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

2017–2018 Annual Report

Imagine what we can achieve together… when we care, listen and act.

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

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Messsage from the HNHB LHIN Board Chair and the Chief Executive Officer

Janine van den Heuvel, Board Chair

Donna Cripps, CEO

While 2017-18 was a year of change for the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN), our focus and priority was always to ensure the people we served continued to receive the care they needed. This Annual Report provides us with an opportunity to highlight the achievements made to support patients, families and caregivers while continuing to focus on a significant health care system transformation.

Enabled by legislative changes and a new mandate from the Ministry of Health and Long-Term Care, the HNHB LHIN and all LHINs across Ontario experienced momentous change in 2017-18 designed to make the health care system more integrated and more accessible for people.

On May 10, 2017 the HNHB LHIN organization experienced a change in structure and responsibility. In addition to its long-standing planning, funding and integrating responsibilities, the LHIN took on the additional responsibility of providing home and community care as well as an expanded mandate through the creation of sub-regions. These changes enhanced the LHIN's ability to improve patient care, allowing us to become the single point of accountability for local health system planning at the regional and sub-region levels.

Over this past year we learned about the natural synergies happening across our health care system and we also discovered opportunities to do things differently and better. With months of advance planning and coordination, we were able to ensure the transfer of home and community care responsibilities was seamless for the people we serve with respect to the delivery of care and support services.

We would be remiss not to acknowledge the significant and transformative impact the changes had for the LHIN board, leadership team and employees and how opportunities were created for our organization to learn how to better care for people, in a timely and responsive way. Patients and families across the HNHB LHIN continued to receive the high quality care they were accustomed to without interruption, thanks in large part to the efforts of LHIN front-line employees whose professionalism and dedication to providing quality care was crucial in minimizing any potential impact to patients and families.

Within our 2017-18 Annual Report you will see how the HNHB LHIN continued to make major strides in a number of areas. Here's a snapshot:

- Based on our mandate and the *Patients First Act*, the LHIN ensured patient voices continue to be at the centre of health care planning through the formation of a Patient and Family Advisory Committee. Patient and Family Advisory Committee members give of their time by lending their experience and expertise related to the health care system.

- We continued to address the growing need for mental health and addictions services by funding programs and enhancing services for our residents who are faced with mental health and addictions challenges. This includes establishing new programs and expanding crisis and addiction services and community health programs across our LHIN to include mental health.

- We are dealing with the opioid crisis in our communities through the provision of funding and resources to develop public education campaigns for at-risk groups, exploring the possibility of harm-reduction strategies in select communities, and making the anti-overdose treatment Nalaxone available to first-responders, pharmacies and in community settings to opioid users.

- We established six sub-regions to be the focal point for planning, funding and integrating the health care system. Anchor Tables were formed, comprised of patients as well as LHIN-funded and non-LHIN funded partners to inform and action the unique and shared priorities across each sub-region.

- We continued incorporate health equity by incorporating the Health Equity Impact Assessment (HEIA) tool into our decision-making. This is important for all people - our goal is to improve the health and wellness of the people we serve across our LHIN with particular attention to Indigenous peoples and Francophone residents.

- We have remained focused on strengthening home and community care to achieve positive outcomes for patients, their families, and caregivers by ensuring we are doing everything possible to create an exceptional patient experience for each person we serve. This means better integration of the health care services provided by health system partners across the continuum of care aimed at providing people with a more seamless approach to care and service delivery.

While there is still much work ahead for the HNHB LHIN, its employees and Board of Directors, we are fortunate to have strong relationships and partnerships across our health care system and community. We are dedicated to transformational change and we are committed to working with others through Governance to Governance sessions. We have a collective commitment to do whatever is necessary to improve health care delivery always motivated first and foremost by the people we serve.

We continue to focus on successful outcomes through the delivery of patient-centred care and look ahead to our journey together with the people we serve and our health system partners, always remembering our change statement ***Imagine what we can achieve together…when we care, listen and act***.

The HNHB LHIN Board of Directors

(As of March 31, 2018)

From left to right: William Chopp, Paul Armstrong, Suzanne Belanger-Fontaine, Shelley Moneta, Janine van den Heuvel (Chair), Madhuri Ramakrishnan, Saqib Cheema, Marianne Knight, Dominic Ventresca, Bill Thompson(Vice Chair)

Janine van den Heuvel, Chair
Appointed: June 30, 2016 Term: 3 years
Appointed: Chair: March 22, 2017

Bill Thompson, Vice Chair
Appointed: May 13, 2015 Term: 3 years
Appointed Vice Chair: April 26, 2017

Dominic Ventresca
Appointed: May 27, 2015 Term: 3 years

Madhuri Ramakrishnan
Appointed: February 24, 2016 Term: 3 years

Paul Armstrong
Appointed: November 28, 2016 Term: 3 years

William Chopp
Appointed: March 1, 2017 Term: 3 years

Shelley Moneta
Appointed: July 11, 2017 Term: 3 years

Suzanne Belanger-Fontaine
Appointed: September 20, 2017 Term: 3 years

Marianne Knight
Appointed: November 1, 2017 Term: 3 years

Saqib Cheema
Appointed: February 2, 2017 Term: 3 years

HNHB LHIN Introduction and Profile

Population

Demographics

At approximately 6,474 km^2 in size the HNHB LHIN includes both rural and urban areas, is home to approximately 1.4 million people (10.4% of Ontario's population) and is projected to grow by 10.0% over the next 10 years *(Source: 2016 Census of Canada, Statistics Canada; Population Estimates [2017, 2025], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Extracted [April 2018]).*

Figure 1 – HNHB LHIN Map

Socio-Demographic Characteristics

A microcosm is described as a community, place, or situation regarded as encapsulating in miniature the characteristics of something much larger (*Source: English Oxford Living Dictionaries https://en.oxforddictionaries.com/definition/microcosm*) and the based on that definition the HNHB LHIN could aptly be described as a microcosm of the province of Ontario. The communities and regions within the HNHB LHIN are diverse. The populations are represented by individuals of different ages, cultural and ethnic backgrounds, socio-demographic characteristics and languages.

The LHIN's population is aging - more than 267,000 people age 65 or older live in the LHIN and this number is projected to increase to approximately 365,000 by 2025 – an increase of more than 30%. Among seniors, the largest growth will be those 75 years and older *(Source: 2016 Census of Canada, Statistics Canada; Population Estimates [2017, 2025], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Extracted [April 2018].)*

Approximately 2.1% of the LHIN population identifies as Francophone with nearly 78.3% of these people residing in Hamilton and Niagara. Welland and Port Colborne (in the Niagara region) have the highest Francophone population compared to the overall population among communities within the LHIN *(Source: 2016 Census of Canada, Statistics Canada).*

There are two First Nations reserves in the HNHB LHIN – Six Nations of the Grand River Territory – which has the largest population of all First Nation communities in Canada – and Mississaugas of the New Credit First Nation. Approximately 2.7% of the total HNHB LHIN population identify as Indigenous. *(Source: 2016 Census of Canada, Statistics Canada).*

While the HNHB LHIN has a lower percentage of immigrants (19%) and visible minorities (13%) than the Ontario average, this is increasing. At a sub-region level, Hamilton and Niagara make up 75% of the percentage of immigrants and visible minority growth while Burlington makes up an additional 15%. The top five countries from which the HNHB LHIN is receiving immigrants are the Philippines, India, Europe, China and Syria. *(Source: National Household Survey, Statistics Canada, 2016).* For 17% of residents, neither English nor French is their first language.

In many ways, the LHIN population is similar to the provincial population on a variety of socio-demographic characteristics; however, there are some significant differences between and within geographic regions within the LHIN. While HNHB LHIN has a similar population proportion of low-income families as Ontario, the rates of low income are higher than the provincial average in Hamilton and Niagara (15.3% and 15.8% respectively). Compared to the Ontario average, HNHB LHIN has a higher percentage of lone parent families and a lower percentage of adults with high school and post-secondary education.

Figure 2 – HNHB LHIN Socio-Demographic Characteristics

Socio-Demographic Characteristic	HNHB LHIN	Ontario
Total Population (2016)	1,399,080	13,448,494
Senior population, age 65+ (2016)	19.1%	16.7%
Population who report English as their mother tongue	81.1%	69.5%
Population who report French as their mother tongue	2.1%	4.3%
Population who are immigrants	19.7%	29.1%
Populations who are visible minorities	13.1%	29.3%
Population reporting Indigenous identity	2.7%	2.8%
Unemployment rate	6.8%	7.4%
% Population living below low income measure	13.5%	14.4%
Population (age 25-64) with completed post-secondary education	61.8%	65.1%

Sources: 2016 Census of Canada and 2011 National Household Survey, Statistics Canada.

Health Status

Health can be measured as perceived or self-reported indicators and/or the presence or absence of disease or injury. Self-reported health can show aspects of health not captured in other measures. A substantial amount, 17% of HNHB LHIN residents, rate their health as 'fair' or 'poor' which is higher than Ontario's rates. *(Source: Health Care Experience Survey Results January 2014 to March 2017, Health Analytics Branch, 2017).*

Illness, Disease and Death

HNHB LHIN residents have a statistically higher prevalence of arthritis and a slightly higher prevalence of cancer, chronic obstructive pulmonary disease, high blood pressure and heart disease compared to the province. Many residents living within the HNHB LHIN have been diagnosed with one or more health issues; self-reported prevalence of residents with one or more and two or more chronic conditions is statistically higher in the HNHB LHIN compared to Ontario *(Source: Statistics Canada, Canadian Community Health Survey, 2015-16).*

Death rates reflect the overall health of the population. Malignant neoplasms (cancers), circulatory diseases, ischaemic heart diseases, respiratory diseases (excluding infectious and parasitic diseases) and lung cancer were the top five leading causes of death within HNHB LHIN. Potential years of life lost rates reflect deaths that occur "prematurely" (i.e. before age 75). The rate of potential years of life lost within HNHB LHIN is 20% higher than the provincial rate *(Source: Buajitti E, Watson T, Kornas K, Bornbaum C, Henry D, Rosella LC. Ontario atlas of adult mortality, 1992-2015: Trends in Local Health Integration Networks. Toronto, ON: Population Health Analytics Lab; 2018).*

Health Practices and Preventive Care

Poor health practices such as physical inactivity or poor dietary habits may increase the risk of chronic disease, disability and death. The rates of daily/occasional smoking are 18.9% in the HNHB LHIN, higher than the provincial average of 16.7%. However, the rates vary within the LHIN from 19.7% in Burlington to 26.0% in Brant region. Relative to the province, more people across the HNHB LHIN report being overweight or obese. In 2015-16, there was a slightly higher percentage of adults within the HNHB LHIN reporting heavy alcohol consumption compared to the provincial average. *(Source: For LHIN combined information - Statistics Canada, Canadian Community Health Survey, 2015-16; for LHIN Sub-Region information - Statistics Canada, Canadian Community Health Survey, 2011-14 combined file).*

Activities that promote health, prevent disease and reduce the risk of injury are important elements in the health and wellness of a population. These activities require individuals to be engaged in their health care and can be facilitated through an effective relationship with a primary physician. More than 93% of adults living in HNHB LHIN reported having a primary care provider, which is higher than the Ontario rate. Preventive health care services such as immunizations and regular health screenings can help prevent and find disease early and reduce illness and death over the long-term. *(Source: Health Care Experience Survey Results January 2014 to March 2017, Health Analytics Branch, 2017; Statistics Canada, Canadian Community Health Survey, 2015-16).*

Summary

Relative to Ontario, the HNHB LHIN has a higher rate of residents who:

- report health as ‘fair’ or ‘poor’ (as opposed to ‘excellent’ or ‘good’),
- are overweight or obese,
- smoke on occasion or daily basis,
- are heavy drinkers,
- have a chronic condition or multiple chronic conditions,
- are diagnosed with arthritis,
- are diagnosed with high blood pressure,
- are diagnosed with heart disease

Health Service Providers and Service Provider Organizations

As of April 1, 2017, the HNHB LHIN held 188 Service Accountability Agreements with health service providers, funding them to deliver health care services within the LHIN. This included nine hospital corporations, 86 long-term care homes and 93 community support service agencies. After transition on May 9, 2017 the HNHB LHIN assumed contracts with 11 Service Provider Organizations. Staff at these Service Provider Organizations delivers home care services to people living across the HNHB LHIN.

Ministry and LHIN Initiatives

Transparency and Public Accountability

Transparency and accountability are two of the HNHB LHIN's organizational values. These values are operationalized by the HNHB LHIN staff and board through policies and practices that enable effective governance, performance management, risk management, and responsible use of resources.

Performance Management

The 2015-18 Ministry-LHIN Accountability Agreement (MLAA) includes 14 local health system performance indicators, eight monitoring indicators and two developmental indicators. These indicators form the core metrics for performance management within the LHIN, and focus on home and community care, system integration and access, health and wellness of Ontarians and sustainability and quality.

The Performance Accountability Policy outlines principles to guide performance management and sets out a clear relationship between the LHIN and health service providers, the role of governance in performance improvement, and identifies the steps to address performance challenges.

Performance management helps answer key questions related to effectiveness, efficiency and quality in the health system:

- Effectiveness: Are health service providers delivering what they're supposed to be delivering?
- Efficiency: Are health service providers delivering services as efficiently as possible?
- Quality: Are there things other health service providers can do better?

The LHIN continues to focus on six measures as priority indicators:

- wait time for home care services for patients in the community,
- emergency department length of stay for complex patients,
- the rate of patients waiting for an alternate level of care,
- the percentage of patients who return to the emergency department for mental health conditions,
- the percentage of patients who return to the emergency department for substance abuse conditions, and
- the percentage of patients who are readmitted to hospital with certain chronic conditions.

Throughout 2017-18, the LHIN engaged regularly with hospitals regarding performance on these priority indicators. A Performance Indicator Action Plan was in place for six out of nine HNHB LHIN hospitals as their performance on priority indicators varied significantly from provincial targets and they were not demonstrating improvement. The hospitals continued work on their Performance Indicator Action Plan for select indicators, as per Article 9.0 of the Hospital Service Accountability Agreement. A total of seven performance indicators across the six hospitals were selected for the Performance Indicator Action Plans.

In 2017-18 the Hospital Service Accountability Agreement in the HNHB LHIN required all hospitals to 'actively strive to meet the targets for health system performance indicators and engage in activities that

include LHIN-wide initiatives, which result in demonstrated improving performance trends on relevant system-level indicators.' Hospitals were also required to report quarterly on the progress made on their Performance Indicator Action Plan. Hospitals within HNHB LHIN have engaged in a variety of activities to work to improve performance on the identified indicators. These activities have resulted in improved performance on some indicators. Notably, Joseph Brant Hospital outperformed the provincial target for the Alternate Level of Care rate indicator in six out of the last eight quarters. This was considerably better than the results from 2015-16.

There were also improvements in the access to hip and knee replacement surgeries in select hospitals, including Brant Community Health System and Joseph Brant Hospital. In fact, performance at Joseph Brant Hospital increased more than 20%. The most recent data also suggests some improvements in the percentage of repeat emergency department visits for patients with substance abuse conditions at Hamilton Health Sciences.

The HNHB LHIN and its Service Provider Organizations are committed to our patients and ensuring quality home care services. The LHIN engages Service Provider Organizations regularly to review organizational performance on several key indicators, including: Referral Acceptance Rate, Overall Satisfaction, Satisfaction with Continuity, Patient-Centred Care Appointments, Discharge Reports, Missed Care and 5-Day Wait Times.

The HNHB LHIN monitors closely the key performance indicators of all Service Provider Organizations on a quarterly basis and more frequently as needed. All 14 LHINs have a common Contract Management Framework (2016) that was built on four elements: measure, monitor, report and manage. The framework identifies and guides the escalating steps LHINs might take in response to Service Provider Organizations that fail to meet targets on key indicators.

One of the tools LHINs can use to manage performance under the Contract Management Framework is to issue a Quality Improvement Notice. Quality Improvement Notices may be issued for missed targets on any key performance indicator. The Quality Improvement Notice serves as written notice of the performance issue or concern and provides assurance that the SPO will follow up on the concern with a detailed action plan. Progress on the Quality Improvement Notice is monitored quarterly. When a Service Provider Organization resolves the performance issue or concern and meets target for consecutive quarters, the Quality Improvement Notice is considered closed. One Service Provider Organization recently worked to improve the rate of missed care and returned to meeting the target of 0.05-0.04% through revisions of internal business processes and the creation of an on-call team.

