Hamilton Niagara Haldimand Brant
Local Health Integration Network

Minutes of the Business Meeting of the Board of Directors August 26, 2015

A meeting of the Board of Directors of the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) was held on August 26, 2015, at the Boardroom, Hamilton Niagara Haldimand Brant Local Health Integration Network, 264 Main Street East, Grimsby, Ontario, beginning at 4:00 p.m.

Present:	Michael P. Shea, Board Chair Ruby Jacobs, Vice Chair Laurie Ryan-Hill, Member Mervin Witter, Member Bill Thompson, Member Dominic Ventresca, Member
Regrets:	Helen Mulligan, Member
HNHB LHIN Staff in Attendance:	Donna Cripps, CEO Helen Rickard, Corporate Coordinator, Recording Secretary Steve Isaak, Director, Health System Transformation Jennifer Everson, Physician Lead Rosalind Tarrant, Director, Access to Care Emily Christoffersen, Director, Quality & Risk Management Linda Hunter, Director, Health Links and Strategic Initiatives Trish Nelson, Director, Communications, Community Engagement and Corporate Services
Guests:	Dr. David Higgins, Chief of Staff, St. Joseph's Healthcare Erin Warman, President, OPSEU Local 294

A. Convening the Meeting

A.1 Call to Order

A quorum was present.

A.2 Approval of the Agenda

MOVED: Mervin Witter
SECOND: Laurie Ryan-Hill

That the agenda of August 26, 2015, be adopted, as circulated.

CARRIED

A.3 Declaration of Conflicts

No conflicts were identified at this time.

B. Delegation to HNHB LHIN

B.1 OPSEU Local 294

Erin Warman, President, OPSEU Local 294

- Presentation will be appended to original set of minutes.

C. Education Session

C.1 Mental Health & Addictions Strategy

(**Appendix 1** appended to original set of minutes)
Presenter: Dr. David Higgins, Chief of Staff, St. Joseph's Healthcare

Key Points of Discussion:

- Ontario's Mental Health & Addictions Strategy is divided into two phases. Phase 1 focused on children and youth mental health led by the Ministry of Children and Youth Services. Phase 2 is led by the Ministry of Health and Long-Term Care and is focused on adults, transitional aged youth, addictions, transitions, funding reform, and performance measurement across the system.
- Phase 2 of the strategy is guided by five strategic pillars.
- Recent opening of Youth Wellness Centre in March 2015 has experienced 50 referrals per month so far.

D. Minutes of the Last Meeting

D.1 Approval of the Minutes of June 24, 2015

MOVED: Bill Thompson
SECOND: Dominic Ventresca

That the minutes of the Board Meeting – Business of June 24, 2015, be adopted as circulated.

CARRIED

E. Reports

E.1 Report of the CEO

MOVED: Michael Shea
SECOND: Ruby Jacobs

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

CARRIED

Key Points of Discussion:

- The CEO presented the report as circulated.
- It was noted that the HNHB LHIN is continuing to assist the Auditor General's Office with requests for information.

E.2 Report of the Chair

MOVED: Mervin Witter
SECOND: Dominic Ventresca

That the Report of the Chair be received and filed.

CARRIED

Key Points of Discussion:

- The Chair highlighted the meetings attended during July/August.

E.3 Report of the Audit Committee Chair

MOVED: Michael Shea
SECOND: Ruby Jacobs

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

CARRIED

- The Audit Committee held a meeting on August 26, 2015. The minutes of the Audit Committee meeting of June 17, 2015, 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 June 17, 2015, be received and filed.

CARRIED

Consent Agenda

The Audit Committee reviewed the consent agenda of August 26, 2015, consisting of:

- Confirmation of Funding
- Aboriginal Funding

Proposed Motion:

MOVED: Bill Thompson
SECOND: Mervin Witter

That the consent agenda of August 26, 2015 be received and filed.

CARRIED

Mobile Crisis Rapid Response Team Expansion
In September 2013, the Hamilton Niagara Haldimand Brant Local Health Integration Network Board of Directors approved funding for St. Joseph's Healthcare Hamilton (SJHH) to support the expansion of the Crisis Outreach and Support Team (COAST), and the phase one implementation of the Mobile Crisis Rapid Response Team (MCRRT) in partnership with Hamilton Police Services.

The first phase of the implementation has demonstrated successful outcomes for clients experiencing crisis as a result of serious mental illness. The HNHB LHIN has supported the expansion of the COAST-MCRRT model to other within our LHIN. As part of this expansion into Halton. Under the leadership of the Halton Regional Police Service planning has commenced and has included St. Joseph's Healthcare Hamilton COAST, Halton COAST, Joseph Brant Hospital, Halton Health Services, our LHIN and Mississauga Halton LHIN staff.

Upon review of the Halton proposal, LHIN staff are recommending that funding be approved to St. Josephs Healthcare Hamilton to support two Mobile Crisis Rapid Response Teams for Halton as a further expansion of the LHIN-wide MCRRT model.

The expansion will allow for two teams to be available 12 hours per day, seven days per week, in order to ensure high risk clients can be diverted from ER and be directed to the specialized services they require.

Key Points of Discussion:
- It was noted that Mississauga Halton LHIN has not provided financial support for this project despite it providing service throughout Halton region.
- Staff committed to continue to work with Mississauga Halton LHIN as this program is implemented.

Proposed Motion:
MOVED: Laurie Ryan-Hill
SECOND: Bill Thompson

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve up to $582,000 in 2015-2016 base funding for St. Joseph's Healthcare Hamilton (SJHH) for the LHIN-Wide Mobile Crisis Rapid Response Team for Halton, including Burlington.

CARRIED

Health Links
On July 13, 2015 the Ministry of Health and Long-Term Care provided our LHIN $2,650,000 in one-time funding for the 2015-16 funding year to support continued development and ongoing operation of our Health Links.

The LHIN has the discretion in allocating the funding based on a number of terms and conditions. Each Health Link provider will be required to submit a 2015-16 Operation Plan that includes financial and performance commitments to support the Health Links strategy.

Key Points of Discussion:
- It was noted that in Burlington the HNHB CCAC is the lead provider for the Burlington Health Link. They work closely with all providers, including Joseph Brant Hospital

Proposed Motion:
MOVED: Laurie Ryan-Hill
SECOND: Dominic Ventresca

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve up to $2,650,000 one-time funding in 2015-16 to support the continued development and ongoing operation of the approved Health Links to the health service provider identified in Appendix A.

CARRIED

Appendix A – Funding Allocation

Health Link	**Health Service Provider**	**Allocation ($)**
Burlington	HNHB CCAC	154,033
Hamilton East	St. Joseph's Healthcare Hamilton	358,505
Hamilton West	Hamilton Health Sciences	390,230
Niagara North East	HNHB CCAC	211,233
Niagara South West	Centre de Santé Communautaire	331,812
Niagara North West	Hamilton Health Sciences	136,051
Niagara South East	Niagara Health System	276,795
Haldimand	Haldimand War Memorial Hospital	184,835
Brant Six Nations	Brant Community Healthcare System	245,993
Norfolk	Norfolk General Hospital	261,211
IDS Analyst	Hamilton Health Sciences	99,301
Total Funding		**$ 2,650,000**

Integrated Comprehensive Care Program One-Time Funding
Our LHIN, working with our providers are working on the development of a new care model based on key elements of the St. Joseph's Health System Integrated Comprehensive Care Program. This model will be implemented across all HNHB LHIN acute care hospital sites for hospitalized patients with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) who are discharged home and/or designated Alternate Level of Care (ALC) awaiting discharge home.

