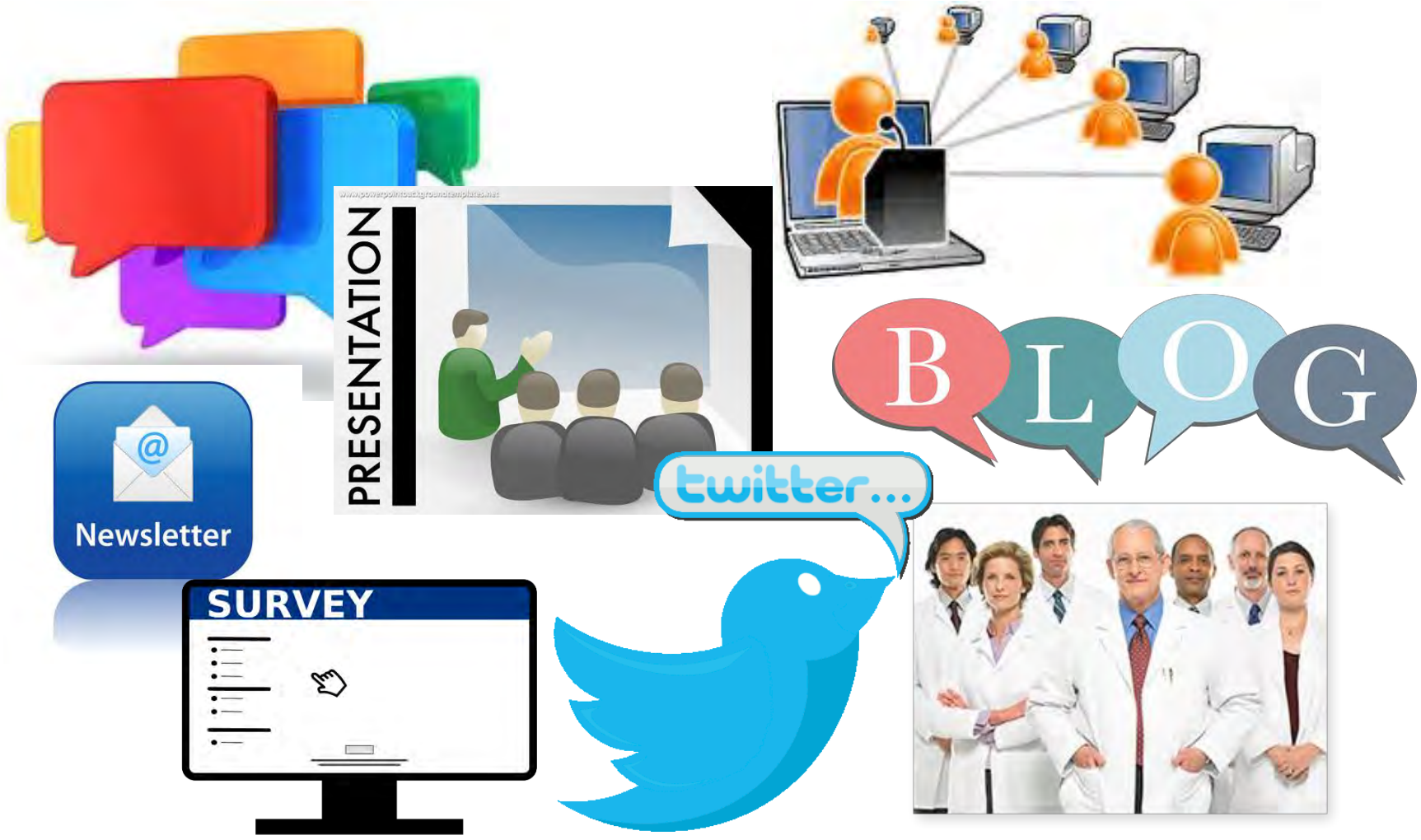
Primary Care

Home and Community Care

Population and Public Health Planning


NEXT STEPS

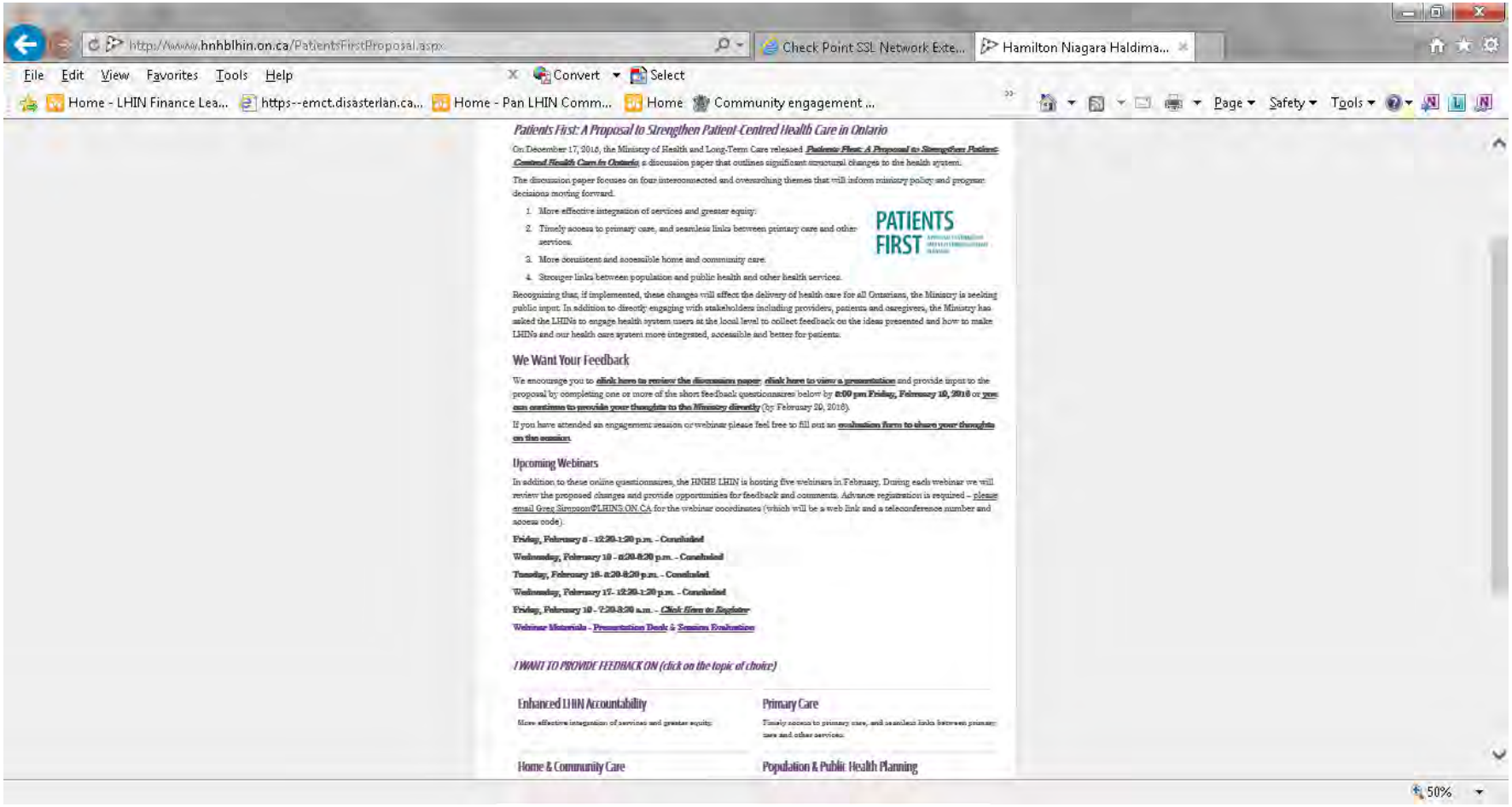
Discussion Paper Consultation on behalf of the MOHLTC
January 11 – February 19, 2016



Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario

Feedback directly to HNHB LHIN