In addition to the quarterly meetings, issue and/or patient specific meetings are held between the HNHB LHIN and Service Provider Organizations following significant complaints or adverse events. Service Provider Organizations participate in quality and safety reviews as required. Quality and safety reviews ensure that the HNHB LHIN and Service Provider Organizations learn from complaints or adverse events and make changes and improvements for the people we serve. One such improvement from 2017-18 is the introduction of a checklist to ensure a safe and smooth transition from hospital to the community for palliative patients.

Enterprise Risk Management

An Enterprise Risk Management (ERM) approach is used to identify, assess, mitigate and communicate key risks in the LHIN. Key elements of ERM include:

- identifying potential risks – the responsibility of employees at all levels of the organization,
- monitoring strategic, operational, financial and reputational risk of the health service providers and the LHIN, and
- mitigating and managing risk to remove or reduce the impact or consequences on individuals and organizations.

The HNHB LHIN utilizes a methodology to rank agency risk on a quarterly basis to assess compliance with service accountability agreements, key performance indicators, data quality and core financial indicators. The number and complexity of health service providers across the LHIN requires prioritization based on identified risks.

LHIN staff reports risks to the Quality and Safety Committee of the Board and the ministry regularly. Monitoring organizational risk is one way LHINs work to ensure value for money as well as assess and ensure access to services and access to the best patient care for the people and their families served by the HNHB LHIN.

Health System Commissioners

Ensuring accessible, high quality, patient-centered services that also reflect value for money is a key strategic priority for the HNHB LHIN. This focus is aligned with the Institute for Healthcare Improvement's Triple Aim[1] statement which recommends that health care organizations focus on improving the health of populations, enhancing the experience of care and reducing costs per capita.

In response to this priority, the HNHB LHIN has been adopting commissioning best-practices to inform funding and resource allocation decisions. Commissioning consists of assessing population needs, identifying available resources, prioritizing health and quality outcomes and procuring products and services and funding bundles of services.

In 2017-18, the HNHB LHIN further developed its role as health system commissioners focusing on quality, volume, price, enterprise risk management and accountability. The creation of sub-regions provided new opportunities for the LHIN to apply the tenets of commissioning at a more local level while ensuring alignment with government priorities and objectives. While there have been various examples of 2017-18 funding decisions that demonstrate commissioning in action; one example is the identification of core services for Mental Health and Addictions, assessment of what services exist in each sub-region and funding decisions to augment existing services or support new programs based on population need. A second example is the allocation of supportive housing services within the HNHB LHIN - in collaboration with providers, staff identified the best possible location for new units based on unmet need, availability of housing units and capacity among service providers.

[1] Feeley, D. (2017). *The triple aim or quadruple aim: Four points to help set your strategy*. http://www.ihi.org/communities/blogs/the-triple-aim-or-the-quadruple-aim-four-points-to-help-set-your-strategy

Improving the Patient Experience

Creating a positive health care experience for people is critically important to the HNHB LHIN and its health service providers. An individual's perception of their health care experience is influenced by all aspects of that care and service.

In 2017-18, the HNHB LHIN once again included an obligation related to patient experience in all Service Accountability Agreements. The obligation required providers to collect and report information regarding two aspects of patient experience: overall satisfaction with the care and services received, and involvement in care decisions. While this helped to create a shared focus on patient experience and gather data about patient experience across the LHIN, ultimately the goal is to improve patients' experiences.

In June 2017, health service providers reported data from the prior fiscal year and 96% of the 188 health service providers submitted a Patient Experience Indicator Survey for 2016-17 (April 1, 2016-March 31, 2017). Based on the two aspects of patient care outlined above, 89.4% of respondents replied favourably to questions about overall satisfaction, and 87.8% of respondents replied favourably that they had been involved in decisions regarding their care. While these results are acceptable, there is clearly room to improve.

In 2017-18, the HNHB LHIN focused on patient experience and noted progress in the percentage of home care clients who responded "Good", "Very Good "or "Excellent" on a five-point scale to client experience survey questions related to overall services, management/handling of care by a care coordinator or service provided by a service provider. To ensure patient experience remains a focus for staff, it will be a prominent indicator within the HNHB LHIN's 2018-19 Quality Improvement Plan.

System-wide Quality Improvement

The HNHB LHIN is committed to dramatically improving the patient experience through embedding a culture of quality throughout the organization and health care system. While significant work has been achieved together by the LHIN and its health service providers, Service Provider Organizations and partners to build quality and engage in quality improvement initiatives, it is important this continues as a strategic direction. A culture of always seeking opportunities to enhance the care experience, health outcomes and system performance has been fostered within the HNHB LHIN and examples of these initiatives are provided throughout this annual report.

The Regional Quality Table continues to inform the quality agenda within the LHIN, support communication and its members act as ambassadors within the various sectors. In 2017-18, the Regional Quality Table focused on continuing education related to quality and patient experience through patient stories, gaining an increased understanding of system-wide performance metrics and aligning quality improvement efforts within sectors, sub-regions and/or across the LHIN.

Quality Obligations

In 2017-18, health service providers from all sectors were required to develop and submit quality improvement plans to the HNHB LHIN. Quality improvement plans outline goals and initiatives to improve health outcomes and the care experience for patients, clients, and residents.

Health Quality Ontario continues to support the quality improvement plan development by providing LHINs with snapshots of those quality improvement plans submitted directly to Health Quality Ontario. All quality improvement plans received were studied by LHIN staff and common themes were identified. The review confirmed that health service providers continue to have clear quality plans with identified improvement initiatives and measures. As a result, the HNHB LHIN maintains confidence in health service providers that creating and sustaining a culture of quality improvement continues to be top of mind.

Moving forward as we focus on sub-regions, the HNHB LHIN will continue to engage health service providers with respect to their quality plans to ensure people receive accessible, integrated, consistent, high quality care.

In 2017-18, the HNHB LHIN created its own quality improvement plan focused on four indicators related to the delivery of home and community care.

- 5 Day Wait Time for Personal Support Worker Services
- 5 Day Wait Time for Nursing Services
- Patient Experience, and
- Patient Falls.

In 2017-18, HNHB LHIN made progress with the percentage of home care clients who responded "Good", "Very Good" or "Excellent" to client experience survey questions related to overall services, management/handling of care by a care coordinator or service provided by service provider. In addition, there was progress on improving 5 Day Wait Times for Nursing Services.

Build Healthy Communities Informed by Population Health Planning

Sub-Regions

Formed in 2017-18, sub-regions are smaller geographic areas within a LHIN that enable health and social service planners and providers to better identify and respond to the needs of local communities, ensuring people are able to access the care they need, when and where they need it. The HNHB LHIN has six sub-regions: Burlington, Hamilton, Brant, Haldimand Norfolk, Niagara and Niagara North West.

At the sub-region level, the HNHB LHIN is collaborating with local health and social services providers on innovative ways to improve the well-being of communities, neighbourhoods and individuals. Utilizing a population-based planning approach and focusing on health equity has helped to identify system gaps and duplication, identify opportunities for integration and ensure programs and services are meeting the unique needs of each community.

This includes strengthening the role of patients and families in planning for their own health care needs and increasing the focus on cultural sensitivity in the delivery of health care services to Indigenous Peoples, French-speaking people, newcomers and other marginalized populations.

2017-18 Sub-region Key Accomplishments

- Bringing people with lived experience together with health and social services providers to build a culture of trust, respect and shared responsibility to enable transformative change.

- Recruitment of four sub-region directors (one sub-region Director was identified for the Niagara and Niagara North West sub-regions, and one for the Brant and Haldimand Norfolk sub-regions) to lead the local work for population-based planning, service alignment and integration and performance improvement across their sub-region.

- Recruitment of six sub-region Clinical Leads who work with the sub-region Directors and Primary Care to understand the needs of their local populations and the people in the sub-region in order to develop a more integrated network of care for each sub-region.
- With input from patients, LHIN-funded and non-LHIN funded partners, *Anchor Tables* have been formed in each sub-region to:

    - assess local population health needs, patient access and wait times, and the capacity of health providers to serve the community;
    - identify and implement priorities for sub-region collaborative initiatives to address gaps and improve patient experience and outcomes;
    - create opportunities for providers and patients to interact and provide input into integrated health system plans; and,
    - engage Indigenous and Francophone populations to ensure diverse voices are heard across sub-regions.

Anchor Table members identified their local needs and priorities ensuring they aligned with ministry and LHIN priorities and from there *Action Tables* were created to action the priorities. The Action Tables were tasked with innovating, redesigning and testing ideas quickly with targeted neighbourhoods,

communities, stakeholders and providers. For example, each Anchor Table identified Mental Health and Addictions as a priority, therefore each sub-region formed a mental health and addictions Action Table to define local sub-region priorities and begin to implement innovation and change. Leveraging an eight-step framework for process change, sub-region planning included a number of initiatives that brought services, providers, organizations and ministries together in a new and integrative way to address identified health gaps and improve patient experience and health outcomes.

Additional sub-region activities completed in 2017-18 include:

- completion of an HNHB sub-region framework and structure;
- facilitation and support of integrative partnerships and funding proposal development;
- recruitment of sub-region Health Links transformative teams; and,
- allocation of community investment funding in all sub-regions to support locally developed mental health and addictions initiatives.

Sub-Region Planning with Indigenous Partners/Engaging Communities

All sub-region Directors have completed Ontario's Indigenous Cultural Safety Training to better understand and mitigate the impacts associated with systemic racism through improved knowledge and awareness. At the sub-region Anchor Tables, members of the Indigenous Health Network (IHN) have an equal voice and identify opportunities for improvement at the local level. Regular connections with the IHN will continue to be a key priority for future sub-region planning. Most recently, a mapping session was conducted from the perspective of Indigenous Peoples and health service providers who serve those living with addictions. That work will help inform the LHIN's future Addictions Strategy. The practice of planning together across sub-regions will further strengthen relationships and ensure the LHIN is addressing the diverse needs of Indigenous populations.

Public Health

Public Health is an essential partner in population health planning. In 2017-18, the LHIN strengthened its relationship with its five public health units through the establishment of a HNHB Public Health Steering Committee to advance ongoing collaboration. The Committee includes representation from each public health unit and LHIN leadership and has established a set of common definitions to guide collaboration.

Health Links

The Health Links Model of Care, introduced as a key commitment in the ministry's 2012 *Action Plan for Health Care*, was designed to address patient-centred goals and needs, through meaningful engagement and collaborative, coordinated care planning. Health Links will transform the health care system by increasing access to integrated, quality services for Ontario's patient population living with chronic conditions and complex needs.

Health Links is the foundation for the HNHB LHIN sub-regions, along with Primary Care and Home and Community Care reforms. In 2017-18, the ministry mandated each LHIN to develop and implement a Scale and Spread Plan to ensure the Health Links Model of Care reached a mature state by March 31, 2020 – this

includes aligning and embedding the model within sub-regions. The care coordination, service delivery and integration activities that are central to the Health Links model are foundational to the *Patients First* strategy.

Health Links Feature: Mary's Story

Pre-Health Links Support

When Mary began working with her local provider utilizing the Health Link Model of Care, she had already been receiving frequent acute care for polysubstance abuse including high emergency department use dating back to 2010. She also had increasing hospital admissions for serious infections related to drug use: cellulitis, abscesses, and endocarditis. Mary had been homeless for the past two years after being evicted from an apartment. She used local women's shelters but services were frequently restricted as a result of not following rules. Prior legal involvement included a jail sentence and probation period, and the two years she was given to complete a court-ordered anger management class or return to custody was coming to a close.

Mary has a significant history of trauma, suffering multiple losses including the loss of custody of her child in 2009. She has been diagnosed with a personality disorder, chronic anxiety and depression along with polysubstance use disorder. Trust is a challenge for Mary; she anticipates rejection then acts out when this fear is realized. When Health Link first began working with Mary, her behaviour could be described as brusque or intimidating.

Post-Health Links Support

The important first step with Mary was to develop a trusting relationship. Once established that we were able to engage those providers supporting her in daily life and together a care plan to address Mary's needs was developed. Mary's care plan involved a spectrum of services including inpatient and outpatient acute care, primary health care and social and legal services. Previously working in silos, the Health Links model brought the various providers together to coordinate one plan for Mary.

Regarding Mary's drug use, it was important to invite and engage her directly to gather information, better understand her wants and needs and meet Mary where she was in her journey before initiating the developed care plan. While Mary declined to entertain any conversation about stopping her drug use (she challenged inpatient providers who recommended abstinence-based treatments), she was open to thinking about harm reduction. Mary's care coordinator was able to step in to ensure Mary's care plan included harm reduction as her preferred approach to manager her drug use. The care coordinator also helped facilitate communication with Mary's other care providers by conferring with them about Mary's wishes for her care. [2] Including Mary in her own care planning with her providers is the Health Links model in action.

[2] Patient story summary was taken from a recent spotlight in Health Quality Ontario's Health Links Quarterly Report for the Period of October 1 to December 31, 2017. To honour Mary's privacy a composite stock photo has been used.

Scale and Spread of the Health Links Model of Care

The HNHB LHIN sub-region Directors along with Health Link lead organizations developed an action plan to scale and spread the Health Links Model of Care. The approach has been driven at the LHIN-level and sub-region levels and is focused on system level changes and model adoption at the front line.

The plan includes:

- System redesign and integration (both sub-region specific and LHIN-wide), including embedding care coordination into primary care;
- Implementation of Health Quality Ontario's innovative practices;
- Capacity building and skills development through training, education, coaching and mentoring:
- Transition of coordinated care plans into the LHIN's *Client Health & Related Information System* and the on-boarding of external providers to the digital e-solution;
- E-solutions for enhanced data and performance management; and,
- Stakeholder engagement, communication and change management.

One of the most demonstrable changes related to scale and spread of the model will be transitioning patient care plans into Client Health and Related Information System. Once achieved care plans will be available to members of the patient's care team for viewing and updating. Planning for the transition to the Client Health and Related Information System has been initiated and will include the migration of existing care plans while adding new external providers to the Client Health and Related Information System for Health Links coordinated care planning.

To implement the Health Links Scale and Spread Plan, an oversight committee structure is in place and Transformation Teams are being established to build on the existing foundation and achievements over the past four years while driving the local implementation of key deliverables within the sub-regions. LHIN-wide roles are supporting priority populations and sectors including Palliative Care, Indigenous Care and Care Coordination. Health Links Action Tables are being established in each sub-region with membership from diverse sectors to direct and guide the local engagement activities to drive the scale and spread, and embed the Model of Care within the delivery of programs and services to achieve the ministry's March 31, 2020 maturity model deadline.

Coordinated Care Planning

As of March 31, 2018 more than 1,100 new coordinated care plans have been implemented in the LHIN for patients living with chronic conditions and complex needs using the Health Links Model of Care. A total of 13 unique organizations are engaged in the Health Links Model of Care within HNHB LHIN, with continued plans to scale and spread to new organizations across multiple sectors.

HNHB LHIN has been tracking the outcomes of those patients with a coordinated care plan and continues to see significant reductions in health system utilization. The following 2017-18 Q2 outcomes for key performance indicators demonstrate the reduction in utilization for patients, when comparing 12 months pre and post-care plan development:

- Number of ED Visits – 23% reduction

- Number of Hospital Admissions – 37% reduction
- Number of Hospitalizations for Ambulatory Care Sensitive Conditions – 21% reduction
- Number of Hospital Readmissions 30 days Post-Discharge – 39% reduction

While there is certainly room for improvement, these results do point to an improved patient experience and a more patients' first approach to care for the people we serve.

Equity, Quality Improvement, Consistency and Outcomes Based Delivery

Equity and Health and Wellness of the Population

Poor health practices such as physical inactivity or poor dietary habits have a negative impact on the health and wellness of individuals and communities. Population health planning is crucial in acknowledging the impact of social determinants of health (for example, income, social status, employment and social and physical environments) have on one's capacity to engage in positive personal health practices. While health inequities result in a lower quality of health care, worse health outcomes for some population groups and increased direct and indirect health care costs, an equitable health care system provides good access, experience and outcomes for everyone, incorporating all the dimensions of quality.

The HNHB LHIN has continued its commitment to address health disparities and embed health equity into population health planning at both the LHIN and sub-region levels, while applying a health equity lens to all LHIN planning, funding and integration activities. Embedding health equity into programs and services helps ensure people get the resources they need in order to achieve their optimal level of health.