St. Joseph's Health System implemented a bundled care model for patients with COPD and CHF and demonstrated:

- Improved patient outcomes: reduced hospital length of stay, lower rate of emergency department utilization, reduced hospital readmission rates, and high levels of patient satisfaction
- Lower total direct hospital costs

To successfully scale and spread the Integrated Comprehensive Care COPD and CHF Program with fidelity to the key principles and success factors identified by SJHS, one time resources are requested by SJHH to support their leadership role. This one-time funding request from the LHIN is to support coaching, mentoring and resourcing the HNHB LHIN zones and teams. The total amount required to fund this support is $500,000.

Key Points of Discussion:

- It was noted that all hospitals, CHC's and the HNHB CCAC are involved in the Integrated Comprehensive Care project.

Proposed Motion:
MOVED: Laurie Ryan-Hill
SECOND: Bill Thompson

That the Audit Committee recommends that the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve the one-time allocation of $250,000 in 2015-16 and $250,000 in 2016-17 for a total of $500,000 to St. Joseph's Healthcare Hamilton (12 months of funding) to support SJHH's leadership role to implement the Integrated Comprehensive Care Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) Program across all acute care hospitals.

CARRIED

Care Transitions

In February 2015, a Collaborative Care Model (CCM) was developed by the HNHB Home and Community Care Collaborative (Collaborative), and outlines a framework for CSS agencies to care for Individual's with lower to moderate care needs while allowing the HNHB CCAC to accommodate increased referrals from hospitals and community for persons needing higher levels of care and case management.

To support the Collaborative Care Model, the HNHB LHIN Board of Directors previously approved $5,000,000 in 2015-16 funding for this initiative. This funding ($5,000,000) supports 159,744 hours of personal support service.

Patient flow continues to be a pressure across the HNHB LHIN. As of August 9, 2015, LHIN hospitals reported 387 individuals waiting in hospital for an alternative level of care with 50 waiting to return home with CCAC services.

This funding request will increase the capacity of the Assisted Living/Supportive Housing agencies to provide personal support services to clients who are stable and have low to moderate needs, which further support the CCAC in providing services and case management to clients with complex care requirements.

Key Points of Discussion:

- It was noted that the CCAC will handle the intake coordination for all requests of clients seeking PSS services at this time.

Proposed Motion:

MOVED: Mervin Witter
SECOND: Bill Thompson

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve up to $2,000,000 one-time recurring funding in 2015-16 to support the expansion of the Home and Community Care Collaborative to the health services providers identified in Appendix A.

CARRIED

Appendix A

HSP	Geography Served	Current Funding ($)	Current Hours of Service	Proposed Expansion ($)	Proposed Expanded Hours of Service	Proposed Total Funding ($)	Proposed Total Hours of Service
AbleLiving Services	Hamilton Burlington	739,091	23,613	295,636	9,445	1,034,727	33,058
Capability Support Services	Hamilton Burlington Dunnville	1,092,157	34,893	436,863	13,957	1,529,020	48,850
Good Shepherd Centre Hamilton	Hamilton	282,735	9,033	113,094	3,613	395,829	12,646
March of Dimes Hamilton	Hamilton Burlington	557,970	17,827	223,188	7,131	781,158	24,958
March of Dimes Niagara	Niagara Haldimand Norfolk	1,537,975	49,137	615,191	19,655	2,153,166	68,792
Participation House Brantford	Brant	488,606	15,610	195,442	6,244	684,048	21,854
St. Joseph's Homecare	Hamilton	301,466	9,631	120,586	3,853	422,052	13,484
Totals		**5,000,000**	**159,744**	**2,000,000**	**63,898**	**7,000,000**	**223,642**

Tele-ophthalmology Program

On October 23, 2013, the HNHB LHIN Board of Directors approved $118,490 in base-funding and $12,200 in one-time funding to St. Joseph's Healthcare Hamilton to support a LHIN-wide Tele-ophthalmology Program to increase access to diabetes retinal screening.

Since receiving approval St. Joseph's Healthcare Hamilton has been challenged to meet their annual target for the number of clients screened.

As of May 2015, the total number of clients screened is 75 out of the targeted 1,320.
In follow up with St. Joseph's Healthcare Hamilton, the technologist' time has been limited to one day per week due to the limited volume and funding has been recovered.

The reduced hours of operation resulted in a projected 2014-15 year end surplus of $64,600. The final year end reported surplus was $102,761 of which $64,600 was recovered at Q2. The balance will be recovered through the Annual Report Reconciliation process.

On June 29, 2015, St. Joseph's Healthcare Hamilton submitted a revised budget (decrease in base funding from $118,490 to $71,050) and a new target volume (decrease from 1,320 to 250 per year).

The St. Joseph's Healthcare Hamilton original budget and target volume allowed for a cost per person screened of $89, which would have been a factor in the LHINs original assessment of the proposal. The revised target volume and budget results in a higher cost per person screened of $284. While the LHIN has not been able to identify an 'optimal' cost per person for this service the LHIN surveyed other LHINs that provide this service; one LHIN reported a cost of $315 per person screened.

St. Joseph's Healthcare Hamilton has committed to meeting the revised target of 250 people per year. LHIN staff will monitor this program quarterly specifically for the number of clients and proportion of those screened that required referral for follow up assessment and/or treatment.

Key Points of Discussion:

- It was noted that the province is moving to developing standardize costs for these types of services.

Proposed Motion:

MOVED: Laurie Ryan-Hill
SECOND: Bill Thompson

That the Audit Committee recommends that the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve for St. Joseph's Healthcare Hamilton in 2015-16:

- a reduction to the annual base funding from $118,490 to $71,050; and
- a decrease in the target for number of clients screened annually from 1,320 to 250 per year

CARRIED

F. New/Other Business

F.1 Hospital Broader Public Sector Accountability Act, 2010

MOVED: Michael Shea
SECOND: Ruby Jacobs

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network receives and files the update on the Hospital Use of Consultation pursuant to the *Broader Public Sector Accountability Act, 2010*.

CARRIED

G. Adjournment

MOVED: Michael Shea
SECOND: Ruby Jacobs

The Board of Directors – Business meeting be adjourned at 5:43 p.m.

CARRIED

ORIGINAL SIGNED BY: SEPTEMBER 30, 2015

Michael P. Shea, Chair **Date**

ORIGINAL SIGNED BY: SEPTEMBER 30, 2015

Donna Cripps, Corporate Secretary **Date**

OPSEU Local 294 Presentation to LHIN

Introduction

- My name is Erin Warman. I'm a community nurse, and the President of OPSEU Local 294. We represent the nurses and administrative staff at CarePartners in the Niagara and Norfolk region.
- I've come today to talk to you about "For-profit providers and the quality of patient care for CCAC referrals". I want to speak about patient care in the community – OUR community.
- My colleagues and I have good insight on this subject, because we work for a private provider of home care services. We see the impacts of privatization on patient care every day.
- CarePartners is a PRIVATE, for-profit, province-wide agency that provides nursing and PSW services. They are paid with public funds through regional CCAC contracts.
- I am not here to talk to you about our strike with CarePartners, which I'm sure most of you will have seen or heard about. I realize this is not the time or place. But I am going to talk to you generally about how poor working conditions created by the profit motive directly affects patient care in the home care system.

About home care and visiting nurses

- In Ontario, we are seeing an increase in hospital closures, an aging population, and a change in medical practices. Hospital stays are getting shorter. Care is shifting from typical hospital care to community care. Patients with increasingly complex care cases are being treated at home by nurses like us.
- Home care has become the future of Ontario health care.
- We provide dialysis, chemotherapy, wound care, diabetic care and health teaching, to name a few, to patients from all walks of life.