http://www.hnhblhin.on.ca/PatientsFirstProposal.aspx

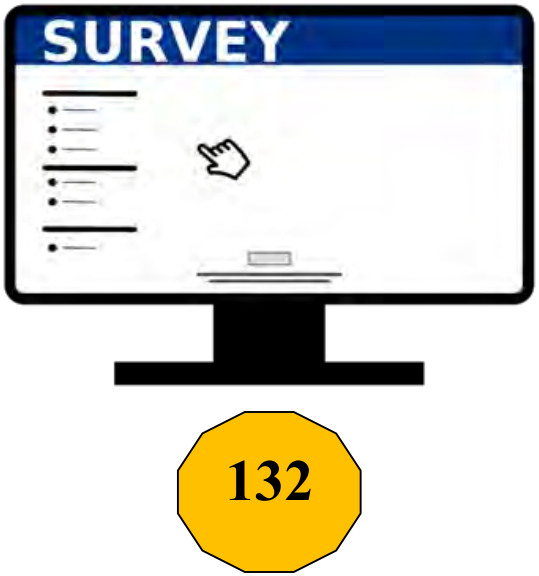


Questionnaires

- Monday, January 11 through Friday, February 19, 2016 – Twitter, LHINsight and Donna's Blog drove traffic to the HNHB LHIN website

  - Four questionnaires posted on the website
  - Geared to patients/clients, caregivers, health service providers, citizens