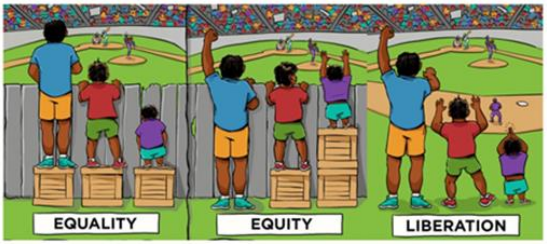
Recognizing the inequity experienced by Indigenous Peoples, Francophone Ontarians and other marginalized populations, the LHIN strengthened relationships and planning structures throughout 2017-18 to work toward improved outcomes related to health equity. Specific activities related to these populations are described in the Indigenous Peoples and French Language Services sections to come.

Health Equity Impact Assessment

The World Health Organization (WHO) has emphasized that one of the most efficient ways of 'closing the equity gap' within a population is to address the health care needs of those who are most disadvantaged.[3] The Health Equity Impact Assessment (HEIA) is a ministry-developed decision support tool that leads users through the steps of identifying how a program, policy or similar initiative will impact population groups in different ways.[4] The tool provides a systematic method to embed equity in planning and decision-making in order to reduce health inequities. The end goal is to maximize positive impacts and reduce negative ones that could potentially widen health disparities between population groups enabling more equitable delivery of the program, service or policy. It can also be used to build capacity and raise awareness about health equity throughout organizations.

[3] Commission on Social Determinants of Health. Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008.
[4] Ministry of Health and Long-Term Care (2008). Health Equity Impact Assessment. Accessed from http://www.health.gov.on.ca/en/pro/programs/heia/

The completion of the HEIA is an HNHB LHIN requirement for Voluntary Integration submissions and Stage 1 Capital Proposals. To further emphasize the importance of equity assessment in all stages of planning, it became an expectation in 2017-18 that an assessment of health equity be a standard component of all LHIN activities including planning, program development, integrations, capital projects, business cases and funding decisions. For example, each mental health and addictions proposal put forward for 2017-18 funding (described further in the Mental Health and Addictions section of this report) needed to have a HEIA submitted, which meant health service providers needed to reflect on equity considerations in their proposals. This made for a focus on providing mental health and addictions funding for services which would support people who may have experienced barriers to access in the past.



Health and Equity through Advocacy, Research and Theatre (HEART)

In 2016, the *Health and Equity through Advocacy, Research and Theatre* (HEART) initiative, led by students from McMaster University, combined participatory action research, public advocacy and research-based 'legislative' theatre to understand issues of health equity faced by homeless individuals in Niagara. This work shone the light on areas for social inclusion and policy reform. The findings and recommendations of the HEART initiative in Niagara were summarized in a policy paper and study results included in several publications. [5]

In 2017-18, the LHIN participated in the expansion of HEART into Hamilton. Members of the local homeless community, health care providers and students were invited to observe, participate and reflect on the theatre production, offering a unique opportunity to engage with people with lived experience and gather their input on the design of health care services and health policy.

HEART represents an innovative approach to embedding equity into health policy-making by direct engagement of population groups with lived experience of health inequities and learnings from the initiative are being integrated into elements of the curriculum at Michael G. DeGroote School of Medicine at McMaster University.

Indigenous Peoples

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. The LHIN is

[5] Hossain et al. 2016. Healthcare First: Improving access to healthcare for the homeless and vulnerably housed in Niagara. Accessed from http://www.niagaraknowledgeexchange.com/wp-content/uploads/sites/2/2017/07/HEART-Healthcare-First-2nd-Ed.pdf

focused on identifying new approaches to care that are culturally appropriate and delivered in safe settings where Indigenous and mainstream providers work together with 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 are responsive to community needs and reflect Indigenous ways of doing, being and healing.

During 2017-18, HNBH LHIN continued to advance existing action plans and initiatives while identifying new areas of priority through the inclusion of First Nation communities, Indigenous health care providers and community members in planning and engagement activities. Key priorities arising from engagement and inclusion activities are strengthened by what would positively impact the interactions, transitions and experiences of Indigenous Peoples accessing the health care system.

HNHB LHIN collaborates directly with Six Nations of the Grand River Territory, Mississauga's of the New Credit First Nation and Indigenous health service organizations, and collectively through the HNHB LHIN Indigenous Health Network (IHN). The IHN gathers approximately 10 times each year to strengthen the voice of Indigenous communities and provide essential advice and direction on local health care priorities, planning and service delivery. In 2017-18, the LHIN and IHN continued to advance the priorities identified in the IHN's 2015-2018 Strategic Plan which include the following:

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

To support these priorities in 2017-18, the LHIN engaged in various activities including:

- November 2017 - the IHN endorsed five Indigenous health care workers to complete Tolerance Scale Facilitator Training hosted by Ontario's Indigenous Cultural Safety (ICS) Program. Through this training, employees 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.
- An Indigenous Addiction Services Mapping session was completed with participation from two First Nations and five Indigenous health care providers including both LHIN-funded and non-LHIN funded organizations. Feedback from this session identified areas for opportunity such as the need for centralized intake processes, support for individuals transitioning between programs and also those transitioning between on and off reserve, harm reduction strategies and peer support. This feedback will contribute to new approaches aimed at improving access to addictions services for Indigenous Peoples across HNHB.
- To inform the LHIN's plan to deliver equitable access to high quality hospice palliative care and support for First Nations and urban Indigenous Peoples, the HNHB IHN and the HNHB Regional Palliative Care Network (RPCN) partnered to host a community engagement gathering in November 2017. The gathering focused on sharing experiences of palliative care from the perspective of Indigenous communities, families and individuals and was attended by approximately 140 individuals including community members and health care providers coming

together to listen, learn and share their stories. While participants identified positive experiences such as supportive staff, dignified care, smooth transitions, they also shared the not so good experiences such as lack of culturally based supports, an end-of-life care plan that resulted in a death in hospital instead of at home and poor communication with family members. Key learnings from the day highlighted that each individual's palliative care journey is unique and does not always follow the same path. Therefore, the health care system should be designed to support each person to choose their own journey.

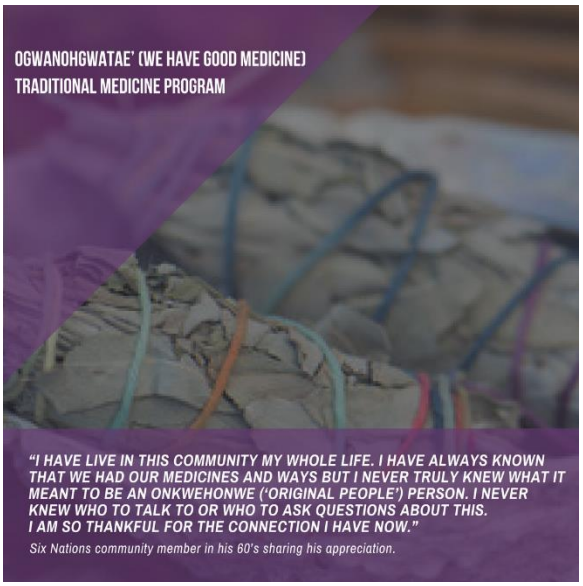
Cultural Safety Training

Ontario's Indigenous Cultural Safety (ICS) training is founded in principles of respect, safety and trust, offering an interactive environment for health care professionals to expand their knowledge of Canada and Ontario's Indigenous Peoples. ICS training increases self-awareness of culture and develops skills to work more effectively with Indigenous peoples. ICS training helps mitigate the impacts of systemic racism by improving communication between health service providers and Indigenous patients and families.

During 2017-18, the LHIN supported access to ICS training for 539 individuals. Since the 2014 launch of ICS training, 1,213 health care workers from 70 different organizations throughout HNHB LHIN have participated in the program. In February 2018, a group of LHIN VPs and Sub-region Directors participated in Six Nation's *Our Hodi: nohshoni: Way of Life Training* to advance the LHIN's understanding of local community cultures and its influences on health and wellness.

Traditional Medicine

Through ongoing outreach efforts and word of mouth in the community, awareness and understanding of Six Nations Ogwanohgwatae:' (We Have Good Medicine), Traditional Medicine Program continues to grow. Between April and December 2017, the Traditional Medicine Program provided 168 individuals with access to Traditional healing services through 618 visits and 194 ceremonial visits. Beginning with health care providers working on Six Nations of the Grand River, a referral protocol was developed and implemented to build clear pathways for community access to Traditional medicine.



Mental Health and Addictions

In the fall of 2017, HNHB LHIN facilitated sub-region planning focused on the development of integrated approaches to provide addictions services that would improve access for individuals living with substance related issues. Six Nations Health Services and Brant Community Healthcare System partnered to co-design and co-develop a model of care that would embed Addictions workers in Brantford General Hospital's Emergency Department. The planning, development and initiation phase for this model of care was completed in 2017-18 and will be operational in 2018-19.

Sub-region Planning with Indigenous Partners/Engaging Communities

Guided by the direction of the Indigenous Health Network (IHN) and local First Nations community health service providers, 2017-18 planning and decision-making across all HNHB LHIN sub-regions included Indigenous partners, The LHIN implemented an inclusion strategy whereby Indigenous representative(s) nominated by the IHN and local First Nations have become members of each sub-region Anchor Table.

Anchor Table members have a leadership role in identifying sub-region planning priorities, and all Table members are working together to ensure the health and wellness of Indigenous Peoples is interwoven throughout all priorities. To support communication and connections across all sub-regions, the IHN, local First Nations and the LHIN met on a quarterly basis to discuss progress in each sub-region, sharing overarching priorities, identifying gaps or supporting all partners to move forward together in a positive way.

HNHB LHIN acknowledges and recognizes the unique health care experience of First Nations Peoples living on reserve, and continues to work alongside local First Nations communities to identify where the

LHIN can be a partner in supporting equitable access to health services within and surrounding these communities.

French Language Services

According to the 2016 Census, French-speaking individuals represent 2.3% of the HNHB LHIN population.

The *French Language Services Act 1990 (FLSA)* outlines the provincial requirement of providing services in French. HNHB LHIN must comply as a crown agency ensuring that services provided directly to the public, including home and community care, are done so in accordance with this legislation.

Across the HNHB LHIN, there are two *designated* health service providers within HNHB LHIN - Foyer Richelieu (long-term care home in Welland) and Centre de Santé Communautaire (a community health centre with sites in Welland and Hamilton) and 33 *identified* health service providers or programs including four hospitals, eight mental health and addictions agencies and one long-term care home.

Designation vs. Identified

Designation	Being Identified
Required to offer French language health services just as a ministry would	
Designation is a voluntary act by the agencies	Process used by MOHLTC or LHINs to identify a service provider that will be responsible to offer French health services
Signifies their engagement within the Francophone community	May still move towards a designated status under the Act

Francophone Health Engagement

The local French Language Health Planning Entité (FLHPE) for HNHB and Waterloo-Wellington (Entité 2) works collaboratively with the two LHINs to ensure a Francophone view is included in the planning and integration of health services in each LHIN area. As part of its ongoing engagement, the HNHB LHIN and FLHPE meet regularly throughout the year.

A joint FLHPE Action Plan is focused on key priority areas of health service delivery. The FLHPE engages the Francophone community on key health priorities and provides feedback to the LHINs. In June 2017, the FLHPE released a report to inform the LHIN on the results, analysis and recommendations regarding access to services from a Francophone immigrant perspective. The results were based on an online survey and highlighted some key characteristics and challenges which will be used by the LHIN to better plan for the health needs of the Francophone population.

Engaging with Sub-Regions

The HNHB LHIN sub-region Anchor Tables consider the needs of the Francophone population through the lens of health equity and population-based health and social service needs. French Language Services (FLS) providers and the FLHPE have been engaged in the Hamilton, Niagara and Burlington sub-regions.

FLHPE is a member of the Niagara Anchor Table, and the Alzheimer Society of Brant, Haldimand, Norfolk, Hamilton and Halton (ASBHNHH) - an identified agency - sits at the Burlington, Brant and Haldimand-Norfolk Anchor Tables.

The Centre de Santé Communautaire has also been engaged regarding embedding care coordination and system navigation across the health system to ensure that Francophones will be actively offered health services in French.

Francophone Senior Fair in Hamilton

In November 2017, the Fédération des ainés et des retraités francophones de l'Ontario, in collaboration with HNHB LHIN, organized a Francophone seniors' fair in Hamilton (attended by more than 100 seniors) to recruit health service providers offering services in French. FLHPE took this opportunity to engage seniors and collected surveys on access to French Language health services.

The Alzheimer Society, Dr. Bob Kemp Hospice, the Canadian Mental Health Association of Hamilton and the HNHB LHIN presented their services and conducted workshops on various topics such as nutrition and falls prevention.

Rendez-Vous Santé en français (Rendez-Vous)

The Rendez-Vous – the largest national gathering focused on French-language health care – is a three-day event that provides the Rendez-Vous an opportunity to understand issues, identify solutions and provide recommendations for the improved management of French Language health care services at the system level. The November 2017 event was held in Ottawa and brought together more than 375 stakeholders and decision-makers. In association with the Réseau Franco Santé du Sud and the FLHPE, HNHB LHIN developed a poster and presentation outlining their joint initiative - the Health Career Bus.

HNHB LHIN Compliance with the *French Language Services Act (FLSA)*

In 2017-18, HNHB LHIN established an internal Working Group to develop and implement a multi-year plan to achieve compliance with the FLSA. The plan includes key components associated with communication, human resources and home and community care services.

In its first year, the Working Group's plan focused on active offer to increase awareness of the availability of services in French, and ensure the home and community care sector was aware of the linguistic preference of clients. The active offer focus is to establish a mechanism to determine the linguistic identity of all clients from the moment of first contact to ensure Francophone people are receiving the care they need in their first language of choice.

Implementation of the OZi Data Collection Tool

HNHB LHIN is working in collaboration with the Réseau (French Language Health Services Network-RSSFE), the FLHPE and the ministry to collect standard information on FLS using to better plan for the delivery of health services. To support this, RSSFE deployed a tool called OZi throughout Ontario to all LHIN-funded health service providers.

The OZi tool collects data to assess the current FLS capacity of health service providers. The HNHB LHIN has supported the deployment of the tool and will utilize the data collected to inform future health service planning for the Francophone community.

Primary Care

Physician Engagement

Physicians continued play an important role assisting with the planning and implementation of the LHIN's strategies and over the course of 2017-18, six sub-region Clinical Leads were active members on their local Anchor Tables.

Many people in the LHIN struggle with mental health and addiction issues, particularly related to chronic pain and opioid use. The Clinical Leads were key in working to increase awareness of the new opioid prescribing and tapering standards with their primary care colleagues as well as working to ensure they were aware of the related community resources available for their patients.

The LHIN's Vision Steering Committee continued to provide strong leadership for improving vision care across the LHIN. The group began implementation of a LHIN-wide quality study with five ophthalmology hospitals and their ophthalmologist participants. Early results are expected 2018-19.

A central intake assessment process for people in HNHB who are potential candidates for hip and knee replacement surgery was developed. The process was developed through collaboration and partnership with orthopaedic leadership, advice from the sub-region Clinical Leads and most importantly feedback from patients. The new patient-focused intake process is intended to ensure reported wait times more accurately reflect those patients ready for surgery and that patients requiring surgery see a specialist in a more timely fashion. More information on this initiative is detailed in the next section of this report.

Hospitals and Partners

Clinical Program Integration

Orthopaedics and Musculoskeletal (MSK)

Orthopaedic services are provided at five HNHB LHIN hospitals; Joseph Brant Hospital, Hamilton Health Sciences, St. Joseph's Healthcare Hamilton, Niagara Health System, and Brant Community Healthcare System.

As of December 2017, HNHB LHIN had completed nearly 4,000 primary hip and knee total joint replacement (arthroplasty) cases.[6] HNHB LHIN performs the second highest volume of cases within the province, second only to the Toronto Central (TC) LHIN. Together, Toronto Central and HNHB LHINs perform more than a quarter of the province's primary hip and knee total joint replacement surgeries.

In 2017-18, the LHIN focused on measures to reduce wait times and improve the patient experience including:

- Investing in 63 net new primary total joint replacement cases to address the patients that were waiting the longest for a hip or knee replacement
- Approving an in-year reallocation of 77 hip and knee replacement cases for hospitals with the longest wait-times and the capacity to perform additional volumes to ensure the maximum number of volumes were completed by the LHIN in 2017-18.