- We chose to practice our nursing in the community because we can provide holistic care in a comforting setting for the patient. People heal well at home, and we are now in an era where medicine has made this very possible.
- In hospitals, nurses will generally work in one area of medicine.
- A community nurse, on the other hand, becomes a Jack or Jill of all trades. Our experience and knowledge has to be vast so that we can treat all age groups, populations, and conditions.

Privatization of the system

- Patients expect, require and deserve competent care. However, increasing privatization in home care is breaking the system. Here is how that is happening:
- Home care used to be provided mostly by non-profit agencies. These agencies employed nurses and personal support workers who received an hourly salary for their work.
- Community Care Access Centres have put home care out for competitive bidding. They accept the cheapest bids from private, for-profit providers like our employer, and these employers find alternatives or loopholes to ensure the next bid is private also.
- Private providers take public health care money out of front line services, this happens in two ways:

    1. First, they skim large profits for their owners out of the public funds they're given before paying for anything else. That money goes directly from our health care dollars into their bank accounts.
    2. Then, to pay for that, they cut corners on patient care and drive down the wages and working conditions of their employees.

How working conditions affect patient care

- You may wonder what working conditions for people like us have to do with patient care. As it happens, they are **directly** linked.

- For-profit agencies have several corner-cutting tactics that add to their bottom line but always hurt patient care.
- One tactic is paying visiting nurses on a piecework rather than a salary model – so paying a flat rate per visit, no matter how long the visit takes. Home care nursing visits can take anywhere up to two or more hours depending on the complexity of the case.
- When nurses are paid by the visit rather than by the hour, it creates an incentive to get in and out as quickly as possible. Especially when the per visit rate is so low that a two hour visit translates to earning less than minimum wage, as is the case in our agency. For example, our nurses start at $16 and change per visit.
- Paying by piecework also doesn't take into account the travel time between patients, nor does it pay for the administrative time nurses need to write case notes and patient documentation after the visit. Nurses should be paid for the hours they work.
- Another cost-cutting tactic that for-profit agencies use is refusing to provide sick leave for employees. This creates pressure on low-paid nurses to come to work sick. We work with vulnerable clients who should not be exposed to routine transmittable illnesses like colds and flus.
- When nurses are forced to rush through visits, work unpaid hours on administrative tasks, and work while they are sick, it creates a great deal of stress and burnout, which in turn creates high turnover. Agencies with high turnover rates cannot possibly provide proper continuity of care to their patients.
- Continuity of care as well we all know, is very important in community nursing. We enter people's homes and provide very personal and intimate services to them. It is very important that patients have the same nurses providing services to them to avoid confusion and distress. Patients going through cancer treatments, or experiencing complications from diabetes, or dealing with dementia need to form a bond of trust with their nurses.

- Continuing education is also extremely important. We need to stay on top of the constantly changing and evolving field of nursing and administration. For-profit agencies like ours do not provide adequate continuing education or nurse educators for their nurses. Workers at our agency have been told to “Look it up on YouTube” when we request continuing education. After all, providing continuing education is a cost that cuts into profits.
- So who is ultimately the one to suffer? **The patient!**
- Think about the experience of a breast cancer patient. She receives chemotherapy, loses her hair, experiences nausea and can’t eat, receives injections, catheter care, and possibly surgery to remove her breasts. All the while, she is dealing with the emotional burden of her condition.
- This patient suffers when a different nurse shows up to her home every day, and she again has to explain her history, experiences, symptoms and upcoming appointments. She needs a nurse who can monitor her condition over time. She needs to develop a bond of trust with her nurse.
- Or how about the dialysis patient, whose kidneys are failing so rapidly that he has to be on dialysis at the same time as he receives intense wound care to save his legs. He also needs catheter care, injections, diabetic monitoring and education, and help with significant dietary changes.
- This patient too has to deal with the stress and burden of his new and very life threatening diagnosis. He doesn’t need a new nurse every day asking the same questions and altering his routine of care. He doesn’t need to be rushed through his visit. He is too tired and weak to handle that kind of disruption.
- Now- Think also about the nurse who provides care in the home. When I go home at the end of my 12 hour day, having only seen 8 patients, I have another 2-3 hours of administrative work to do.
- I have to fill out funding documents, order supplies, and make phone calls to physicians and family members. Now, my 12 hour day has stretched into a 15 hour day.

- Then I realize that I have made minimum wage or sometimes even less for that day, and I worry. I worry about how I will pay the mortgage. I worry about how I will put food on the table for my children.
- And on top of that worry are the tears, the tears I shed for my patients. I KNOW they are suffering. I KNOW they are not receiving the help and proper care they need.
- And top of all of this I know that someday this will be me or my family members who will need home nursing care. I know from firsthand experience that the system I work for is broken and I'm terrified.

Conclusion

- It is our experience that private agencies like CarePartners treat patients like widgets on an assembly line. As workers, we feel pressured to rush through our visits, see as many patients as possible per day, and come to work sick. Our working conditions create stress that our patients can feel.
- Patients deserve better than that. They deserve to have nurses who can spend the time with them that they need. They deserve to have nurses who are not distracted by stress and illness. They deserve to develop a relationship of trust with the same nurses over time and above all else be treated by that nurse holistically.
- Patients all over Ontario are dealing with compromised care because of private agencies skimming our public health dollars for their profits and cutting corners on front line patient care to pay for it. The system is *broken because of privatization.*
- In conclusion we would like to see this LHIN stand up for quality patient care and the employees who provide it by demanding accountability and responsibility from the for-profit providers that they fund, like CarePartners.
- The LHIN needs to ensure that providers put our public health dollars into front line patient care rather than into their bank accounts.

- You have a responsibility not only to the patients in our community, but to *yourself* and *your family members* who one day will need the services of community healthcare and will absolutely need a nurse.
- We share the vision of your mission statement – a health care system that keeps people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.
- Thank you for hearing our submission today.

HNHB LHIN Mental Health & Addictions Strategy

Dr. David Higgins
President, St. Joseph's Healthcare Hamilton

August 26, 2015

Comments on complexity of mental health landscape

- Multiagency
- Multi ministry
- Multisource funding
- Metrics not mature or well defined
- Unmet need documented in multiple studies
- Stigma a challenge across sector and society as a whole and profound in certain subcultures
- Strong association of mental illness with social deprivation BUT affects ALL sectors of society
- Significant interactions of those suffering with mental illness with justice system