    - **Enhance LHIN Accountability**
      - *25 responses ENG / 6 responses FR*
    - **Home and Community Care**
      - *49 responses ENG / 6 responses FR*
    - **Primary Care**
      - *22 responses ENG / 6 responses FR*
    - **Public and Population Health**
      - *14 responses ENG / 4 responses FR*



Webinars

- Five public webinars* hosted throughout February
- Promoted via Twitter, LHINsight and Donna's Blog
- Geared to patients/clients, caregivers, health service providers, and citizens
- Targeted invites sent to Citizens' Reference Panel (CRP) members
- Presentation provided by the Ministry of Health and Long-Term Care
  - **Friday, February 5 - 12:30-1:30 p.m. –** ***20 participants***
  - **Wednesday, February 10 - 5:30-6:30 p.m. -** ***3 participants***
  - **Thursday, February 11 - 12-1pm* –** ***21 participants***
  - **Friday, February 12 – 12-1pm* –** ***3 participants***
  - **Tuesday, February 16 - 5:30-6:30 p.m. -** ***15 participants***
  - **Wednesday, February 17 - 12:30-1:30 p.m. -** ***8 participants***
  - **Friday, February 19 - 7:30-8:30 a.m. –** ***14 participants***

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*Two additional webinars geared to LTCH staff and Medical Directors

Physician Consultations

- Physician consultation in each LHIN sub-region as well as Grimsby/West Niagara (based on special request)
- OMA local chapter mail-out to membership; also promoted via LHIN website and Twitter
- Evening sessions geared specifically to HNHB LHIN physicians – though did have participation from physicians in other LHINs
- Focused on Primary Care transformation within the Discussion Paper
  - **BRANT -- January 25 –** ***13 participants***
  - **HAMILTON -- January 27 (all day)–** ***500 participants***
  - **BURLINGTON -- February 3 –** ***12 participants***
  - **NIAGARA -- February 11 –** ***20 participants***
  - **GRIMSBY/WEST NIAGARA -- February 16 –** ***15 participants***
  - **HALDIMAND-NORFOLK -- February 23 –** ***8 participants***

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Physician Consultations *cont'd*

- **Caroline Family Health Team (Burlington) – February 11 – *12 participants***
- **Burlington Family Health Team (Burlington) – February 16 – *5 participants***
- **Stoney Creek -- February 18 – *15 participants***
- **East Mountain -- February 22 – *16 participants***
- **Downtown Hamilton -- February 24 – *25 participants* *(expected)***

Health Links Consultation Meetings

- **Presented Patients First information at each Health Links' Steering Committee meeting**
- **While discussion was limited, had opportunity to direct to both the HNHB LHIN and Ministry websites for input**
  - **Hamilton Health Links – January 11 –** ***12 participants***
  - **Niagara Health Links – January 25 –** ***16 participants***
  - **Haldimand Health Link – January 27 –** ***6 participants***
  - **Burlington Health Link – January 28 –** ***20 participants***
  - **Norfolk Health Link – February 12 –** ***10 participants***
  - **Brant Health Link – February 24 –** ***18 participants***

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Additional Meetings

- Patients First discussion was added to existing meeting agendas where possible during January and February
- Feedback was gathered at the meeting as well as provided via the website
  - HNHB LHIN Family Health Teams – *29 participants*
  - Mental Health Advisory Committee – *11 participants*
  - HNHB LHIN VP Clinical Services Committee – *12 participants*
  - HNHB LHIN Physician Leads – *6 participants*
  - Brantford Family Medicine Doctors (FMDs) – *24 participants*
  - Community Leaders Council – *8 participants*
  - HNHB LHIN Quality Guidance Council – *10 participants*
  - HNHB LHIN Medical Officers of Health – *11 participants*
  - HNHB LHIN Patient Flow Steering Committee – *23 participants*
  - HNHB LHIN Home and Community Care Collaborative – *9 participants*
  - HNHB LHIN Long-Term Care Council – *6 participants*
  - HNHB LHIN Leaders in Diabetes – *12 participants*
  - HNHB LHIN Aboriginal Health Network – *10 participants*
  - HNHB LHIN Hospital and CCAC CEOs – *10 participants*
  - HNHB LHIN French Language Health Planning Entity – *123 participants*
  - HNHB LHIN Emergency Services Steering Committee– *9 participants*
  - Hamilton Health Sciences Board of Governors – *22 participants*

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HNHB LHIN Participant Total

And of those…

are Physicians in our LHIN

Organizational Written Submissions Received

- Alzheimer Society of Niagara Region
- Halton Region
- HNHB CCAC
- Niagara Dental Health Coalition
- Haldimand War Memorial Hospital
- Ontario Primary Care Council
- Joseph Brant Hospital
- North Hamilton Community Health Centre
- Alzheimer Society Foundation Brant Haldimand Norfolk Hamilton Halton
- Haliburton, Kawartha, Pine Ridge District Health Unit