As referenced earlier in this report (Primary Care: Physician Engagement), one of the greatest areas of focus in orthopaedics in 2017-18 was the scale and spread of the central intake and assessment model for primary hip and knee arthroplasty referrals and low back pain referrals. The MSK Central Intake and Assessment Centre (CIAC) is operated by HHSC with patient assessment centres in Burlington, Niagara, Hamilton and Brantford.

In its first year the MSK CIAC has yielded significant benefits to patients and the system, including providing patients with education about treatment options, individualized treatment recommendations and management plan. It also provides more accurate information with respect to surgeon wait-times. Between April and December 2017-18 the MSK CIAC saw a decrease in the time patients wait for surgery after seeing the orthopedic surgeon – there was a 4% decrease for hip and 15% decrease for knee replacement surgery.[7,8]

[6] Access to Care Informatics, Cancer Care Ontario, Adult Surgery Wait Times and Efficiency Report (December 2017)
[7].7,8 Ibid Access to Care Informatics, Cancer Care Ontario, Adult Surgery Wait Times and Efficiency Report (December 2017)

[8] Ibid

Diagnostic Imaging

Between April and December 2017 HNHB LHIN hospitals completed approximately 55,000 Magnetic Resonance Imaging (MRIs) and 71,000 Computed Tomography (CT) procedures. Median wait times for adult diagnostic imaging procedures remained relatively consistent throughout 2017-18. As of December 31, 2017 the median wait time ranged between 9 to 11 days for CT and 44 to 59 days for MRI.

In an effort to improve patient care and address wait time across the LHIN, a common referral for MRI/CT was implemented in 2017-18.[9]

Ophthalmology

Ophthalmic services including cataract surgery are offered at five HNHB LHIN hospitals: Joseph Brant Hospital, St. Joseph's Healthcare Hamilton, Niagara Health System, Brant Community Healthcare System, and Norfolk General Hospital.

St. Joseph's Healthcare Hamilton's Hamilton Regional Eye Institute supports clinical advances in the investigation, treatment and prevention of visual disorders. In 2017-18, nearly 17,000 routine/unilateral cataract procedures were performed across the HNHB LHIN. The LHIN continued to demonstrate strong performance in terms of surgical wait times in the last fiscal year. Between April and December 2017, surgical wait time targets were achieved in roughly 88% of cases (Wait 2, Priority 2–4 patients).

Strong clinical leadership for ophthalmology is provided by the HNHB LHIN Vision Steering Committee. Major initiatives spearheaded by the committee in 2017-18 included:

- Implementation of a LHIN-wide quality study with participation from each of the five ophthalmic hospitals. The study, a first of its kind within the province, can be used to support future ophthalmology quality initiatives.
- Reallocation of approximately 291 unilateral cataract cases to the hospitals with the longest wait times in the LHIN.
- Engagement of local Chiefs of Ophthalmology to promote improvements to emergency ophthalmic care in the ED.

[9] Access to Care Informatics, Cancer Care Ontario, Adult Surgery Wait Times and Efficiency Report, December 2017

System Capacity and Seamless Transition to Avoid Alternate Level of Care

Restorative Programs to Maintain or Improve Functional Status

In 2017-18, HNHB LHIN focused on rehabilitative care initiatives to improve patient transitions through the health care system by providing access to rehabilitative care in the right place at the right time, and to improve the understanding of referring partners, patients and families on what rehabilitative care is and what to expect.

In 2017-18, LHINs supported a third two-year mandate for the provincial Rehabilitative Care Alliance (RCA) which is working to optimize patient and system outcomes through the integration of rehabilitative care at all levels of health services policy, planning and delivery.

Rehabilitative care initiatives of the LHIN's include:

Seniors Mobile Assess Restore Team (SMART) Model

- Provides seniors experiencing functional decline and/or are at risk of functional decline at their time of presentation or admission to hospital, with access to a mobile, dedicated, inter-professional, team-based, rehabilitative care model. Interventions are provided to patients either in the Emergency Department or acute care setting.
- In 2017-18, 3,539 patients participated in the SMART model. 87% of these patients were discharged home from acute care and they experienced an average 44% increase in the extent to which they functioned at home independently. This result is as measured by pre and post administration of the Barthel activities of daily living index.[10]

While being a model of care that puts patients first, the SMART model has also demonstrated the potential for significant cost avoidance by providing rehabilitative care in parallel with acute care to impact the recovery journey. The model has shown the following:

- A decreased need for rehabilitative care in hospital (86% of individuals are discharged home).[11]
- A decreased amount of time individuals wait for rehabilitative care (4.7% decrease; 363 days).[12]
- For those who need post-acute rehabilitative care, a decrease in the amount of time required (4.9 days).[13]

Watch Lillian's story – https://youtu.be/TiNEpsTcvHg to understand how SMART has the potential to change the trajectory of an individual's health care and life journey.

[10] Q4 2017-18 LHIN SMART reporting.
[11] Q4 2017-18 LHIN SMART reporting.
12 Q4 2017-18 LHIN SMART reporting.
13 Q4 2017-18 LHIN SMART reporting.

Standardize Referral Process and Definitions for Rehabilitative Care

As of March 31, 2018, the LHIN completed community rehabilitative care referral option tools for all HNHB sub-regions. The LHIN ensured the information regarding community and bedded rehabilitative care programs, whether progression or maintenance, was aligned with the provincial Rehabilitative Care Alliance standard definitions. The information also needed to be publicly available and accessible to referring health service providers that refer to community rehabilitative care programs.

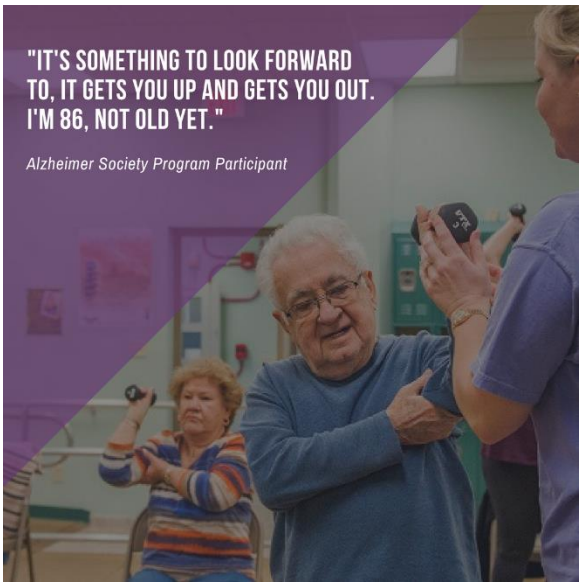
Tools to help patients, families, and referring partners including primary care providers, understand what rehabilitative care is and what to expect were created including bilingual letters for communication to patients and families during transitions in care.

Exercise for Healthy Active Seniors

Fall-related injuries represent a significant health concern among individuals over the age of 65 and are of particular concern for individuals living at home or in the community independently. [14] Individuals experiencing a fall often suffer from devastating physical and psychological injuries which can have a negative impact on quality of life and activities of daily living.

Research has shown that progressive, tailored exercise programs contribute to improvements in a person's strength, gait and balance, and also offer seniors an opportunity to socialize and become more educated about key risk factors for falls. From April to December 2017, LHIN-funded exercise and falls prevention classes served more than 12,000 individuals across more than 350 classes throughout HNHB. Participant testimonials from one of the initiatives - Centre de santé communautaire Hamilton/Niagara's Keeping Balance Falls Prevention program – spoke to how taking part in the classes contributed to pain reduction, improved general mobility and enhanced social connections.

[14] Public Health Agency of Canada, *Seniors' Falls in Canada: Second Report*, 2014.



Emergency Department and Admission Avoidance

The amount of time an individual spends in an emergency department – from the time they are registered or triaged (whichever comes first) to the time they are discharged to either home or admitted to an inpatient unit – is considered to be their emergency department length of stay. During the time they spend in the ED, patients see medical staff and receive care.

The HNHB LHIN has 13 emergency departments and five urgent care centres. The five urgent care centres treat individuals with minor and uncomplicated conditions, reducing the demand on larger emergency departments. The 13 emergency departments include sites dedicated to burns, cancer, cardiovascular, neurosurgery, pediatrics, trauma and stroke.

In 2017-18, nine of the 13 emergency departments participated in the ministry's Pay for Results program. The Pay for Results initiative aims to improve the patient experience by reducing emergency department wait times while measuring a variety of indicators. HNHB LHIN hospitals strive to improve their performance on Pay for Results metrics to improve the experience of patients in their emergency departments.

The number of individuals who visited emergency departments in the LHIN increased year over year. As of February 2018, HNHB emergency departments reported 521,009 visits representing a 28% increase over ten years and 75% (390,753) of those visits were by people with complex care needs. [15]

In addition to increased emergency department volumes, a higher number of patients arrived by ambulance. This is particularly evident in Hamilton at the HHS General and Juravinski sites where, for the period of January 2016 to February 2018, 30-32% arrived by ambulance compared to the provincial average of 16-17%. Arrivals by ambulance have increased across the LHIN since 2015-16 – 111,878 in 2015-16; 116,642 in 2016-17 and, as of December 2017, 87,752 with a projected year-end volume of approximately 117,450.

[15] Access to Care, *Fiscal Year Report*, February 2018.

Despite having the highest ambulance volumes in Ontario[16], between April and December 2017, 80% of complex patients were seen within the 8-hour target and 83% of minor/uncomplicated patients were seen within the four-hour target.[17] It is important to note that, for this same period, 92% of non-admitted complex patients were seen within the eight hour target, while only 26% of admitted complex patients were seen within the eight hour target.[18] More information about these results can be found in the MLAA Performance Indicators Chart later in this report.

A patient who is in an acute care hospital bed awaiting access to their next level of care means that bed is not available to a patient who need to be admitted from the emergency department and this is commonly referred to as 'patient flow'. It is patient flow pressures that in large part contribute to the length of time patients in emergency departments had to wait for an inpatient hospital bed. Despite the challenges, hospital sites achieved improvements in the time to move a patient from the ED to an inpatient bed. As of December 2017-18 with Hamilton Health Sciences' West Lincoln Memorial Hospital site improvement 40% and Norfolk General Hospital saw a 36% improvement compared to the previous year. As of February 2018, Hamilton Health Sciences' McMaster Children's Hospital achieved 31% improvement in ambulance offload time compared to February 2017.[19]

Working with stakeholders the LHIN undertook a variety of initiatives to improvement ED wait times for patients:

- In November 2017, seven HNHB hospitals opened 162 surge beds to provide additional bed capacity.
- Emergency Department eNotification was implemented to provide real-time electronic messages/reports to Primary Care and the LHIN home and community care staff when their patients presented at the emergency department. This technology was implemented at all hospitals sites as of April 2018.
- Community Paramedicine programs began operating in Brant, Hamilton, Niagara and Norfolk. Community paramedicine program staff identify high users of hospital and 911 services, enroll them in the community paramedicine program and provide the necessary in-home supports to reduce their need for 911 and hospital services. The community paramedicine programs are helping individuals remain longer in their home.
- Initiatives to avoid unnecessary emergency department visits from long-term care homes were successful, including the nurse-led outreach teams, attending Nurse Practitioners, palliative shared care outreach teams and Behavioural Supports Ontario Long-Term Care Home Mobile Team. As of September 2017, HNHB long-term care homes reported the lowest number of potentially avoidable ED visits for long-term care home residents compared to other LHINs.[20]

In 2017-18, the HNHB LHIN Emergency Services Steering Committee, in collaboration with the LHIN, hired a Community Paramedicine Strategic Lead to align the LHIN's various community paramedicine programs, develop focused ED avoidance program goals, improve system-level coordination and explore opportunities for collaboration and knowledge transfer. The four community paramedicine programs have adopted Remote Patient Monitoring as an evidence-based tool to support patients in their homes and to reduce unnecessary 911 and hospital utilization.

[16] Access to Care, *Fiscal Year Report*, March 2016, March 2017 and February 2018.
[17] Access to Care, *Fiscal Year Report*, February 2018.
[18] Ibid.
[19] Ibid.
[20] Health Analytics Branch, *Potentially Avoidable Emergency Department Visits for Long-Term Care Home Residents*, February 2017 and February 2018.

Community Paramedicine: Meet Bill

Bill is more than 60 years old and lives alone with limited social contacts, no family nearby and he is living with a number of chronic conditions. During a 9-month period before joining the Community Paramedic program, Bill visited the ED 74 times for pain. When Bill joined the community paramedicine program, he was referred to a number of community programs including a pain clinic where he is learning to manage his chronic conditions. The community paramedic accompanies Bill to his medical appointments which help Bill gain a better understanding of his health conditions and symptoms, manage his pain and increase Bill's confidence as a self-advocate. His ability to manage his health and medications has improved. Bill undergoes a full health assessment on a weekly basis by the community paramedic who also provides Bill with coaching and education to help improve his health and well-being. Thanks to the community paramedicine visits, Bill is reassured that he is doing well and, while some of him symptoms are serious, they may often be addressed without having to attend the ED. After joining the community paramedicine program, Bill visited the ED 11 times over a subsequent 9-month period – an 81% reduction in ED visits. Thanks to his involvement with the community paramedicine program, Bill has become more knowledgeable about his health issues, he can now advocate for himself and his ability to manage his own health has improved. As a result, Bill's calls to his community paramedic have reduced significantly.

Transitional Care across the Continuum – Innovative Approach

In the health care environment, transitions in care refers to the movement of a patient between health care locations, providers, or different levels of care within the same locations as the person's conditions and care needs change. These transitions involve a set of processes designed to ensure coordination and continuity of care for the patient.

Suitable communication and documentation practices during patient transitions are essential to ensure safe, quality care for patients. Improving patient transitions from hospital to community once medical treatment is complete remains a focus for the HNHB LHIN. There is still a small percentage of patients unable to return to their previous living environment and, therefore, alternative arrangements must be made. Waiting in hospital for an alternate level of care (ALC) is not in the person's best interest as this can put them at risk of functional decline and hospital-related complications.[21]

The HNHB Transitional Care Program, developed in 2014 in collaboration with LHIN hospitals and community partners, provides those patients unable to return to their pre-hospital living environment with an alternative, temporary setting where they can receive the level of care they require while waiting for a more permanent living arrangement. The Transitional Care Program also provides individuals with time and support to optimize their strength and independence before transitioning to the more appropriate permanent community setting.

[21] Annual Report of the Office of the Auditor General of Ontario, 2010, Chapter 3, Section 3.02, Discharge of Hospital Patients.

Key Accomplishments

- The Transitional Care Program expanded to207 beds across 15 unique sites in Hamilton, Burlington, Niagara and Brant communities. In 2017-18 the Transitional Care Program reported 812 admissions and 845 discharges for a total of 2,783 admissions and 2,646 discharges since the program opened in October 2014. Since October 2014, patients have accumulated a total of 154,282 days in the Transitional Care Program - this equates to ALC days avoided in hospital. (*Source Transitional Care Program March 31, 2018 Report)*
- When access to affordable housing with supports was identified as a barrier to discharge in some communities, the HNHB LHIN increased access to 51 Subsidized Seniors Supportive Housing units – 40 in Hamilton, eight in Brantford and three at Six Nations of the Grand River.
- A collaborative 10-unit community-based residential high-support housing program was established for patients with Dual Diagnosis. Dual Diagnosis includes schizophrenia, schizoaffective and bipolar disorders and/or intellectual disability/autism.

Population Based Strategies

Integrated Stroke Recovery System

HNHB LHIN continues to dramatically improve the patient experience for individuals who experience a stroke. A stroke is a sudden loss of brain function caused by interrupted blood flow to the brain (ischemic stroke) or ruptured blood vessels in the brain (hemorrhagic stroke). A warning stroke is a temporary blockage of blood flow to the brain (Transient Ischemic Attack-TIA).

The stroke best practice evidence indicates persons who receive their post-stroke care in a stroke unit by a dedicated inter-professional team are more likely to be alive, independent and living at home within one year of suffering the stroke.[22] For this reason, HNHB LHIN partnered with the Central South Regional Stroke Network (CSRSN) and stroke care providers to increase access to stroke unit care and to build an integrated stroke recovery system.