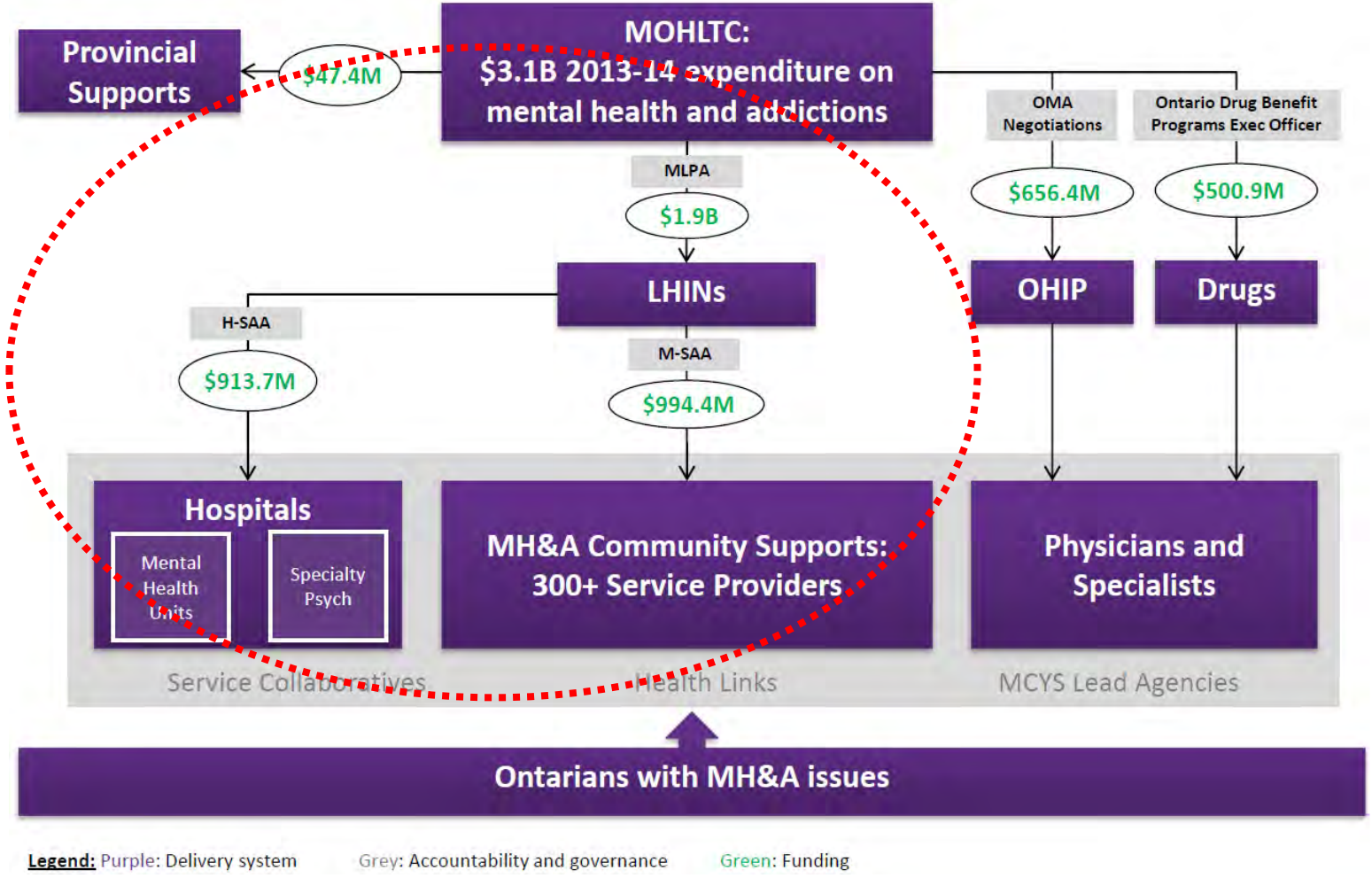
Objectives

- Review the provincial Mental Health & Addictions (MH&A) strategy
- Provide an overview of the HNHB LHIN MH&A Advisory Group
- Review the HNHB LHIN MH&A strategic planning to date

Ontario Mental Health & Addictions Strategy

An Overview

Complex Ministry of Health & Long-Term Care MH&A delivery system, accountability/ governance mechanisms and funding structures



Legend: Purple: Delivery system Grey: Accountability and governance Green: Funding

Source: MOHTLC presentation to MHA Leadership Council, February 6, 2015

Challenges identified at the provin

Limited focus on prevention and early intervention:

- Limited focus on public health and health promotion
- Self-help options not maximized
- Limited training for providers about early identification

Unmet need:

- Access to services
- Supportive housing
- Employment supports
- Justice transition and diversion

G

- Uncoordinated care
- Funding based on historical allocations

Weak data collection and performance measurement:

- Inconsistent data collection
- Limited performance reporting
- Minimal service cost data
- Minimal provincial public reporting

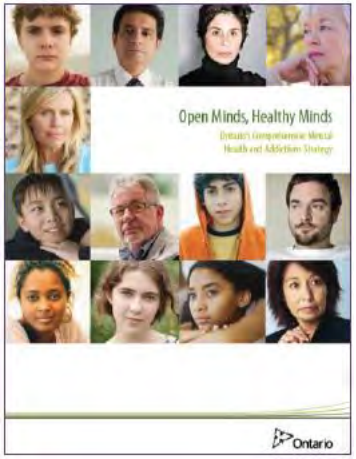
Note focus on social determinants, care coordination and transitions, justice system, mal-alignment of funding

Contrast "Med/Surgical/Diagostic imaging/ER-accountability

Source: MOHTLC presentation to MHA Leadership Council, February 6, 2015

Ontario's Mental Health and Addictions Strategy

- Launched in 2011, Open Minds, Healthy Minds is Ontario's comprehensive mental health and addictions strategy, which aims to address these systemic issues



- Strategy vision statement: Every Ontarian enjoys good mental health and well-being throughout their lifetime, and all Ontarians with mental illness or addictions can recover and participate in welcoming, supportive communities

- The Strategy is divided into two phases:

Phase 1: Launched 2011

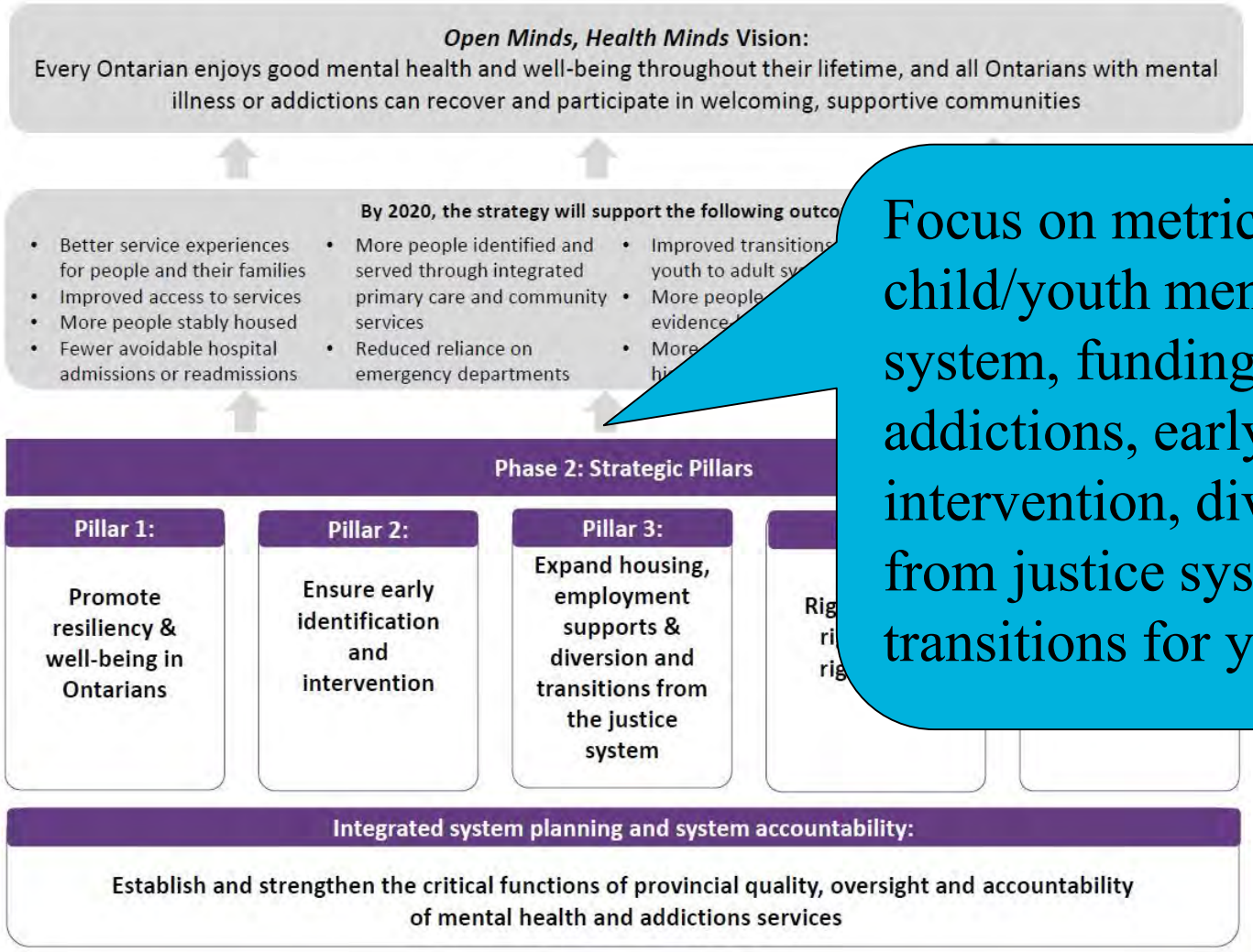
- Led by the Ministry of Children and Youth Services.
- Focused on children and youth mental health.
- Ongoing transformation in children and youth mental health system will be be aligned with Phase 2.