Consistent themes gathered from the consultation process

Connecting Different Parts of the System

- I like how you are using more of a figurative "carrot" versus a "stick" to foster continuous health service quality improvement among primary, home and community care providers.
- With regards to the efforts required to affect the envisioned change, I think the LHINs should, and—based on the paper—will, be the glue between providers from multiple disciplines and sectors (i.e. primary, home, and community care).
- I think LHIN personnel should - and it seems they will - work closely with HQO personnel and with frontline care providers from each sector.
- Hospitals and primary care have to be more accountable and get on board with care coordination. Most don't understand home and community care, and even fewer have bothered to take the time to understand how it works.
- There is still a long way to go to gain consistency in how agencies report performance. It is quite frankly all over the map.
- Local Health Integration Networks have been around since 2007 and are well known. I wouldn't recommend changing the name since the changes in structure and areas of responsibility will be confusing enough for the general public without a new name.
- I support the concept of LHIN sub-regions. These would provide for more local focus and planning, with an expected higher "buy-in" or sense of ownership with the public. A raised awareness of more localized issues would be helpful.
- Health Service Providers including those not funded by the LHIN (e.g. pharmacists) need a platform to share information easily among all providers including the doctors, hospital and community care providers.

Consistent themes gathered from the consultation process

Primary Care

- People want to see their doctor in a timely manner. People want to know that their PC provider hears them. They don't want to be rushed. Low income people often feel that they don't matter, they don't have rights and this is even when it comes to health care. People want their primary care provider to explain what to do and be linked right from the primary care office to care- tests, services, etc.
- Having services more accessible (i.e on evenings, weekends, etc.) will decrease the hospital and clinic wait times. Having access to information between primary care and community care providers more accessible will also be helpful. An understanding of what "same day" means to patients vs physicians, e.g. I have an opening at 2pm but patient wants to come at 10am.
- Improved care tailored to the needs of each community is a great start.
- Patient accountability needs to be there; how to fix this; some sort of disincentive; rostered patient identified on OHIP card and when swiped they have to either pay or can't be seen, provide assistance in booking appointment with their family doctor. Family doctors to have time set aside each day for these referrals from walk-ins or ER; afraid to tell patient that this visit is not appropriate; shouldn't be in the MD's responsibility; patient education required. Hope province is looking at walk in clinics and interface with primary care.
- Dental hygienist who has spent six years operating a mobile practice – operating bedside. Idea of system navigator is brilliant. She's in database for CCAC yet has only been referred by CCAC once. Almost no dentists who do visits to an institution or home – this is a gap in dentistry care that's linked to overall health. Example – patient not eating – this could be due to oral/dental issue. Including dental in the picture would be a huge step forward in health care.
- Primary care providers should be more patient-centred and address the needs of a patient in a holistic way. They definitely should not be posting in their offices that one and only one issue can be addressed at each visit as holistic care involves discussing more than one issue, as patients needs are multifaceted.
- Why can physicians refuse to take on certain patients? This leaves the most vulnerable with the only option but to go to the local hospital for health care.
- Not sure why we dividing up the LHIN into geographic regions. Doctor have families all over the province that come to me because they want to. Why are they doing this?

Consistent themes gathered from the consultation process

Home and Community Care

- Reduce the number of health professionals who contact the patient prior to the actual service beginning. Currently, there are too many steps that occur before the actual home visit is made.
- To increase the availability of inhome services, seamless transition of services from one home care program to another, increased collaboration between hospital, primary care and home/community services and need to provide standardized assessment tools for children's health services.
- We have to look at who the caregiver is and if they can manage. Sometimes we send people home and back into a crisis situation and one or both end up back in hospital. Caregivers need to know what services are there to help to sustain them. We're hearing from caregivers that we aren't looking at their needs enough. Hospitals only focus on the patient. We need to look at the caregiver too.
- Seamless, efficient transition for patients/families from hospital to home. Currently communication between hospitals and the nurses going into the homes is very cumbersome.
- Communicate regularly with referral facility to optimize appropriate care. More collaborative communications and working together between all providers.
- Understand that there are many patients who do not belong to a Family health team or community health centre. Care coordinators are the back bone of home care - all the other agencies call when there are patient issues.
- Earlier conversations about discharges which include the care coordinator would be helpful. Some hospital care coordinators don't have timely information on discharges which causes backlogs. Doing a better job of talking to patients about the types of services they're eligible for would be good too. Ideally, we would want to visit the patient in their home much sooner, but with very high caseloads, that isn't always possible. Consistent messaging regarding eligibility criteria is also key. Eligibility criteria is different in hospitals versus in the community, which isn't good.