Increased Access to Integrated Stroke Care

Advancements in stroke care continued in 2017-18 with the integration of stroke services at the Hamilton Health Sciences Regional Stroke Centre on January 8, 2018. Stroke care provided previously at St. Joseph's Healthcare Hamilton is now provided at the Hamilton Health Sciences Regional Stroke Centre. The integration meant all patients diagnosed with a stroke admitted to St. Joseph's Healthcare Hamilton's emergency department or inpatient units would be transferred to Hamilton Health Sciences and receive care within an Integrated Stroke Unit model by a dedicated team of professionals with expertise in stroke care. The Integrated Stroke Unit provides integrated stroke services for those people requiring acute stroke care, stroke inpatient rehabilitative care services and outpatient stroke prevention clinic services.

[22] Stroke Unit Trialists' Collaboration. Organized inpatient (stroke unit) care for stroke. Cochrane Database of Systematic Reviews 2007, Issue 4. Canadian Best Practice Guidelines for Stroke) Care, 2010.

Increased Access to Endovascular Therapy for Stroke

Endovascular therapy (EVT) is a treatment for patients diagnosed with acute ischemic strokes that removes large stroke-causing clots from the brain and substantially improves the chance for a better outcome.

Five major stroke research trials in early 2015 demonstrated the effectiveness of endovascular therapy (EVT) and have significantly changed the management of individuals post-stroke with a blood clot caused by a large vessel blockage. HHS is one of eight centres within Ontario that provides 24/7 access to this intervention. The CSRSN has been successful in creating regional access to this life-saving treatment for every person in HNHB and Waterloo Wellington LHINs. As of December 2017, 62 EVT procedures were performed on patients.

Access to Best Practice Stroke Rehabilitation in Rural Areas

A successful Community Stroke Rehabilitation Model (CSRM) is ongoing in the Brant and Haldimand-Norfolk sub-regions. The model provides access to best practice, in-home and community rehabilitative stroke care for individuals who live more than 30 minutes from an outpatient therapy centre and/or do not have the tolerance to travel.

In-home rehabilitative care is delivered in a timely way from a consistent expert stroke team providing intensive best practice stroke care.

In 2017-18:

- within 2.8 days, 66 individuals received timely access, to best practice intensive community stroke rehabilitation with an average of 19.2 in-home therapy visits;
- 92.7% of patients who experienced a stroke met their personal recovery goals, with a 16.1 % increase in the reintegration to normal living index score; and,
- there was an 8% decrease in the number of participants with symptoms of depression.

HNHB LHIN Performance in Stroke Care

In October 2017, an Integrated Decision Support (IDS) Regional Stroke Dashboard was developed to report on current data. The Regional Stroke Dashboard demonstrated improvements in a number of stroke indicators due in large part to increased access to integrated best practice stroke care.

Several improvements have been noted in the HNHB LHIN:

- 63% of individuals who experienced a stroke were treated in a stroke unit
- 17% of patients experiencing a stroke caused by a blood clot (ischemic stroke) received clot busting medication (tissue plasminogen activator - tPA) in the ED or an acute care setting
- 36% of individuals post-stroke were admitted to inpatient rehabilitation after discharge from acute care
- On average, individuals post-stroke were admitted to rehabilitation within 7.5 days.

The Ontario Stroke Network's (OSN) annual Stroke Report Card reports on stroke care at the provincial and LHIN levels and its 2017 Report Card reports data for 2015-16. Compared to the 2016 report card, the LHIN has demonstrated improvements on 14 indicators.[23]

- At the facility level, the LHIN is the provincial leader on the two clot-busting indicators. The LHIN is a top performer for timely access and the proportion of individuals who receive clot busting medication (tPA door-to-needle time) at the Hamilton Health Sciences Regional Stroke Centre.
- The LHIN is also a high performer for the proportion of patients experiencing a stroke or warning stroke (TIA) who arrived by ambulance at the ED.
- The proportion of individuals who receive stroke rehabilitation achieving the target length of stay has increased from 43.7% to 63.7%, with Hotel Dieu Shaver Health and Rehabilitation Centre in Niagara achieving the greatest improvement in the province.
- The proportion of patients experiencing a stroke or warning stroke (TIA) discharged from the ED and referred to secondary stroke prevention services has increased from 80.6% to 85.4% due to ED staff education on the importance of timely assessment of individuals in the stroke prevention clinic. (*Source Ontario Stroke Report Card 2015-16)*

Diabetes

Diabetes is a chronic condition that stems from the body's inability to sufficiently produce and/or properly use insulin which the body needs to use sugar as an energy source.[24.] Diabetes can lead to nerve damage (diabetic neuropathy) causing muscle weakness or wasting and loss of pain and sensation which can lead to wounds and ulcers.

As of April 2016, approximately 12.7% of the adult HNHB LHIN population (150,276 people) were living with diabetes. This presents a slight increase over the number reported for 2015 (143,317) and will likely be found to be higher still in 2017. Compared to other LHINs, HNHB LHIN reports the third highest number of adults with diabetes.[25]

A focus for HNHB LHIN is to provide individuals with the knowledge and support to manage their diabetes and reduce complications. There are 15 Diabetes Education Programs located across the HNHB LHIN. Diabetes Education Programs support individuals and their families to improve quality of life and avoid complications related to diabetes. Included as part of the 15 Diabetes Education Programs are three Indigenous and four pediatric programs that work with those specific populations. Leaders from the Diabetes Education Programs work collaboratively to identify new approaches and opportunities to promote awareness, management and prevention of diabetes.

Diabetic foot ulcers are a complication that of the nerve damage that can result from diabetes which causes loss of sensation in the foot that when combined with pressure (i.e. shoes, trauma) can lead to the development of foot ulcers. Diabetic foot ulcers can cause substantial morbidity (disease) and put people at risk for complications, such as wound infections, which impair healing and could result in amputation of the foot or leg.

[23] Ontario Stroke Network Report Card 2015-16.
[24] Government of Canada Website: https://www.canada.ca/en/public-health/services/chronic-diseases/diabetes.html. Accessed January 8, 2018.
[25] Health Analytics Branch, *Diabetes System Indicators*, 2017.

Offloading devices are wound care devices that may include removable, non-removable and total contact foot casts. These devices can significantly improve a person's quality of life by relieving pressure around the heel, ankle and toes so the foot wound can heal properly. These devices are a key component of treating DFUs and preventing recurrence by reducing or redistributing pressure on the foot. In November 2017, the Ministry of Health and Long-Term Care (ministry) approved new base funding to support the Ontario Health Technology Advisory Committee's recommendations to publicly fund offloading devices for the effective treatment of DFUs.

In 2017-18 highlights of key activities:

- HNHB Diabetes Education Program members exhibited at the 2017 Evidence-Based Management of the Diabetes Epidemic organized by McMaster University. This was an opportunity to share information about the services they provide with fellow health care providers in order to increase Diabetes Education Program awareness as a tool for patients with diabetes.
- Provided access to diabetes off-loading devices for patients with DFU to improve wound healing. The funding will support increased access to approximately 483 devices across the LHIN at six hospitals, seven Nursing Care Centres and one Community Health Centre.
- Participation in education opportunities for assessment and fitting of off-loading devices was also supported through this funding, to build capacity among the health service providers involved in the program.
- The HNHB LHIN Pediatric Diabetes Education Committee focused on improving access to timely pediatric consultation in the care of complex children and youth with diabetes by evaluating the newly-developed guidelines for referral to a tertiary care centre.
- The Adult and Pediatric Diabetic Education Program committee:
    - developed guidelines to streamline the transition from youth to adult diabetes care to ensure continuous, comprehensive, and coordinated care
    - collaborated with the HNHB regional bariatric program to provide seamless targeted education to high-risk populations to reduce diabetes onset and to improve self-management for those living with diabetes.
    - As of December 31, 2017, 15,654 individuals received service from HNHB LHIN-funded DEPs.[26]
- A Mentorship program was developed between Six Nation's Diabetic Education Program and Brant Community Healthcare System DEP to provide training for management of Gestational and Pediatric diabetes clients.
- Education was provided to the Leaders in Diabetes committee members as well as Brant Community Healthcare System Diabetic Education Program staff on Indigenous Cultural Safety and Truth and Reconciliation and how this informs diabetes education.
- The LHIN's hospital readmission rate for diabetes declined from 15.07% in Q1 2016-17 to 11.85% in Q1 2017-18. [27]

[26] HNHB LHIN Adult DEP Report, Fiscal Year 2017-18 Q3, March 2018.
[27] Discharge Abstract Database (DAD), Ministry of Health and Long-Term Care, SAS Server, 2016-17 Q2 data, February 2017.

Dementia

While it is difficult to calculate a true estimate of the number of people living with dementia (various reports use different methods of estimation and are challenged by the fact that up to two-thirds of dementia cases may be undiagnosed[28]), Ontario data indicates that from 2009-2015 the prevalence of dementia increased by 30% to 175,694 with almost 76% of that growth happening in the community. *(Source: Ministry of Health and Long-Term Care Dementia Planning October 13, 2017).* HNHB LHIN specific data indicates that, in 2013-14, there were 20,038 people living in HNHB LHIN with a diagnosis of dementia.[29] The Ontario Ministry of Finance projects that the population of older adults (age 65 and over) will grow from 16% (2.2 million people) in 2015 to more than 25% (4.5 million people) by 2041, which will greatly impact the prevalence of dementia.[30]

In 2017-18, the HNHB LHIN, with key stakeholders including the Alzheimer Society and the Regional Geriatric Program, initiated the capacity planning process for community dementia services. The development of this capacity plan will be key to informing LHIN planning going forward and will also be informed by the HNHB Dementia Network's 2017 Strategy Paper which outlined three guiding themes: Education and Awareness, Living Well with Dementia and Person-Centred Approach to Dementia Care.

Since people living with dementia and their care partners represent a diverse population, where no one type of program fits all, the HNHB LHIN funds a number of programs including early identification and navigation, caregiver support and education, exercise classes, adult day programs, overnight respite services and in-home respite care.

Select initiatives in 2017-18 include:

Expansion of System Navigation via First Link

The Alzheimer Society's First Link referral program "links" individuals newly diagnosed with dementia, and their care partners, to appropriate community supports early on, promotes positive patient experiences of care, and provides opportunities to build knowledge and coping skills through support provided by the Alzheimer Society.

In 2017-18, new funding supported the expansion of the First Link program with additional navigators. These additional resources allow the program to support the education and emotional needs of up to 61 people living across the dementia continuum and 109 care partners.

[28] Warrick N, Seitz, D, Prorok, J. (2017). A Scoping Review of Interventions Targeting Community-Dwelling Persons Living with Dementia.
[29] Ministry of Health and Long-Term Care, Dementia Capacity Planning: Regional Profile Tool, 2017.
[30] Ministry of Finance, Ontario Population Projections Update, 2015-2041 2016 [Available from: http://www.fin.gov.on.ca/en/economy/demographics/projections/]

Feature: Linking Mr. & Mrs. Smith

"[Our involvement] has been very helpful, especially in identifying the different services involved and helping to connect me and my wife to other services needed to make our life more comfortable." – Mr. Smith

Mr. Smith, 83 year old, is the Care Partner for his 82-year old wife whose dementia is progressing. Mr. Smith is having a difficult time trying to deal with the changes in his wife's dementia and changes in her physical health. Her diabetes is especially hard to manage and because of his wife's low blood sugars Mr. Smith had to call 911 three times in the last few months, which resulted in hospital admission, infections and mood changes. First Link visited Mr. and Mrs. Smith to provide information and discuss strategies to manage Mrs. Smith's behaviors and to connect them with providers. These included LHIN Home and Community Care, Primary Care, rapid response team, Adult Day Services, DEPs, foot care services, in-home respite and ongoing support through the Alzheimer's Society.

Since their involvement with First Link, Mr. and Mrs. Smith had not called 911 and Mr. Smith reported less stress overall and greater acceptance of his wife's condition.

Expansion of Music for Memory programs to Adult Day Programs

Individualized music programs have been shown to have positive therapeutic effects for older adults and people living with dementia.[31] The Alzheimer Society of Brant Haldimand-Norfolk Hamilton-Halton offers a music program called Music for Memory which brings personalized music into the lives of people living with dementia through digital music technology. Using portable and personal mp3 players trained staff develop and provide personalized playlists to people with dementia in order to improve their quality of life by enabling them to reconnect with the world through music-triggered memories,. In 2017-18, HNHB LHIN expanded access to Music for Memory materials to 34 adult day programs across the LHIN.

Self-Care for the Caregiver

Focused on the mental health needs of caregivers to persons living with dementia, this 16-week course aims to strengthen and expand caregiver coping strategies, and create an increased level of caregiver resilience. In 2017-18, the program served 226 caregivers across the HNHB LHIN. Programming also includes the provision of respite care for the persons living with dementia (if appropriate) thereby giving the caregiver personal time to attend to their own affairs.[32]
One participant of the program said: "I wish I'd taken this course 20 years ago! I 've learned a great deal and acquired new insights that are helping me put things in perspective to lower my stress level."[33]

[31] Sung HC, Chang AM (2005). Use of preferred music to decrease agitated behaviours in older people with dementia: a review of the literature. J Clin Nurs. Oct;14 (9):1133-40.
[32].Alzheimer Society of Brant, Haldimand Norfolk, Hamilton Halton, data report, March 2018.
[33]Alzheimer Society of Brant, Haldimand Norfolk, Hamilton Halton, December 12, 2018

Young Carers

The Young Carers initiative supports young people (ages five to 25 years) living with and/or supporting a family member. Their circumstances may be due to parental absence, disability, elder care, mental health issues, addictions, chronic illness, or a language barrier. When compared to their non-caregiving peers, young carers are at greater risk of experiencing mental health impacts due to their caregiving role including increased stress, depressive symptoms, lower self-esteem, higher levels of anxiety, loneliness and isolation, poorer academic performance and higher school absenteeism.[34]

As of September 2017, the Young Carers Initiative supported 335 young carers from the Niagara and Haldimand Norfolk sub-regions, and 406 parents/guardians.[35]

Behavioural Supports Ontario

The HNHB LHIN's Behavioural Supports Ontario Strategy crosses the continuum to support persons who exhibit, or are prone to exhibiting, responsive behaviours in the community, hospital or in long-term care homes, with a focus on quality of care and quality of life.[36] The HNHB Behavioural Supports Ontario strategy is guided by a statement developed by LHIN providers to represent the voice of the individual with cognitive impairment:

"I am who I am, so help me continue to be me."

The HNHB Behavioural Supports Ontario Strategy was developed to wrap a network of supports around the person exhibiting behaviours and their family/caregiver as they transition across the health care continuum. The Behavioural Supports Ontario Strategy crosses all sectors and consists of several components; all of which continued to support patients, caregivers, long-term care homes, hospitals and the community.

- **Behavioural Supports Ontario Connect** – a single point of information and referral for clients, caregivers, and health care providers, pulling services toward clients

[34] Sexton, C., Chalmers, H., & Lakman, Y. (2016, May). The Stress of Young Carers: The Role of Coping Strategies in Psychosocial Outcomes. Association for Psychological Science (APS), 28th Annual Convention: Chicago, Illinois.
[35] The Change Foundation, *Environmental Scan of Programs and Services Supporting Ontario's Young Carers*, November 2017.
[36] Source for all Behavioural Supports Ontario data: HNHB Strategic Lead Office.

- **Behavioural Supports Ontario Community Outreach Team** – five teams with geriatric expertise embedded within existing community crisis teams providing 'just in time' support to individuals with, or prone to developing, responsive behaviours and linking them to longer term support
- **Behavioural Supports Ontario Responsive Behaviour Specialist** – consultation, strategy development, education, and transition planning for individuals residing in long-term care homes and retirement homes
- **Integrated Community Lead Service Model** – one community agency acts as the single point of contact for Behavioural Supports Ontario clients
- **Behavioural Supports Ontario Hospital Clinical Leads** – four Behavioural Supports Ontario Clinical Leads, employed by four host hospitals – Niagara Health System, Hamilton Health Sciences, St. Joseph's Healthcare Hamilton, and Brant Community Healthcare System. Core functions of the Clinical Leads include collaborating with hospital staff in the development of patient behavioural care plans, transition plans, and capacity building
- **Behavioural Supports Ontario Long-Term Care Mobile Teams** – five multi-disciplinary teams serving the LHIN's 86 long-term care homes and Transitional Leads who support clients and care partners before, during, and after transitions into long-term care. The model is referred to as TACT (Teams Assisting Clients through Transitions).