Phase 2: Launched 2014

- Led by the Ministry of Health and Long-Term C
- Expanded scope and scale of Phase 1 to focus on adults, transitional aged youth, addictions, transitions, funding reform, and performance measurement across the system.

Key initial foci of LHIN MHA strategy, transitions, early intervention, metrics, addiction.

Provincial Mental Health & Addictions Strategy Phase 2



Focus on metrics, child/youth mental health system, funding reform, addictions, early intervention, diversion from justice system and transitions for youth

Source: MOHTLC presentation to MHA Leadership Council, February 6, 2015

Three initial implementation priorities

1. **Enhance oversight and accountability:** Establish Mental Health and Addictions Leadership Advisory Council to advise the Minister and to report on Phase 2 progress, and establish a dedicated Aboriginal engagement process.

2. **Improved performance measurement:** Work with Health Quality Ontario (HQO) and the Institute for Clinical Evaluative Sciences (ICES) developing a scorecard and evaluation framework to measure progress and outcomes.

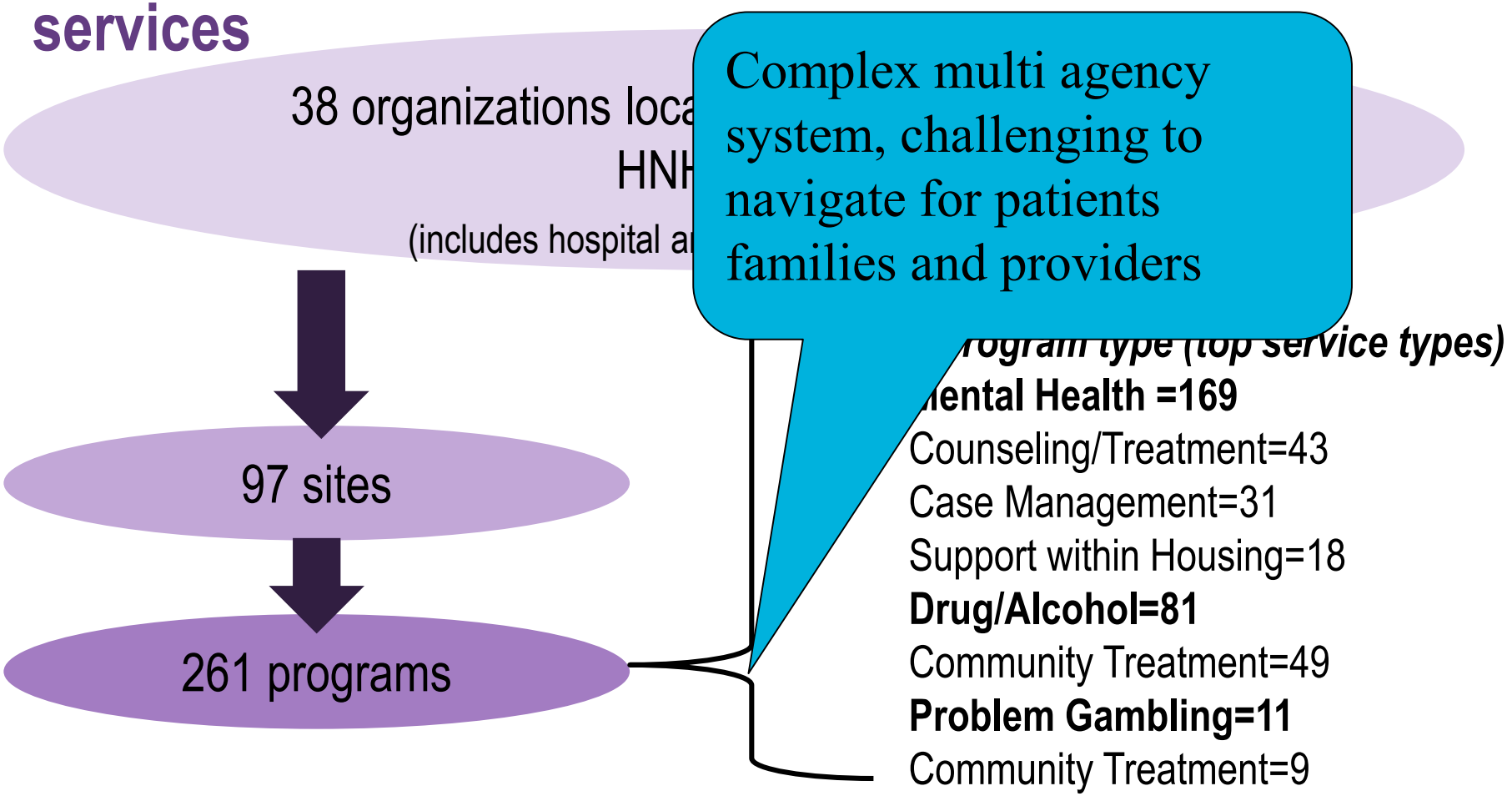
3. **New initiatives and funding investments:** $138 million over three years through the 2014 Budget to community service agencies to help increase access to services such as peer support groups, treatment programs, and crisis and early intervention initiatives.