Consistent themes gathered from the consultation process

Population and Public Health Planning

- I don't have a good knowledge of the public health services offered or how they fit in the health system.
- Accessibility and cost effective initiatives. Some families need these vital services but cannot afford to attend nor are they within the community. Having to travel to outer areas to receive the benefits that should be provided through BPS funding programs !
- We live in a city with a large Code Red area and we would like more utilization of mental health services by the general public in those areas that need help. We have mental health workers riding with the police at certain times.
- A focus on public health can go a long way to improving the health of the wider community.
- What Public Health does in each area is very different - consistency not there. Different roles in outbreak management and different rules in various LHINs –so good opportunity.
- With the growing threat of obesity and resulting malnutrition, a multi-modal and comprehensive lifestyle intervention approach is necessary in each community, just as it was with smoking cessation campaigns. Both primary care and public health are well poised to take such programming on.
- There is alignment between LHIN boundaries and municipal boundaries so that there is a single LHIN for Halton Region.

Themes from engagement with Aboriginal Health Network

"We want to engage with First Nations, Metis and Inuit partners about how this process can complement our ongoing work to strengthen health outcomes in Indigenous communities." – Minister Dr. Eric Hoskins
(Discussion Paper, December 17, 2015)

- Needs of Indigenous communities must be integrated throughout all aspects of the discussion paper.
- Rostered patients should not be dismissed – 'fired – when they access a walk-in clinic because the family doctor was not available.
- High risk patients have difficulty finding a family doctor because they are seen as too complex.
- More engagement needed around the primary care experience and how to improve it. Physicians need to be trained in Indigenous Cultural Safety. This should be required by their college.
- Indigenous peoples still have a fear of going to the family doctor.

Themes from Franco-Ontarians

- The community sees the evolvement of LHIN's role as an opportunity to plan better for services in French.
- The community has concerns about the LHIN sub-region planning and wonders if it is going to disadvantage the French Language population.
- Ensure that the home and community care subcontractors (care providers) have the capacity to serve in French or coordinate with FLS providers.
- Care services and coordination should be linguistically and culturally appropriate to the patient (which is not actually the case) and along the continuum of care.
- Make sure there is an alignment between LHIN and Public Health territories
- Public Health Units must have the mandate to serve in French

Themes from Primary Care engagements

- Equitable access to allied health, specialists and CCAC patient
- Appropriate/consistent access to palliative care and CCAC providers
- Current Primary care contracts (FHT/FHO) do not allow innovation /partnerships re after hours and sharing resources
- Ensure formation of sub-regions does not create geographic boundaries allowing hospitals/specialists to refuse admissions/consults
- E-consult/e-Referrals and common intake
- Common IT platform
- EMR that connect with each other
- Requirement for acute care to inform of admissions and timely discharge /transfer of care info.
- Hospital coordinators connect with community coordinators so consistent, accurate and timely transfer of care
- Access to OHIP data to assist with planning of care
- Performance deliverables/targets are appropriate and developed in partnership with MOH,LHIN and primary care
- Patient Satisfaction Process - carefully developed to prevent inappropriate delivery of care to improve " satisfaction rating."
- Ensure appropriate mechanism for sustainable physician and allied health recruitments Primary care physician/patient freedom to access care as appropriate
- An understanding of what "same day" means to patients vs physicians, e.g. I have an opening at 2pm but patient wants to come at 10am; I do have 10am tomorrow though.

IMAGINE

Our patients…

Our system…

Our future...

Can Mount Sinai be serious? The answer is a resounding yes. In fact, we couldn't be more serious.

Mount Sinai's number one mission is to keep people out of the hospital. We're focused on population health management, as opposed to the traditional fee-for-service medicine. So instead of receiving care that's isolated and intermittent, patients receive care that's continuous and coordinated, much of it outside of the traditional hospital setting.

Thus the tremendous emphasis on wellness programs designed to help people stop smoking, lose weight and battle obesity, lower their blood pressure and reduce the risk of a heart attack. By being as proactive as possible, patients can better maintain their health and avoid disease.

Our Mobile Acute Care Team will treat patients at home who would otherwise require a hospital admission for certain conditions. The core team involves physicians, nurse practitioners, registered nurses, social workers, community paramedics, care coaches, physical therapists, occupational therapists, speech therapists, and home health aides.

Meanwhile, Mount Sinai's Preventable Admissions Care Team provides transitional care services to patients at high risk for readmission. After a comprehensive bedside assessment, social workers partner with patients, family caregivers and healthcare providers to identify known risks such as problems with medication management and provide continuing support after discharge.

It's a sweeping change in the way that health care is delivered. And with the new system comes a new way to measure success. The number of empty beds.