Behavioural Supports Ontario Connect

- 1,257 clients served as of December 31, 2017
- 100% of caregivers/clients connected to service/support after calling Behavioural Supports Ontario Connect
- 52.6% of those clients had no prior services before calling Behavioural Supports Ontario Connect.

Behavioural Supports Ontario Community Outreach Teams

- 1,130 clients received crisis support as of December 31, 2017 (6,535 since program implementation April 1, 2012)
- 436 family members and informal care providers were supported in the community
- Members of the Community Outreach Teams attended LHIN-wide local Complex Case/ situation tables to collaborate with community partners to support clients with complex needs necessitating multi-agency support

Behavioural Supports Ontario Long-Term Care Mobile Team

- 1,922 referrals received as of December 31, 2017 (13,547 since April 1, 2012)
- 642 clients were supported through transitions to/from long-term care, community, acute care, and/or tertiary care settings as of March 31, 2017
- In February 2018, the Behavioural Supports Ontario Long-Term Care Team and Seniors' Mental Health Outreach brought together the external partners serving long-term care to learn about the

services and create plans to collaborate and serve long-term care in a seamless and organized fashion. 42 people attended, with representation from Behavioural Supports Ontario, Seniors' Mental Health Outreach, Nurse-Led Outreach Teams, Psychogeriatric Resource Consultants and Pain and Palliative Consultants. When asked to rate the session's value on a scale from 1 (not valuable) to 10 (very valuable), participants assigned an average rating of 9.2/10.

- Supported 1,052 education sessions with 8,718 participants learning best practices for assisting the Behavioural Supports Ontario population. An in-person education day was held in November 2017, with more than 90 long-term care Responsive Behaviour Leads/ Champions in attendance. One attendee said: "I look forward to bringing some new ideas to our Responsive Behaviours team at our home, and some new improvement processes can be implemented".

Behavioural Supports Ontario Transitional Leads

- Between April 1 and December 31, 2017 153 referrals were received by Behavioural Supports Ontario Transitional Leads to support clients anticipated to demonstrate responsive behaviours upon moving to long-term care
- As of December 31, 2017, the Behavioural Supports Ontario Transitional Leads supported 71 transitions from community to a long-term care home.
- When asked if they would recommend the Behavioural Supports Ontario Transitional Lead service to others, 100% (19/19) of long-term care home staff and 100% (27/27) of families/ informal caregivers responded 'yes'.
- Families and informal care partners who interacted with the Behavioural Supports Ontario Transitional Lead were asked to rate their agreement with a statement that the Transitional Leader made a positive difference in settling their family member/friend into a long-term care home. On a scale from 1 (strongly disagree) to 5 (strongly agree), respondents assigned an average rating of 4.9.

Behavioural Supports Ontario Hospital Clinical Leaders

- At December 31, 2017, 346 patients referred to the Behavioural Supports Ontario Hospital Clinical Leaders for responsive behaviours were discharged from hospital: 95 people moved to a long-term care home, 70 people moved to a transitional bed, and 47 people moved to a private home (Note-presence of responsive behaviors can be a barrier to discharge)
- 23 patients were diverted from resource-intensive care settings e.g. Behavioural Assessment Units,
- More than 280 multidisciplinary hospital staff members caring for patients with cognitive impairment and responsive behaviours attended an educations session to learn about assessing, addressing and documenting responsive behaviours in inpatients.

Integrated Community Lead Model

- To support the ongoing use of the Integrated Community Lead approach by community providers, regular Integrated Community Lead meetings were held in each sub-region to share updates and discuss successes, challenges and promising practices. In response to themes and gaps that arose from the Niagara Integrated Community Lead meeting, more than 100 participants attended an educational event in March 2018 to understand consent, capacity, supporting clients with complex needs and navigating community resources better.

- The Alzheimer Society of Niagara Region adopted the Integrated Community Lead approach as a standard of care for the clients they serve, and included the approach in their Strategic Plan. To support the staff in using this approach, a three-hour training session was provided to 15 frontline staff and managers in January 2018.

Hospice Palliative Care

Hospice palliative care engages individuals and their families in planning for the care they want at different stages in their illness based on their own goals and values and on a clear understanding of their prognosis and treatment options (advance care planning). When people have access to palliative care services, they report fewer symptoms, better quality of life, and greater satisfaction with their care.

Hospice palliative care strives to help individuals and families:

- Address physical, psychological, social, spiritual, and practical issues, and their associated expectations, needs, hopes and fears.
- Prepare for, and manage, self-determined life closure and the dying process.
- Cope with loss and grief during the illness and bereavement experience.

The Ontario Palliative Care Network (OPCN) is responsible for the development of a coordinated and standardized approach to the delivery of hospice palliative care in the province.[37] The provincial palliative care structure includes Regional Palliative Care Networks (RPCN). For the HNHB region, the RPCN is the principle regional advisor accountable to the LHIN's Chief Executive Officer and Cancer Care Ontario Regional Vice-President.

In 2017, the HNHB RPCN identified six key actions focused on high-quality hospice palliative care:

- Integrate and coordinate access to palliative care services
- Evaluate the early identification guide pilot site
- Develop an evidence-based capacity plan for palliative/end of life (EOL) care
- Identify and develop a scorecard to assess performance
- In collaboration with the LHIN's Indigenous Peoples on and off reserve, develop a plan that provides HNHB First Nations, urban, and rural Indigenous Peoples with equitable access to culturally safe, high-quality, palliative care services
- Develop and implement a communication and stakeholder engagement strategy.

The action items support meaningful change and align with the OPCN's recently released *Action Plan 1: 2017-2020* which will guide how the partners of the OPCN will work together to improve availability of, and ease of access to, equitable, high-quality, sustainable palliative services for all Ontarians.[38]

[37] Ontario Palliative Care Network https://www.ontariopalliativecarenetwork.ca/en/node/31841/
[38] Ontario Palliative Care Network, *Ontario Palliative Care Network Action Plan 1: 2017 – 2020*.

Hospice Palliative Care Highlights 2017-18

- Work continues on integrating and enhancing the Palliative Care Outreach Teams in all sub-regions including the addition of a full-time palliative physician in Niagara
- 400 *Learning Essential Approaches to Palliative Care* (LEAP) mini sessions were completed by family physicians, care coordinators, and nursing teams. The sessions increase knowledge and skills to provide a palliative care approach for all patients with progressive life limiting illnesses.
- Increased access to palliative care and care coordination occurred with the expansion of patient referral criteria.
- As a result of the IHN Palliative Engagement Session (November 2017) and the First Nations Palliative Knowledge Exchange (March 2018) there has been an increase in cultural competency and awareness
- Patient and Family Advisors have been active within the RPCN, providing feedback to the OPCN and input on local projects and work
- Home Virtual Visits technology was launched in March 2018 and is helping to connect primary care to specialists as well as specialists to patients.

In 2017-18 the following supports were provided to patients and caregivers across the LHIN:

- As of February 2018, 818 people have received shift nursing and 851 group education sessions were held at residential hospices
- As of February 2018, LHIN Home and Community Care Palliative Nurse Practitioners served 600 people
- As of February 2018, LHIN Home and Community Care provided in-home EOL care to 4,418 individuals. *(Source: HNHB LHIN Home and Community Care Client Health and Related Information System report, February 2018)*
- Within the HNHB LHIN, 1,510 individuals were cared for using 117 hospital beds designated palliative/end of life beds. 1,268 of these individuals passed away in hospital. The average length of stay at a hospice was 23 days (*Source Hospital 2017-18 Complex Care Report).*

Mental Health and Addictions

The complexity of the mental health and addictions system can present a challenge for persons needing access to mental health and addictions services, their families, primary care providers and other agencies supporting the person. While the HNHB LHIN funds 37 health service providers to specifically provide mental health and addictions services, there are numerous other non-LHIN funded health service providers /agencies/organizations that provide support to persons with mental illness and/or addictions including those funded by other ministries and Health Canada.

In 2011, the Government of Ontario released its 10 year Mental Health and Addictions Strategy, *Open Minds Healthy Minds*, outlining its plan to support mental health and addictions from childhood to old age, and to provide integrated services to support Ontarians. The Strategy has four guiding goals:

1. Improve mental health and well-being for all Ontarians
2. Create healthy, resilient, inclusive communities

3. Identify mental health and addictions problems early and intervene
4. Provide timely, high-quality, integrated, person-directed health and other human services.

The Provincial Mental Health and Addictions Leadership Advisory Council (Council) was established in 2014 with a three year mandate to advise the Minister of Health and Long-Term Care (Minister) on the implementation of the *Open Minds Healthy Minds* Strategy. In its third and final report, *Realizing the Vision*, released in March 2017, the Council continued to build on previous guidance, identified critical conditions for success and identified areas for future consideration.

In 2017-18, HNHB LHIN developed a mental health and addictions Peer and Family Advisory Committee in alignment with Health Quality Ontario Patient Engagement Framework. The mental health and addictions Peer and Family Advisory Committee brings the perspective of individuals with lived experience of mental health and addictions to, thus strengthening, the LHIN's governance infrastructure. Together with the mental health and addictions Advisory Committee, the mental health and addictions Peer and Family Advisory Committee recommends actions and activities to develop and strengthen a comprehensive, integrated and person-centered mental health and addictions system, and provides leadership to advance the HNHB mental health and addictions goals:

Reduce variation in mental health and addictions services:

1. Build capacity within the mental health and addictions system
2. Improve access to mental health and addictions services
3. Reduce stigma in mental health and addictions services.

In 2017-18 the LHIN, with the support of the mental health and addictions Advisory Committee, worked with health service providers to achieve the following items from the 2016-18 Action Plan:

- Built on the concurrent disorders capacity building strategy by:
  - Providing education to an additional 2,200 individuals (for a total of over 2,500 individuals since 2016-17)
  - Creating open access concurrent disorders resources for health service providers
  - Assisting in building a facilitated community of practice for ongoing sharing of best practices information between clinicians across the LHIN
  - Supporting health service providers to complete concurrent disorders capacity assessments, providing service and practice improvement recommendations back to organizations
- Developed draft integrated service delivery models for the LHIN's primary crisis response e.g. Mobile Crisis Rapid Response Team and secondary crisis response e.g. Crisis Outreach and Assessment Team services and invited stakeholders to review and feedback on their content and further development. Stakeholders included individuals with lived experience and service providers from the health, children's, developmental disability, and police service sectors.
  mental health and addictions better supported in the community, and developed quality improvement initiatives to reduce inappropriate ED use and to improve coordination of care for those sub-populations.
- Together with health service providers and other partners, completed a current and future state mapping of the LHIN-funded addiction services by sub-region, and identified opportunities to improve access and service gaps, which have been used to inform sub-region service planning.
- Expanded the following existing services and programs:

- Added an additional 60 mental health and addictions supportive housing units, including eight Indigenous provider-led units, to the Brant, Burlington, Haldimand-Norfolk, Niagara, and Niagara North West sub-regions, and expanded supports at one supportive housing building in Niagara
- Expanded community-based Addictions counselling services in Brant, Burlington, Niagara, and Niagara North West to serve an additional 1239 individuals per year.
- Expanded residential supportive addictions programming in Niagara by 12 beds – six for men and six for women.
- Expanded community withdrawal management in shelters for youth in the Hamilton sub-region to serve an additional 181 individuals per year.
- Expanded the Rapid Access Addiction Medicine Clinic in Niagara to serve an additional 250 individuals and approved funding for a new Rapid Access Addiction Medicine Clinic in the Hamilton sub-region to serve 500 individuals per year.
- Approved funding for a 57-unit high-supportive housing apartment building located in the Hamilton sub-region dedicated to individuals with mental health and/or addictions concerns.

- Introduced the following new services and programs:
  - As a result of the findings from the Schedule 1 Long-Stay Population Review, collaborated with the Ministry of Community and Social Services (MCSS) to develop a 10-unit high-support housing program for individuals with a dual diagnosis of a development disability and a mental illness and/or addiction, operated by both health and developmental agencies.
  - Added community withdrawal management in shelters for men in the Hamilton sub-region to serve 600 individuals per year.
  - Added an outreach Primary Care Mobile Addictions team in Haldimand-Norfolk to serve 1200 individuals per year.
  - Added an outpatient/community mental health and addictions program: *Prioritizing Health through Acute Stabilization and Transition* in Burlington offered collaboratively by four agencies.

Innovation, Health Technologies and Digital Health

Digital health tools are helping to streamline workflows commonly used in health care and are becoming even more valuable in delivering efficient and high quality care for patients. The adoption of various digital health technologies by physicians and clinicians continues to progress well. In 2017-18, the partnership between HNHB LHIN and the Health Information Technology Services (HITS) eHealth Office at Hamilton Health Sciences (HHS) again proved successful in creating significant awareness and use of solutions such as ClinicalConnect™ and eConsult to improve patient care.

ClinicalConnect™ | CONNECTING SOUTH WEST ONTARIO

ClinicalConnect allows physicians and clinicians practicing in south west Ontario to view their patients' health information in a secure, consolidated view, improving their efficiency as providers and easing the burden for patients by not having to repeat details of their health journey or potentially undergo duplicate medical tests unnecessarily.

Digital health is bridging gaps across the continuum of care, especially as patients and their families often see multiple health care professionals in multiple sub-regions across our LHIN meaning providers may

not always be aware of their patients' admissions to hospital. New for 2017-18 and an example of digital health at work, primary care physicians within Health Report Manager (HRM) and HNHB LHIN home and community care staff through their Client Health and Related Information System, are now notified when their patient has been admitted/discharged from an HNHB LHIN hospital inpatient unit or discharged from an Emergency Department. Known as eNotifications, providers have a greater awareness of their patients' encounters at HNHB LHIN hospitals made possible by leveraging existing hospital data integrations to ClinicalConnect.

In 2017-18, the HITS eHealth Office continued its deployment and enhancement of ClinicalConnect. In addition to data from south west Ontario's 72 acute care hospital sites, home and community care and regional cancer programs, ClinicalConnect also collects data from a variety of provincial sources to help give authorized users a more complete, real-time view of their patients' health history.

Examples of ClinicalConnect information available to credentialed health care providers include:

- Diagnostic Imaging (DI) Common Service – diagnostic images and reports from hospitals and Independent Health Facilities in Ontario
- Digital Health Drug Repository (DHDR) – dispensed pharmacy medications and pharmacy services, plus monitored drugs and controlled substances as entered into the Narcotics Monitoring System
- Ontario Laboratories Information System (OLIS) – laboratory tests performed at community-based labs and hospitals in Ontario

This past year marked the achievement of another major milestone for patient care, with funding from Canada Health Infoway for the deployment of MyChart™, a patient portal operated by Sunnybrook Health Sciences Centre. Deployment of MyChart, the first regional deployment of its kind in south west Ontario, is expected to begin in summer 2018 to patients registered at various clinics at McMaster Children's Hospital in Hamilton, one of the project's early adopter sites.

Home and Community Care

The HNHB LHIN took on the provision of home and community care on May 10, 2017 and as the transition has rolled out, the premise has always been to continue supporting people of all ages and populations to remain independent and cared for in their own homes and communities for as long as possible. Positive health outcomes are achieved when appropriate supports are available and accessible to people. Types of home and community care and supports may include nursing care, physiotherapy, occupational therapy, speech language therapy, personal support services, respite support for care givers, access to specialized services and programs, and medical home health care supplies and equipment.

During 2017-18, HNHB LHIN continued to focus on strengthening home and community care to achieve positive health outcomes for people and their caregivers by ensuring we are doing everything possible to create exceptional patient experiences. This means better integration of care and services provided by health system partners across the continuum of care to provide patients and families with a more seamless approach to care and service delivery.

By assisting people with seamless navigation of the health care system, LHIN home and community care team – in collaboration with our system partners – are able to support shorter hospital stays and also help patients delay or avoid admissions to hospitals or long-term care homes. Home and community care and

services coordinated and delivered by the LHIN are necessary for our health care system to carry out our commitment to provide people with the right care, in the right place at the right time.

In 2017-18, home and community care and support services were provided by to patients and families throughout the HNHB LHIN as outlined in the following statistics:

- **89,877** people received care and services
- **5,406,924** people were visited by contracted service providers
- **10,628** people received health support and services in schools
- **16,015** people received care in one of HNHB LHIN's 11 Nursing Care Centres
- **3,538** people received assistance for placement in long-term care homes
- **4,732** people received hospice palliative/end-of-life care.