Source: MOHTLC presentation to MHA Leadership Council, February 6, 2015

HNHB LHIN Mental Health & Addictions Services

An Overview

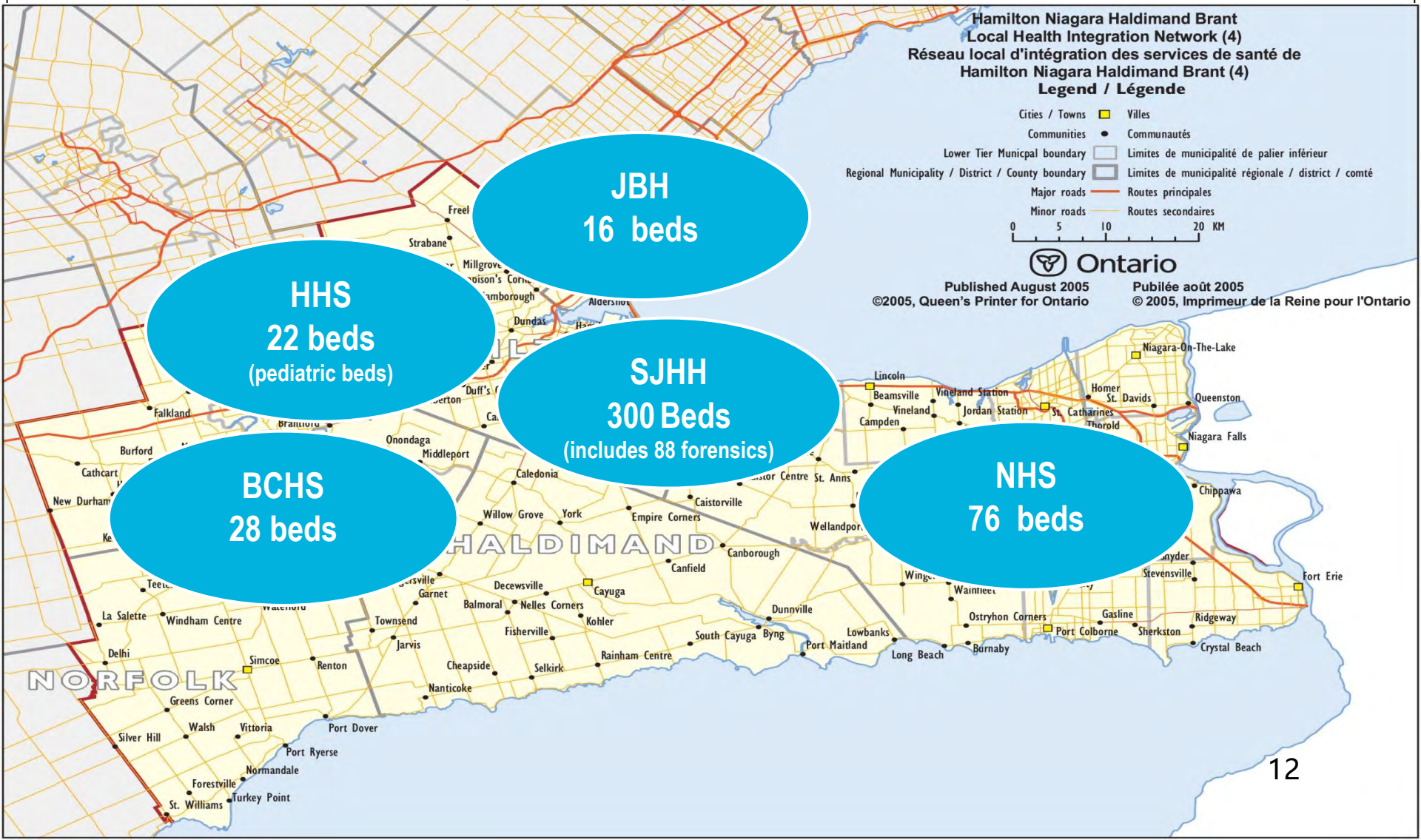
LHIN-funded Community Mental Health & Addiction services



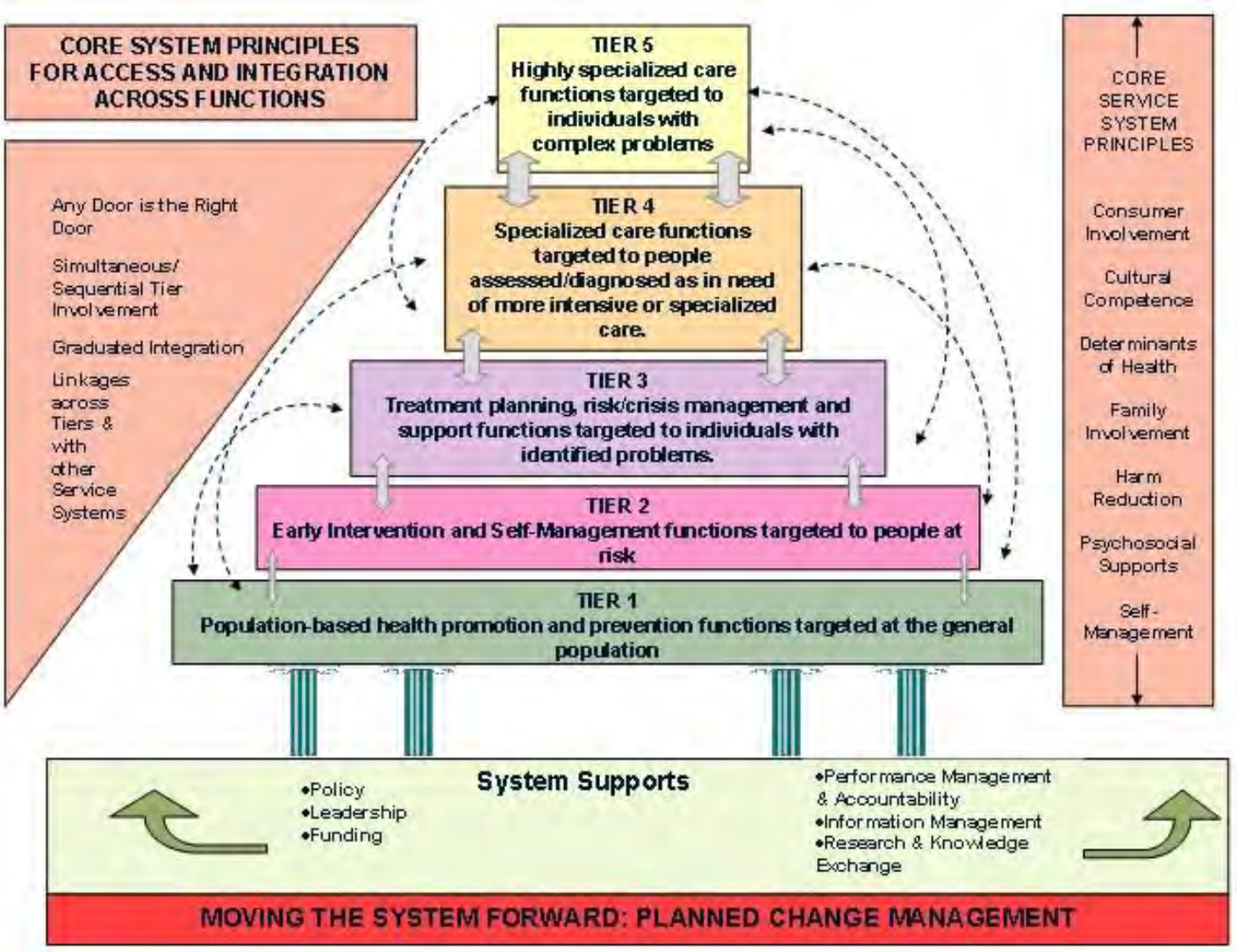
ConnexOntario maintains a database of detailed drug, alcohol, problem gambling, and mental health service related information. More detailed up to information and interactive data analysis is available at: http://www.connexontario.ca/

Number of Mental Health Beds in the HNHB LHIN by Hospital, Q3 2014-15

Source: SRI, Q3 2014-15 Quarterly Report. IP-MH- Avg Beds Staffed & in Operation. Actual.



Towards a population and needs-based planning approach



Rush et al., CAMH, 2013.