1-800-MD-SINAI
mountsinaihealth.org

Mount Sinai

IF OUR BEDS

ARE FILLED,

IT MEANS WE'VE FAILED.

QUESTIONS

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

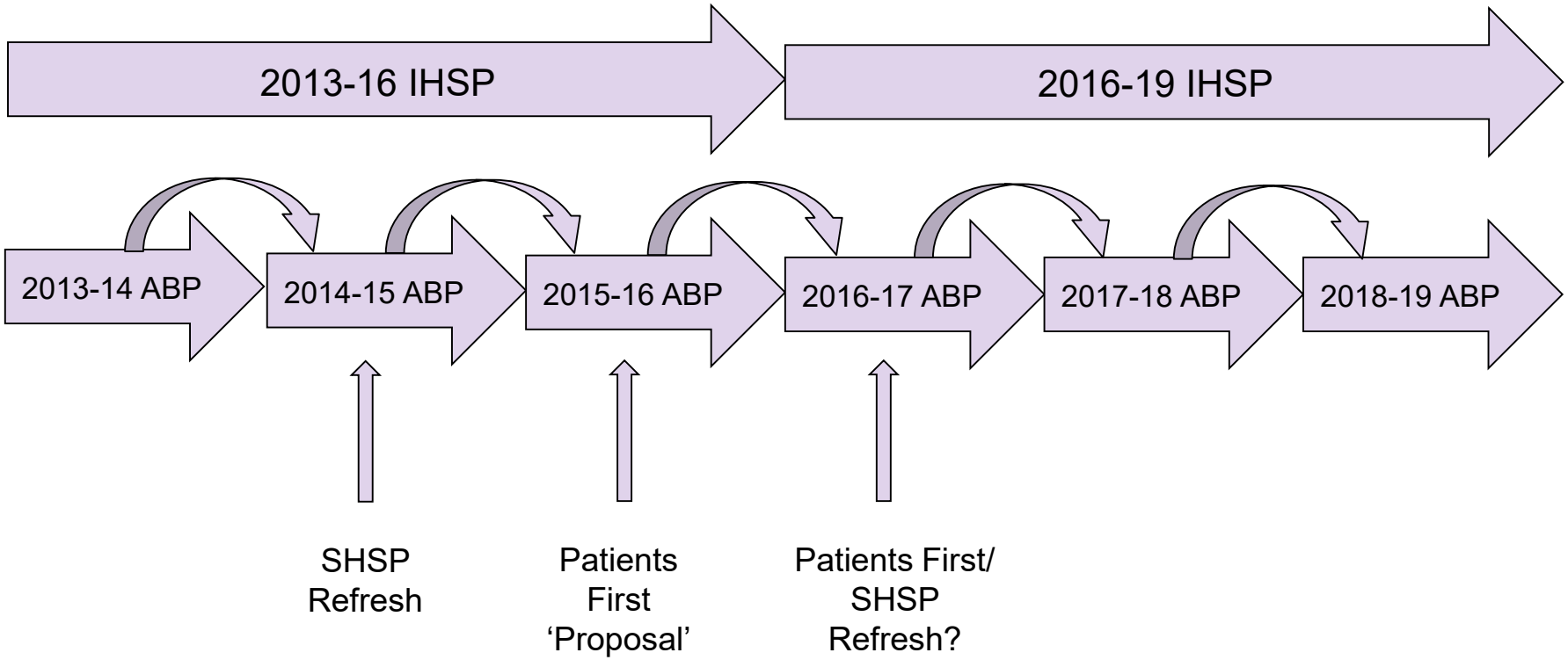
2016-17 Draft Annual Business Plan

Presentation to the
Hamilton Niagara Haldimand Brant
Local Health Integration Network
Board of Directors
February, 2016

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

HNHB LHIN Strategic Priorities Framework

5 year Strategic Health System Plan - 2013-2018
"Dramatically Improving the Patient Experience through Quality, Integration & Value"



Strategic Aim and Directions

Strategic Aim: Dramatically Improving the patient experience through quality, integration and value.

- **Quality**: embedding a culture of quality throughout the system.
- **Integration**: integrating service delivery.
- **Value**: evolving the role of the LHIN to become health system commissioners.