HNHB LHIN continues to lead the implementation of a transformation agenda focused on integrating home and community care with other key service providers across the health care system including primary care physicians, hospitals, social services and community support service agencies. This "one sector" approach is aligned with priorities such as integration, consistency, capacity, quality and value as outlined in the ministry's *Patients First* strategy.

The *Patients First Act, 2016* brought about significant changes to how home and community care services are delivered in Ontario. Between May and June 2017, all home care services provided previously by Community Care Access Centres transferred successfully to Ontario's 14 LHINs, including HNHB LHIN.

As part of this foundational transformation work over the past year, HNHB LHIN aligned its home and community care structure across the Patient Services Operational Leadership team with the sub-region leadership structure. This alignment facilitated a partnership across transformation teams to strengthen relationships between the home and community care and other sectors including mental health, social services, and primary care across the six sub regions. These efforts continue to be focused on standardizing and improving the consistency, access and quality of care provided to people across the continuum of care at home and in the community.

System Integration, Transitions in Care and Patient Experience

In order to set the foundation for new hospital partnerships, home and community care restructured the Patient Services hospital leadership operations portfolio to improve transitions in care across the health care system and build a more seamless, integrated experience for people moving from hospital to the community.

In addition, a LHIN-wide patient flow portfolio was established along with the development of a functionally integrated management framework across the hospital corporations. As a result, this new structure has set the foundation for bringing hospital discharge planning teams and home care teams together, working as one system under the *Home First* philosophy by following formalized shared accountability structures. This will ensure people are indeed getting appropriate care, where and when they need it.

In the fall of 2017, HNHB LHIN collaborated with hospital partners to implement Integrated Managers of Transitions in HNHB hospital sites. This role is designed to work in concert with both hospital and home and community care teams involved in supporting patient transitions in care and discharge planning. This allows the LHIN Home and Community Care team to build relationships between the two sectors focused on achieving common goals while improving the patient experience. Together we are putting the needs of the people we serve first.

The main objectives for the Integrated Managers of Transitions are to develop consistent standards of practice for discharge planning grounded in the home first philosophy, and to ensure patients are getting the care they need when and where they need it. This approach keeps the patient at the center of care planning and means they tell their story only once in order to receive the most appropriate level of care and to support independence at home for as long as desired.

While implementation continues across all HNHB LHIN hospital sites, there has been marked improvements achieved in system flow during the short time this work has been underway and is being recognized by hospital partners. Some examples include:

- More than 19,000 hospital discharges with home and community care services supporting restoration and independence at home[39]
- An approximate 50% reduction in the number of patients waiting in hospital for long-term care[40]
- More than 250 patients were placed in long term care from hospital in the same time frame[41]
- Approximately 20% reduction in the number of patients waiting in hospital for transfer to transitional care beds[42]
- 379 patients were transferred to transitional care in the same time frame[43]

HNHB LHIN's shared work with our health system partners will continue in order to further integrate a system that supports the patient's right to receive safe, quality care in any environment.

Reducing Caregiver Burden

HNHB LHIN continues to improve the coordination and consistency in accessing caregiver respite services to lessen caregiver burden and help people remain in their own homes for as long as possible.

The LHIN funds a variety of services to support caregivers including:

- Adult day programs
- Companion support

[39] HNHB LHIN Home Care, Long Term Care Placement, and Complex Care Referrals to HNHB CCAC from HNHB Hospitals report; October 2017 – March 25, 2018

[40] HNHB LHIN ALC Point In Time Sundays Final Long-Term Care and Transitional Care Bed Reductions report; October 28, 2017 – March 25, 2018

[41] HNHB LHIN Monthly Count of Placement by Priority Code and Location report; October 2017 – March 2018

[42] HNHB LHIN ALC Point In Time Sundays Final Long-Term Care and Transitional Care Bed Reductions report; October 28, 2017 – March 25, 2018

[43] HNHB LHIN Transitional Bed Month End Report; October 1 2017 – March 27, 2018

- Educational "self-care" programs
- In-home and overnight respite

In 2017-18, as part of home care services and supports delivered through HNHB LHIN, we 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 Caregiver Distress Index as a tool to assess and address caregiver burden and those who are at high risk of adverse outcomes and who could benefit from respite support.

The Caregiver Distress Index screener is now applied to all long-stay community patients as part of the assessment process, and 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 Caregiver Distress Index screener, HNHB introduced a flexible model of care allowing patients and caregivers to "bundle" their available hours to meet their needs. This caregiver-centred approach allows LHIN care coordinators to develop care plans that consider the strengths and needs of patients and their caregivers.

Reducing caregiver distress will continue to be a focus for the LHIN Home and Community Care team over the coming year to support people who want to remain living in their own homes for as long as possible. As of Q3 2017-18, 100,829 respite hours had been provided to 1,750 individuals.[44] This represents a 51% increase in caregiver support hours resulting in 30% more patients and caregivers being served compared to 2016-17.

Improvements to Nursing Care and LHIN Nursing Care Centres

The HNHB LHIN worked in collaboration with its front-line employees, service provider organizations, primary care providers and patients to make improvements to our nursing services. A comprehensive review was completed through this stakeholder engagement which led to the revision of LHIN nursing eligibility criteria and guidelines to continuously provide our patients with high quality nursing care that is consistent and equitable.

This approach was implemented to better support patients receiving individualized nursing care in a location that is appropriate to their care needs while allowing for flexibility to support patient-centred transitions based on the needs of the patient. As a result, 893 nursing patients were transitioned successfully to either self-managed care with the support of primary care and/or are now receiving care at one of the HNHB LHIN's 11 Nursing Care Centres. The Nursing Care Centres option allows patients to schedule appointments at a time that is convenient for them. Patients who receive care at our Nursing Care Centres also benefit by getting out in the community as it supports independence, socialization and improves mobility.

In addition, improvements made to the provision of LHIN nursing care provides value to the health care system by reducing unnecessary costs for medical supplies and deliveries, building capacity in the system to deliver nursing care at home for those who require it, and increasing the number of patients whose nursing care needs can be met outside of the home.

[44] HNHB LHIN Home and Community Care Q3 2017-18 Data

Supporting Vulnerable and Marginalized Populations:

Specialized Geriatric Services Outreach Partnership with the Regional Geriatric Program and HNHB LHIN

The HNHB LHIN has developed a partnership with the Regional Geriatric Program and the Shelter Health Network to ensure physicians working with vulnerable and marginalized populations have access to care coordination. This access will ensure patients are directed to equitable, high quality community-based services. The model of attachment is an embedded approach (See section *Embedding Care Coordination within Primary Care* below) with the Regional Geriatric Program.

The LHIN care coordinator attends two clinic sites on a weekly basis to assist with the joint assessment of patient needs and participate in collaborative care planning to refer patients to appropriate services. The attachment with physicians at the Shelter Health Network is a virtual model with care coordination available to address access to care issues. The goal of these partnerships is to strengthen linkages between these services and LHIN home and community care to minimize service duplication and address gaps in service plans. This illustrates a "Health Links" approach to care in breaking down silos with respect to care coordination and access to home and community care services.

Attention is directed to ensure person-to-person, also referred to as 'warm', transitions occur among and between providers with coordinated care plans providing a vehicle for knowledge exchange and the development of patient-centred care plans. Since the inception of these collaborations, 73 active HNHB LHIN patients have been provided with care coordination in collaboration with the interdisciplinary teams of the Regional Geriatric Program and the Shelter Network. Next steps will involve further analysis and response to those patients requiring intensive system navigation across sectors in addition to home and community care supports.

Embedding Care Coordination within Primary Care

During 2017-18, HNHB LHIN began its work to move care coordination closer to the patient by putting primary care at the centre of care planning and care coordination. This initiative embodies the Health Links approach to care and ensures seamless communication and collaboration related to the care of patients. During the first phase of this work in 2017, 100% of all LHIN community care coordinators were attached virtually to one or more primary care settings across our six sub regions.

During the second phase of this work in early 2018, HNHB LHIN launched a strategy to physically co-locate and place dedicated care coordinators into primary care settings. This work began with all Community Health Centre locations, Aboriginal Health Centres and select Family Health Teams. This second phase was geared to marginalized populations to put in place improved access and more consistent care coordination. In addition, a better understanding and transparency for primary care in determining which services are available to their patients is being supported.

HNHB LHIN Home and Community Care also launched a mental health and addictions step down model of integrated care coordination across the continuum. The step down model aims to support individuals to transition back into the community following hospitalization in partnership with primary care and

community mental health and addictions service providers, and to improve the quality of recovery for people living with mental health and addictions.

Community Engagement

Engaging our Communities

Community engagement is a core function of Ontario's LHINs and is written into the Local Health System Integration Act (LHSIA), 2006 – the legislation that created LHINs. As part of its work, the HNHB LHIN engages a diverse range of people, including residents, health professionals, and those who are actively involved in the health system as well as members of the Indigenous and Francophone communities. The LHIN recognizes, respects, and seeks to understand and address the unique needs of its diverse communities.

HNHB LHIN Speakers Bureau

The HNHB LHIN provides information and ongoing engagement through our Speakers Bureau events focused on creating awareness about the role of the LHIN as a funder, planner and provider of local home and community care. This engagement opportunity has an HNHB LHIN representative provide a formal presentation or participate in an information session to community groups, individuals, workplaces and among our health system partners.

These presentations are a means to engage, inform and educate the public about the work of the HNHB LHIN including home and community care supports available within the region, and information about the long-term care placement process. Feedback received from these events is documented, actioned and used to inform future presentations, HNHB LHIN materials and planning

Throughout 2017-2018 more than 1,340 people participated in one of 29 Speakers Bureau presentations in our communities. As anticipated, many of the requests for information came from community groups interested in learning more about service availability in response to the LHIN's expanded role in the coordination and delivery of home and community care.

- 17 presentations related to senior-specific subject matter to such organizations as the John Deere Retirees, Retired Teachers Association of Niagara and participation at community information fairs such as the Dundas Seniors Fair and Coronation 50 Plus Recreation Centre Seniors Fair
- 11 presentations provided an overview of the LHIN and home and community care support and services such as the Alzheimer's Society, Caregivers Resource Fair, Niagara Amputee Association and McMaster University Sociology Department.
- 1 home and community care awareness session for the Francophone community at Club Age d'or Hamilton

Engaging Patients and Families in Health Care Decision-making

Patient and Family Advisory Committee

Expanding patient engagement across the health care system is a key commitment outlined in the *Patients First Act*. The main element of this approach was to establish Patient and Family Advisory Committees in each of Ontario's 14 LHINs, the province-wide Minister's council and coordinated information sharing between these committees with the creation of the Provincial Patient and Family Advisory Committee Leadership Table.

Through sharing their unique health care stories, opinions, perspectives and experiences, the voices of HNHB LHIN Patient and Family Advisory Committee members will help to inform and influence programs and services within their local health care system.

Recruitment for the HNHB LHIN Patient and Family Advisory Committee began in July 2017 with promotional materials distributed to stakeholders and community members through HNHB LHIN social media platforms and publications, including the LHINsight monthly newsletter and directed email campaigns, to ensure materials were reaching a diverse audience. Members were selected to ensure diversity that is reflective of the LHIN's population, including age, gender, cultural diversity, socio-economic status, geographic distribution across the LHIN region and experience with the health care system.

Mandate

The Hamilton Niagara Haldimand Brant Local Health Integration Network's Patient and Family Advisory Committee will aim to assist in shaping the LHIN's programs, services and initiatives designed to improve care in the LHIN.

***From left to right**: Shirley Verhage, Polliann Maher, George Goto, Olga McNeill, Bernice King- Minister's Patient and Family Advisory Committee member, Julie Drury-Chair, Minister's Patient and Family Advisory Committee, Josephine Quercia, Jori Warren, Anne Marie Cargnelli, Co-chair, HNHB LHIN Patient and Family Advisory Committee, Janice Kucharew, Clarence Wheaton, Christina Gilman - Minister's Patient and Family Advisory Committee member*

The LHIN Patient and Family Advisory Committee will apply its 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 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 LHIN CEO, LHIN staff, service providers and partners.
- Link and collaborate with other patient and family advisory groups within the LHIN and across the province as appropriate.

Patient and Family Advisory Committee – Progress To Date

The HNHB LHIN Patient and Family Advisory Committee held its inaugural meeting September 14, 2017. Members shared their personal experiences and motivation for joining Patient and Family Advisory Committee and LHIN staff provided an overview of the HNHB LHIN and reviewed the Minister's mandate.

At its January 2017 meeting, the Minister's Patient and Family Advisor Council Chair, ministry staff and Minister's Patient and Family Advisor Council members who live within the HNHB LHIN attended the meeting to share their vision for how the Minister's Patient and Family Advisor Council and local Patient and Family Advisory Committees will work together.

As part of her role as Patient and Family Advisory Committee Co-Chair, Anne Marie Cargnelli will be to serve as the HNHB LHIN Patient and Family Advisory Committee representative at the Provincial Patient and Family Advisory Council Leadership Table. The Patient and Family Advisory Council Leadership Table will provide an opportunity for the Co-Chairs to learn what is happening at the ministry level and to share that information across the LHIN. HNHB LHIN's Patient and Family Advisory Committee is now focused on creating a work plan that will identify priorities for the next few years and the recruitment of a Francophone Committee member continues.

Caregiver Recognition Program

Caregivers are essential and valued partners in health care. HNHB LHIN is pleased to continue the existing *Heroes in the Hom*e Caregiver Recognition Program, which recognizes and celebrates unpaid caregivers who give their time, effort and devotion to care and support their loved ones who may at home, in hospital, in the community at retirement homes, convalescent care, long-term care homes or at school.

Anyone can nominate a caregiver who lives within the HNHB region and provides care and support to anyone living in Ontario. Nominations are accepted throughout the year with recognition events held in the fall across the region.

For 2017, caregiver recognition events were held in four communities across the LHIN – St. Catharines, Burlington-Hamilton, Brantford, and Simcoe – celebrating 120 unpaid caregivers. Planning and promotion for the 2018 *Heroes in the Home* program began in December 2017 and events will be held in the Fall of 2018.

Local Health System Performance

MLAA Performance Indicators

Figure XX: MLAA Performance Indicators

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)
Performance Indicators									
1. Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date they were authorized for personal support services*	95.00%	85.39%	85.36%	89.86%	88.50%	89.37%	90.28%	89.92%	89.84%
While higher than the provincial average, HNHB LHIN's current performance remains below the provincial target. In Q3, the HNHB LHIN continued to audit all instances when personal support service was not delivered within five days. The analysis identified where in the process of accessing care a delay or barrier may have occurred. In Q3, contributing factors were found to be: Patient/family member initiating a change in the first visit (e.g., prefer to delay, cancelled by patient, not available – 56%); LHIN ordering service outside of the expected five days (6%). A recent case review found that the Patient Available Date (PAD) was not being changed/updated to reflect the patient's preference to delay or cancel a first visit. **Action:** The LHIN conducted a review of service authorization practices based on patient available date with hospital teams; however, a more fulsome strategy is required to support community teams and is currently underway. This includes the ability to pre-plan services based on the date a medical intervention is required or a when a patient requests a change in first visit date. This will ensure that the five day target is maintained in all circumstances. Focused education was developed in Q4 and executed in Q1. The LHIN expects to see a 3-5% improvement in this metric once the PAD is used appropriately.									
2. Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	94.00%	96.07%	96.21%	92.67%	93.69%	95.97%	95.92%
The HNHB LHIN exceeded the provincial target for this metric in Q3 and Q4. The percentage of individuals receiving their first nursing visit within five days was slightly higher for hospital referrals (96.8%) compared to community referrals (94.8%). The 'contributing factors' audit tool continued to be used with nursing providers to ensure each case was reviewed and tracked to provide deeper analysis for action. Patient preference to delay the first visit continues to be the top contributor. **Action:** A review of contributing factors is completed with each service provider at their quarterly meeting and will continue to monitor performance. An analysis of ordering errors was recently undertaken to inform messaging to staff. Refresher education regarding appropriate use of Patient Available Date is currently underway and is anticipated to result in a 1.5-1.7% improvement. The LHIN will continue to explore opportunities to sustain or improve current performance. HNHB LHIN expects to continue to achieve the provincial target for this indicator in Q4 2017-18.									