Volume of Activity in the HNHB LHIN

In one year:

- Over 60,000 individuals served in the community (not unique individuals)

+

- Over 155,000 inpatient mental health days / 6,400 admissions (not unique individuals)

HNHB LHIN Funding

Does ***not*** include funding MCYS, Social services, NGOs, muncipalities, public health , OHIP, other sources of physician funding or pharmacy

Hospital Adult Inpatient $63.2M

Hospital Fore Inpatient $9.7M

5 Providers (HBAM 2014-15 Expected Expenses v

$92.9M
+
$79.4M
=
$172.3M

Funding by agency ranges: $98k-$89M

38 Providers (2015-16 LHIN Funding as of May 7, 2015)

Community Mental Health $58.8M

Addictions $16.8M

Problem Gambling <$1.0M

Sessional Fees $2.0M

Psychiatric Outpatient Medical Salaries $1.0M

HNHB LHIN Mental Health & Advisory Group

An Overview

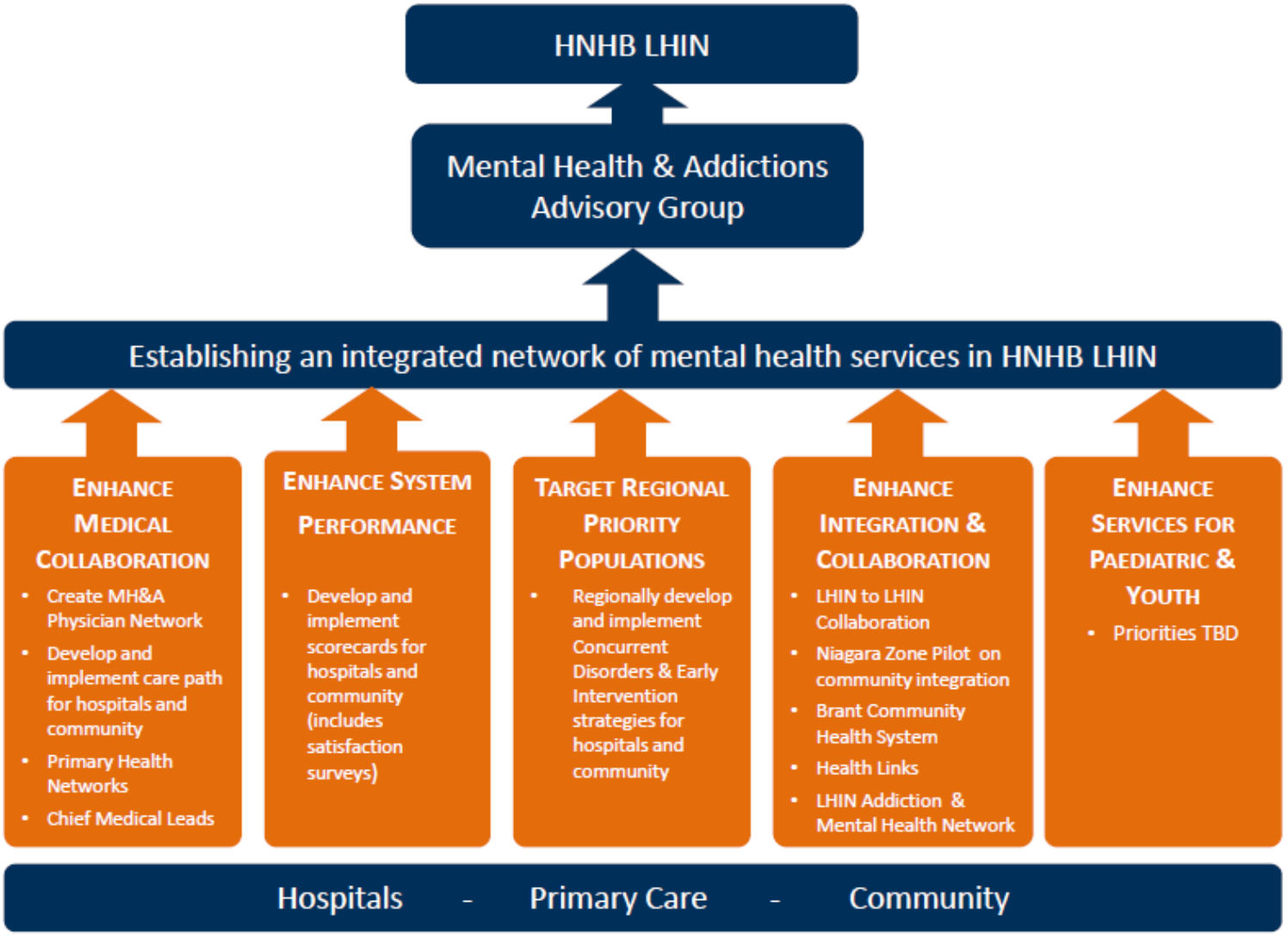
Goals and Objectives

Goal: To support an integrated network of mental health and addictions services in the HNHB LHIN, and to optimize available resources and clinical expertise

Objectives:

- Provide a forum for identifying issues that impact the delivery of MH&A services
- Provide a structure for network planning of MH&A services in HNHB LHIN
- Provide a forum to share experiences, successes and failures of local initiatives
- Provide for the identification of service gaps and the need to build local capacity to address the gaps
- Identify the need and approach to sharing clinical expertise, best practice, and research
- Ensure alignment with LHIN initiatives and strategic planning

LHIN 4 Mental Health & Addictions Advisory Group reporting structure and strategic pillars (2015)



HNHB LHIN Investments 2014-15 and 2015-16 (to date) *

* Total approximate HNHB LHIN investments (one-time and base) for 2014-15 and 2015-16
** HNHB LHIN MH&A Advisory Group-supported initiatives

HNHB LHIN Mental Health & Addictions Advisory-Supported Initiatives

Youth Wellness Centre

- Opened March 16, 2015
- 50 referrals per month so far:
  - ¾ emerging mental illness
  - ¼ transitions from the child and youth sector to the adult sector
- LHIN has funded:
  - LHIN-wide Coordinator position
  - 5 programs for youth-focused MH&A services
- Joint youth engagement strategy and assessment tools (GAIN suite of tools)
- Triple Aim-based joint evaluation plan

HNHB LHIN Mental Health & Addictions Advisory-Supported Initiatives

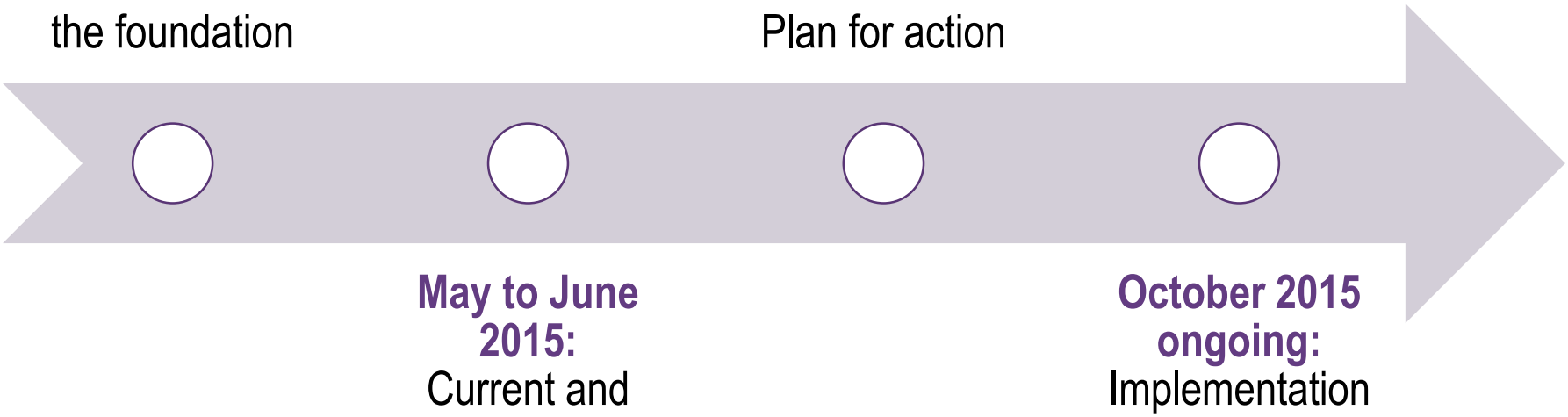
LHIN-wide Concurrent Disorders Capacity-Building Initiative