Embedding a Culture of Quality throughout the System

HNHB LHIN 2016-17 ABP

Focus

- Improve health system performance monitoring, by:
  - Establishing 'big dot' indicators
  - Focusing on outcome measures
  - Enhancing performance review and risk assessment processes
- Build capacity and promote knowledge translation related to quality and best practice
- Align priorities, resources, and efforts on quality initiatives for system level improvements

Key Anticipated Outcomes

- Whole system measures (e.g. MLAA) will be monitored and improvements demonstrated.
- Best possible outcome-based indicators will be collected at the program/service levels
- Web-based quality resources will be developed to build capacity for quality and performance improvement
- Quality Guidance Council mandate will be expanded and aligned provincially
- AGO audit recommendations will be implemented as per the pan-LHIN work plan

Integrating Service Delivery

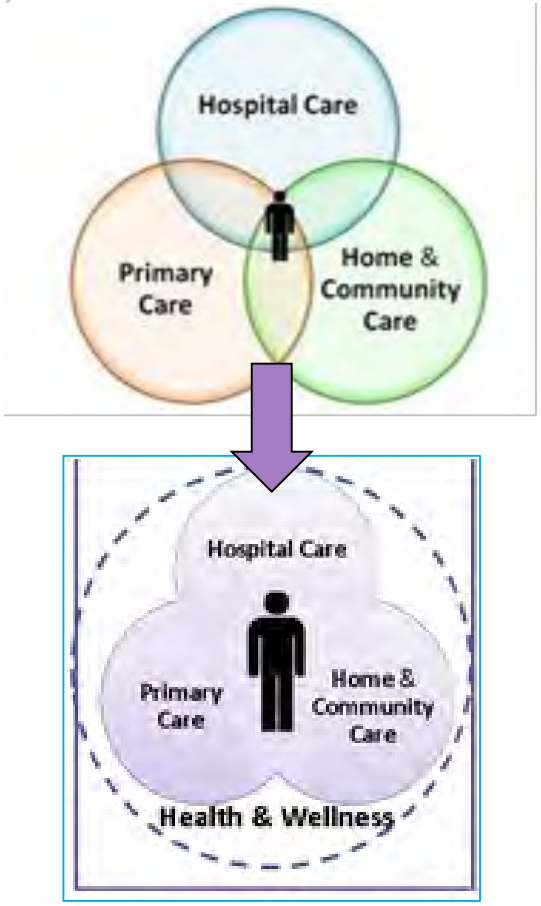
HNHB LHIN 2016-17 ABP

Focus

- Develop population based, geographically integrated LHIN sub-regions
- Sub-regions will be geographically defined areas where providers work in collaboration to ensure that every person has access to necessary health services

Key Anticipated Outcomes

- Patients experience easy links and seamless transitions at various points along the continuum of care
- Providers participate in interprofessional teamwork, and coordination of tasks, service and care
- HSP's participate in inter-agency relationships to provide seamless, integrated service delivery



Evolving the Role of the LHIN to become Health System Commissioners

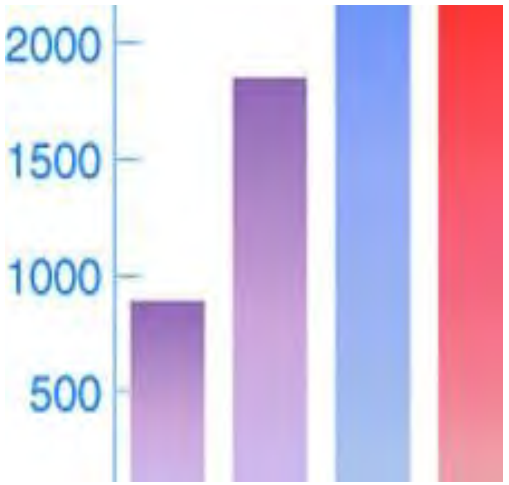
HNHB LHIN 2016-17 ABP

Focus

- Focusing on quality, volume, price and accountability
- Applying a population health lens to assessing current and future needs
- Making health system decisions based on evidence and performance
- Monitoring HSP performance to ensure that outcomes are being met for patients

Key Anticipated Outcomes

- Work in partnership with HSP leaders to collaboratively examine and optimize funding and service volume allocations within the LHIN
- Create detailed asset maps and related data about the health services available within the LHIN region. Data will be used to inform planning, assessments of equity and access, and funding decisions.



Key Priority Areas

- Primary Care
- Home and Community Care
- Health Links
- Health and Wellness of the Population
- LHIN-wide Integrated Clinical programs
- LHIN-wide Population-Based Strategies

Primary Care

HNHB LHIN 2016-17 ABP

Focus

- Engagement with and input from primary care providers and other stakeholders
- Following the ministry's lead, the LHIN will facilitate a data and evidence-driven planning process to ensure alignment of primary care with the needs of the population

Key Anticipated Outcomes

- Improved primary care attachment and after-hours, holiday, and weekend access for patients
- Decreased rate of ED visits for conditions best managed elsewhere and decreased rate of hospitalization for ambulatory care sensitive conditions
- Increased percentage of acute care patients with physician follow-up within 7 days of discharge