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)
Performance Indicators									
3. 90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	29.00	29.00	30.00	29.00	23.00	25.00	28.00	28.00
HNHB LHIN's current overall performance of 25 days is three days better than the provincial performance and four days worse than the provincial target for this metric. The wait time for this metric is measured in two intervals: application to authorization and authorization to first service. The 90th percentile wait time interval from application to authorization is currently 19 days, which is the same as provincial performance. The wait time interval from authorization to first service is currently seven days, which is four days lower than the provincial performance of 11 days. Reasons for delay from application to authorization: Difficulty contacting patient/family to book home visit to determine patient's eligibility for Home Care services; Patient/family request e.g. spouse/child to be present for Care Coordinator's home visit; Home Care referral opened for a reason other than direct service provision e.g. long-term care home application and remained open as 'Case Management only' until the patient later required direct service provision. Delay from authorization to first service visit include: Service Provider experienced similar delays in contacting patient/family to book first visit; Pre-planning of service. **Action:** One of the initiatives the HNHB LHIN continues to explore is a sub-region specific mobile intake assessment model that places the first intake visit within five days of the referral. This model will improve the patient experience by reducing duplication of assessment and moves the comprehensive intake assessment from a phone-based assessment to a face-to-face assessment in the patient's home. In addition, as the model for embedding Care Coordinators in primary care progresses, new referrals that originate in primary care offices will be processed more efficiently as a result of improved communication identifying need for urgency with referral, thus reducing the delay between referral from primary care to processing time at the LHIN. Both initiatives should reduce the 'application to authorization' interval.									
4. 90th Percentile Wait Time from Hospital Discharge to service Initiation for Home & Community Care*	TBD	7.00	7.00	7.00	7.00	6.00	7.00	6.00	6.00
HNHB LHIN's current performance (six days) is better than the provincial performance (seven days). There is no provincial target. For home and community care referrals that originated from a hospital, 90% of patients received their first service provider visit within six days. HNHB LHIN performance has been stable at six days or less for the past seven quarters. Services are ordered and initiated based on medical directives or discharge planning care plans at time of hospital discharge. First service date is clinical aligned with the medical order. Delays may occur when provider availability of personal support staff become challenging or when patient or family make changes to the established first visit date. **ACTION**: There are no performance issues to address at this time. When performance issues arise, the HNHB LHIN will discuss performance specific to hospital referrals.									

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)
Performance Indicators									
5. 90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	9.97	10.38	10.75	13.28	12.83	14.53	15.97
There has been a declining trend in performance in the HNHB LHIN from 2015-16 to 2017-18 in the 90th percentile ED length of stay for complex patients, with a declined performance of 1.4 hours over the last year. Most hospital sites have 90th percentile length of stay for complex patients longer than the 8 hour target. Provincial performance has also seen increased wait times and ED length of stay continues to be fewer hours than the HNHB LHIN. Time spent in the ED by admitted patients is the driver impacting the LHIN performance. Challenges for improving the metric include increased ED volumes, increased patient acuity, increased ambulance volumes and hospital occupancy pressures. **Actions taken to improve performance** focused on increasing capacity within the hospital and community, these include: designated funding to support 159 surge beds, introducing designated Patient Flow Directors and Integrated Managers of Transition, introducing of hospital Behavioural Supports Ontario Clinical Leads, establishing the Seniors Mobile Assess Restore Team (SMART) program, expanding community Transitional Care Program and supporting 51 subsidized supportive housing units for patients waiting in hospital. The Emergency Services Steering Committee continues to put an emphasis on community and admission avoidance initiatives, as well as the patient flow strategies.									
6. 90th Percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.15	4.38	4.50	4.55	4.57	5.08
HNHB LHIN did not meet the MLAA target of 4 hours for the non-admitted ED length of stay for minor/uncomplicated patients in 2017-18 by 1.08 hours. The length of stay has increased by about 30 minutes since 2015-16. Two hospital sites in the HNHB LHIN are meeting the target; the remaining hospital sites have wait times approximately 1.5 hours longer on average than the target. Sites with the longest length of stay for minor patients are continually pressured by the volume of complex patients in the ED and ambulance arrivals. These hospital continue to report challenges in redirecting resources away to the minor/uncomplicated patient population when the volume of complex patients is larger. During the winter flu surge season hospitals are also more challenged to direct resources away from critical and complicated flu patients. **Actions**: Hospital sites make regular adjustments in order to meet the needs of minor/uncomplicated patients by assessing patients in rapid assessment zones, and starting nursing and physician assessments while patients are still in the waiting room.									
7. Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.97%	78.47%	77.99%	75.06%	79.22%	73.88%	66.32%
HNHB LHIN decreased in performance in this metric since 2015-16 fiscal year and continues to fall below the target of 90%. Overall HNHB LHIN wait time performance is driven largely by HHSC as the LHIN's largest provider of hip/knee replacement surgeries. The need for hip replacement surgery continues to significantly outpace available surgical resources. Flu season coupled with existing pressures for access to hospital bed resources resulted in surgical cancellations. **Actions**: HNHB LHIN focused on reallocation of funding to hospitals with additional capacity to ensure cases were completed. HNHB LHIN expanded the Regional Joint Assessment Program to all include mandatory central intake for hip and knee replacement cases. Central intake and assessment is expected to significantly improve data quality and accuracy with respect to wait times, as well as improve a patient's ability to make an informed decision on the basis of expected surgical wait times. HHSC will be managing the musculoskeletal (MSK) Central Intake and Assessment Clinics (CIAC) across the HNHB LHIN.									

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)
Performance Indicators									
8. Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	79.14%	75.02%	73.72%	72.25%	75.32%	66.34%	63.41%
HNHB LHIN decreased in performance in this metric since 2015-16 fiscal year, and continues to fall below the target of 90%. Overall HNHB LHIN wait time performance is driven largely by HHSC as the LHIN's largest provider of hip/knee replacement surgeries. The need for hip replacement surgery continues to significantly outpace available surgical resources. Flu season coupled with existing pressures for access to hospital bed resources resulted in surgical cancellations. **Actions**: HNHB LHIN focused on reallocation of funding to hospitals with additional capacity to ensure cases were completed. HNHB LHIN expanded the Regional Joint Assessment Program to all include mandatory central intake for hip and knee replacement cases. Central intake and assessment is expected to significantly improve data quality and accuracy with respect to wait times, and to improve a patient's ability to make an informed decision on the basis of expected surgical wait times. Hamilton Health Sciences will be managing the musculoskeletal (MSK) Central Intake and Assessment Clinics (CIAC) across the HNHB LHIN.									
9. Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.50%	15.69%	15.18%	18.23%	16.21%	16.27%	16.39%
In 2017-18, HNHB LHIN noted a 0.13% increase in the Percentage of ALC Days compared to 2016-17 and continues to perform higher than the target of 9.46%. Performance also remains slightly higher than the provincial average. ALC days are influenced by the discharge of patients who have accumulated a high number of ALC days while waiting for discharge to the most appropriate destination. Patients experiencing long waits for discharge are a focus for the HNHB LHIN. **Actions**: HNHB strategies focused on revitalizing the home first philosophy across HNHB LHIN. Components of this work include: standardization of processes for ALC designation, determining appropriate discharge destinations, and standardized messaging and communication. Additional strategies include supporting discharge of patients with higher care needs requiring enhanced services through LHIN Home and Community Care, introduction of designated Patient Flow Directors and Integrated Managers of Transition, introduction of hospital Behavioural Supports Ontario Clinical Leads, expansion of community Transitional Care Program and supporting 51 subsidized supportive housing units for patients waiting in hospital.									
10. ALC Rate	12.70%	13.70%	13.98%	15.19%	15.68%	15.78%	13.61%	14.31%	15.91%
In 2017-18, HNHB LHIN has seen increase in the ALC rate compared to 2015/16 and is higher than the MLAA target of 12.70%. The high volumes of patients presenting to the ED with complex medical needs and being admitted, limited social support to return home, and limited financial capacity to access alternative environments like retirement homes, are some of the factors contributing to the high ALC rate. **Action**: HNHB LHIN continues to work on a number of strategies to improve patient flow, these include; revitalizing the home first philosophy across HNHB LHIN, supporting discharges for patients with higher care needs requiring enhanced services through LHIN Home and Community Care, introduction of designated Director of Patient Flow and Integrated Managers of Transition, introducing hospital Behavioural Supports Ontario Clinical Leads, expansion of community Transitional Care Program and supporting 51 subsidized supportive housing units for patients waiting in hospital.									

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)
Performance Indicators									
11. Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.19%	20.67%	20.97%	18.59%	18.78%	20.40%	19.97%
In 2017-18, there has been a slight decrease in the percentage of unscheduled emergency visits for mental health conditions compared to 2016-17. Performance remains higher than the target of 16.30% however is lower than the provincial average. HNHB LHIN has the second highest volume of ED visits for mental health conditions across the province. Clinically, stress related conditions continue to represent the highest volume of ED visits. **Actions**: expansion of the Health Links model, working with the HNHB Mental Health and Addictions Advisory Committee on a plan that focused on increasing knowledge and expertise on concurrent disorders. Identified factors contributing to repeat use of ED supported the introduction of new programs such as the Prioritizing Health through Acute Stabilization and Transition (PHAST) program at Joseph Brant Hospital, Burlington for individuals age 16+ with mental health and/or addictions concerns who are assessed to have an urgent need for acute stabilization interventions.									
12. Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.01%	32.50%	32.25%	27.11%	30.10%	29.57%	29.63%
In 2017-18, HNHB LHIN had similar performance in the percent of repeat unscheduled emergency visits for substance abuse conditions, compared to 2016-17. Performance continues to be higher than the target of 22.4% and is consistently better than the provincial average. HNHB LHIN has the second highest volume of ED visits for substance abuse conditions across the province. **Actions**: In 2017-18 the HNHB LHIN completed current and future state mapping of addictions services by sub-region, together with health service providers and community partners. The focus was to identify a coordinated and integrated pathway for addiction services and identify opportunities to optimize existing capacity, populations served, and potential service gaps/duplications. In 2017-18, the LHIN invested in a range of strategies across the LHIN with a focus on opioid use.									
13. Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65%	16.74%	16.41%	16.50%	16.60%	16.97%	16.07%
HNHB LHIN performance for Readmission within 30 days for selected HIG conditions has improved by 0.9% from 2016-17 to 2017-18 and continues to be within 10% of the 15.5% target. This performance is slightly better than the provincial performance. Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Gastrointestinal diagnoses are clinical cohorts that inflate this metric. **Actions**: the LHIN continues to work with its Integrated Comprehensive Care Program, Caring for My COPD, Health Links, and Diabetes programs to improve hospital readmissions.									

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)
2. Monitoring Indicators									
14. Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	88.09%	85.01%	83.95%	84.78%	85.21%	84.90%	88.76%
There has been an improved performance in this metric in the HNHB LHIN from 2014-15 compared to 2017-18. HNHB LHIN performance is better than the province. The HNHB LHIN Vision Steering Committee provides strong clinical leadership with a focus on improving access and quality of services. **Actions**: reallocation of unilateral cataract cases to hospitals with the longest wait times.									
15. Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	59.47%	62.58%	67.57%	69.77%	58.73%	60.45%	61.45%	70.24%
There has been an improving trend in HNHB LHIN performance for percent of priority 2 and 3 cases completed within target for MRI scans from 2014-15 to 2017-18, however performance continues to fall below the provincial target of 90%. **Action**: The HNHB Diagnostic Steering Committee introduced a common referral form in 2017-18 across LHIN hospitals. The HNHB LHIN continues to closely monitor the performance of hospital sites.									
16. Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	78.25%	78.18%	82.11%	84.73%	72.83%	74.70%	71.75%	78.18%
HNHB LHIN performance for the percentages of priority 2 and 3 cases completed within target for CT scans has improved but continues to fall below the provincial target of 90**%. Action**: The HNHB Diagnostic Steering Committee introduced a common referral form in 2017-18 across LHIN hospitals. HNHB LHIN continues to closely monitor the performance of hospital sites specifically hospital sites completing high volumes of CT scans.									
17(a).Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	13.00	14.00	9.00	8.00	8.00	8.00
The performance for wait time to complete eligibility for long-term care has remained steady and above provincial average from the community setting. This wait time metric is directly impacted not only by the work of the LHIN staff internally but also the turnaround time for health assessors such as physicians and nurses to submit the health assessment form which is a required piece of the application package used to determine eligibility. In addition patients and families must submit a facility choice form in order to complete the application package. The time it takes for families to make these decisions and submit their facility choice form also directly impacts the total wait time to be determined eligible as this facility choice form is a part of the eligibility determination package. **ACTION –** The LHIN is looking at opportunities to use internal direct care registered nurses to complete the health assessment form for patients to reduce wait time.									

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)
Monitoring Indicators									
17(b).Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	7.00	7.00	6.00	5.00	6.00	8.00
The performance for wait time to complete eligibility for long-term care has deteriorated from the hospital setting with the growing number of patients who were designated as needing an alternate level of care to long-term care inside of the hospital setting. This wait time metric is directly impacted not only by the work of the LHIN staff internally but also the turnaround time for health assessors such as physicians and nurses to submit the health assessment form which is a required piece of the application package used to determine eligibility. In addition patients and families must submit a facility choice form in order to complete the application package. The time it takes for families to make these decisions and submit their facility choice form (they often are encouraged to tour facilities before making choices) also directly impacts the total wait time to be determined eligible as this facility choice form is a part of the eligibility determination package. **ACTION –** with the renewed Home First philosophy fewer patients will be placed from hospital. For those who must be placed from hospital as they cannot return to community a dedicated LTC assessor will be assigned to expedite the process. Assessors will be working with families and caregivers to achieve a target of 3- 5 days for the submission of the facility choice form and ensuring they are aware of how a timely submission impacts their eligibility determination.									
18. Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	18.47	17.12	12.06	22.27	20.06	19.61	13.34
HNHB LHIN has demonstrated considerable improvement in the rate of emergency visits for conditions best managed elsewhere with a reduction of 6.27 since 2016-17 and 8.93 since 2014-15. The rate remains somewhat higher than the provincial average however. **ACTIONS**: Family Health Teams and other primary care practices are encouraged to provide same day appointments and ensure after-hours access for patients. There have also been focused communications to the public to increase awareness of alternatives to Emergency Departments for seeking care as appropriate. This includes seasonal messages during peak times with high rates of influenza.									
19. Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	320.13	321.18	243.31	389.33	397.01	411.62	300.54
The rate of hospitalization for conditions that are sensitive to ambulatory care intervention and monitoring improved considerably in the HNHB LHIN between 2016-17 and 2017-18. The rate is also lower than the provincial average. ACTIONS: There are a number of programs that have been implemented within HNHB LHIN that could contribute to the improvement in this rate. Patients who receive coordinated care plans as part of the Health Links model experienced significantly fewer hospitalizations after implementation of the care plan. There are four Community Paramedicine led programs in the HNHB LHIN that support individuals in their homes or in clinics living with chronic conditions. These programs have resulted in reductions in the number of 911 calls, and avoidance of ED visits and lengthy hospitalization. Finally, HNHB LHIN home and community care work directly with hospital partners to discharge patients home from the ED with support, and mitigate the risk of hospitalization.									

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Result (Year to Date)	2017/18 Result (Year to Date)
Monitoring Indicators									
20. Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	46.61%	47.43%	47.31%	47.71%	48.07%	48.25%	49.43%
HNHB LHIN has demonstrated modest improvements in this indicator since 2014-15 and continues to perform slightly better than that provincial average. Actions: There have been efforts to improve the communication between hospitals and primary care to ensure that they are notified when patients are admitted. This enables primary care to better facilitate post-hospital follow-up as appropriate.									

***FY 2017/18 is based on the available data from the fiscal year (Q1-Q3, 2017/18)**
****FY 2017/18 is based on the available data from the fiscal year (Q1-Q2, 2017/18)**

Financial Statements and Notes

https://healthcareathome.ca/document/hnhb-financial-statement-2017-18en/

Board Members

(as of March 31, 2018)

Janine van den Heuvel
Chair

Bill Thompson
Vice Chair

Shelley Moneta
Board Member

Dominic Ventresca
Board Member

Madhuri Ramakrishnan
Board Member

Paul Armstrong
Board Member

Saqib Cheema
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Suzanne Belanger-Fontaine
Board Member

Marianne Knight
Board Member

William Chopp
Board Member

Senior Staff Member

Donna Cripps
Chief Executive Officer

On behalf of the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network, we are pleased to submit this Annual Report for the period ended March 31, 2018.

ORIGINAL SIGNATURES TO BE ADDED

Janine van den Heuvel
Chair, Board of Directors

Bill Thompson
Vice Chair, Board of Directors

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

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