- LHIN-wide Project Coordinator in place
- Kick-off held May 22, 2015
- Five regional planning tables developed
    - Goal is for each local table to identify at least 2 collaborative change projects with clear outcomes related to concurrent disorders capacity building
- There will be the opportunity for training and education where needed; however, the focus will be on implementing clear, measurable changes

HNHB LHIN Mental Health & Addictions Strategy

Strategic Planning Activities to Date

HNHB LHIN MH&A Strategic Planning



Strategic Planning Process

1. Establish an MH&A Strategic Planning Working Group *(established March 2015)*
   - 15 members, from the LHIN and from our MH&A health service providers
   - Makes recommendations on the strategic planning *process*, and supports its implementation
   - Members don't represent a specific constituency (sector, service, professional interest, geographic area); are system-level contributors, bringing expertise and desire to advance the system as a whole

2. Hold Triple Aim workshop for MH&A Leadership *(held April 20, 2015)*

3. Explore existing service landscape, outline future vision, and set priorities and collaboratively address priorities *(held June 24, 2015)*

4. Develop MH&A strategic action plan *(to be completed September 2015)*
   - Event executive summary and high-level action plan currently out for feedback from MH&A health service providers)

5. Launch and implement MH&A strategic action plan *(October 2015)*

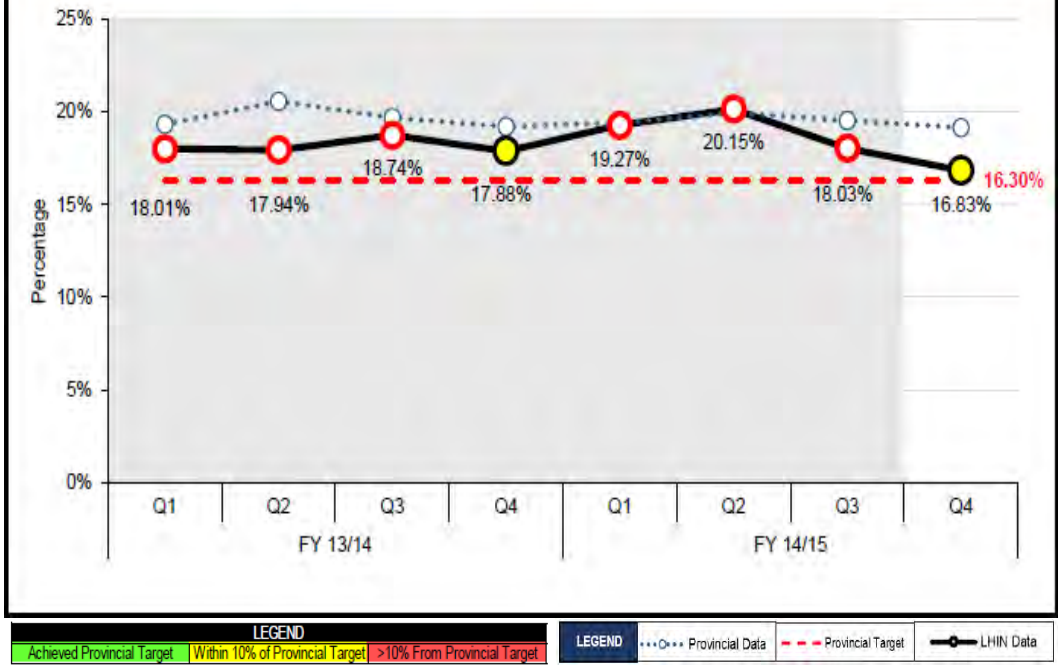
Repeat Unscheduled Emergency Department (ED) Visits within 30 days for Mental Health and Substance Abuse Conditions

As of Q4 2014-15

Repeat ED Visits for Mental Health Conditions

Definition: Percent of repeat unscheduled emergency visits within 30 days for a mental health condition, presented as a proportion of all mental health emergency visits.

Summary (Q4 FY 14/15)	LHIN Performance	Provincial Performance	Provincial Target (FY 15/16)
	16.83%	19.15%	16.30%



707 Repeat Unscheduled ED Visits for Mental Health Conditions Within the Current Reporting Period (471 unique people)

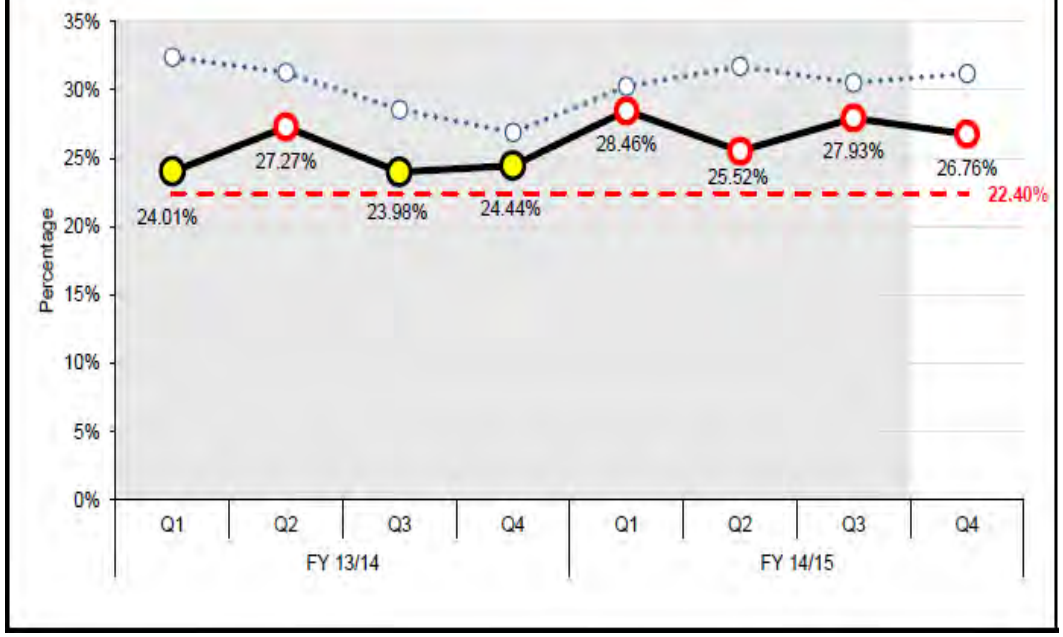
Provincial Ranking for Current Reporting Period (of 14 LHINs): 6th

Data Source: *NACRS, Canadian Institute for Health Information*

Repeat ED Visits for Substance Abuse Conditions

Definition: Percent of repeat unscheduled emergency visits within 30 days for a substance abuse conditions, presented as a proportion of all substance abuse emergency visits.

Summary (Q4 FY 14/15)	LHIN Performance	Provincial Performance	Provincial Target (FY 15/16)
	26.76%	31.18%	22.40%



LEGEND: Achieved Provincial Target | Within 10% of Provincial Target | >10% From Provincial Target

LEGEND: Provincial Data | Provincial Target | LHIN Data

396 Repeat Unscheduled ED Visits for Substance Abuse Within the Current Reporting Period (196 unique people)

Provincial Ranking for Current Reporting Period (of 14 LHINs): 8th

Data Source: *NACRS, Canadian Institute for Health Information*