Home and Community Care

HNHB LHIN 2016-17 ABP

Focus

- One Sector Model
- Increase Community Support Services (CSS) capacity
- Integrated Comprehensive Care
- Improving care transitions

Key Anticipated Outcomes

- Increase in the percentage of home care clients with complex needs receiving personal support visit within five days.
- Decrease in the 90th percentile wait time from community for CCAC in-home services.
- Reduce readmission to hospital
- Improve client satisfaction and confidence in health care system

Health Links

HNHB LHIN 2016-17 ABP

Focus

- Continue to implement and standardize the Health Link model of care
- Define and identify the 5% patient population in real-time
- Build virtual teams to integrate services and transitions
- Work with HSPs to scale and spread the Health Link model of care in 'Care Communities'
- Monitor and manage performance related to quality integration and value
- Embed roles and responsibilities in Accountability Agreements

Key Anticipated Outcomes

- More people living with complex chronic conditions with coordinated care plans completed
- More people with regular and timely access to a primary care physician
- Increasing trend in reducing 30-day readmission to hospital
- Progress toward home care visits referral time
- Increasing trend in reducing emergency department visits for conditions best managed elsewhere

Health and Wellness of the Population

HNHB LHIN 2016-17 ABP

Focus

- Develop and implement a Health Equity Action Plan
- Continue to apply the health equity planning framework to identified target populations
- Support Public Health efforts to reduce smoking rates and improve population health outcomes

Key Anticipated Outcomes

- Apply a health equity and population health lens to planning for identified populations
- Increase the number of HSPs using the Health Equity Impact Assessment Tool
- Improve health system performance monitoring through establishment of health equity indicators and outcome measures
- Increase number of HSPs using the Public Health 5A minimal contact tobacco intervention to support provincial efforts to reduce smoking rates.

LHIN-wide Integrated Clinical Programs

HNHB LHIN 2016-17 ABP

Focus

- Phased approach, building on current integrated clinical program structures, including (for example) Cancer, Laboratory, Diagnostic Imaging, Vascular, Thoracic, Orthopedics, Ophthalmology, Cardiac
- Data and evidence-driven process, engaging leadership from hospital management and medical staff
- Continuous monitoring and improvement

Key Anticipated Outcomes

- More patients with more urgent medical needs (priority 2 and 3) will receive their surgical/diagnostic procedure within the recommended access time to reduce/sustain wait times.
- Variability in patient wait times for the same procedure across hospitals will be reduced.
- Wait times for surgical and diagnostic procedures will be reduced/sustained to the greatest degree possible within existing resources through efficiencies, appropriateness and standardization.

LHIN-wide Population Strategies

HNHB LHIN 2016-17 ABP

Focus

- Older adults and caregivers
- Persons transitions across care continuum
- Complex and/or chronic conditions
- Hospice palliative approach to care
- Mental health and addiction
- Children and youth

Key Anticipated Outcomes

- Decrease in the number of people and number of days people wait in hospital to access another level of care.
- Reduce the time people with complex conditions spend in the emergency department (ED) before they are discharged home or admitted to a hospital bed.
- Reduce unplanned ED visits within 30 days for people with mental health and substance abuse conditions

LHIN-wide Population Strategies – Indigenous Health

HNHB LHIN 2016-17 ABP

Focus

- Knowledge building
- System navigation
- Respectful partnerships
- Engaging communities

Key Anticipated Outcomes

- 300 health care providers receive Indigenous Cultural Safety Training
- Improve access to early intervention mental health and addiction services for indigenous children and youth in Hamilton
- An increase in the number of clients that receive access to cultural appropriate health care services through the Aboriginal Patient Navigator program.

LHIN-wide Population Strategies – Francophone Health

HNHB LHIN 2016-17 ABP

Focus

- Building awareness
- Access to services
- Engaging communities
- New health technologies

Key Anticipated Outcomes

- Increase health system awareness among Franco-Ontarian communities
- Ensure and improve access to health care in French
- Satisfy the needs of diverse Franco-Ontarian communities and improve their patient experience
- Explore new health technologies to better connect patients and French-speaking health care professionals

Enabling Strategies

HNHB LHIN 2016-17 ABP

Focus

- Build on effective communication and engagement tools, including the Citizen's Reference Panels
- Encourage opportunities for knowledge development and translation among LHIN staff and HSPs regarding system transformation
- Explore opportunities to leverage ClinicalConnect to support specific health system transformation initiatives

Key Anticipated Outcomes

- A continued and evolved understanding of the vision for health system transformation and the ongoing work of the LHIN to support its Strategic Aim
- LHIN staff and HSPs understand their contributions to and support the vision for health system transformation
- Continue to expand ClinicalConnect enrollment of health service providers and use of other strategies including Personal Computer Video Conferencing (PCVC)

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