North East **LHIN**
RLISS du Nord-Est

NORTH EAST LOCAL HEALTH INTEGRATION NETWORK

Annual Business Plan 2013/14

June 2013

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

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TRANSMITTAL LETTER FROM THE NORTH EAST LHIN BOARD CHAIR

June 4, 2013

Catherine Brown
Assistant Deputy Minister
Health System Accountability and Performance Division
Ministry of Health and Long-Term Care

Dear Assistant Deputy Minister Brown,

The North East Local Health Integration Network (NE LHIN) is pleased to provide you with our 2013/2014 Annual Business Plan (ABP) as required by the Local Health System Integration Act, the Ministry/LHIN Memorandum of Understanding, and the Ministry/LHIN Performance Agreement (MLPA).

This ABP focuses on the first year of our 2013-2016 Integrated Health Service Plan. It speaks to our mission to provide "*Quality Health Care When Northerners Need It.*" It builds on our previous year's successes, and encourages transformational change. It aligns with Ontario's Action Plan for Health Care and the desired outcomes of the Excellent Care for All Act (2010).

Determined through discussions and extensive engagement with fellow Northerners, the four priorities of our IHSP include the need to:

- Increase Primary Care Coordination
- Enhance Care Coordination and Transitions to Improve the Patient Experience
- Make Mental Health and Substance Abuse Treatment Services More Accessible
- Target the Needs of Culturally Diverse Population Groups

These priorities are supported by the enablers of: electronic health record opportunities; realignment and system transformation; and the recruitment and retention of health human resources.

We will continue to focus our efforts on shifting the local health care system from a provider-centered system of care to a more patient-centered one. Knowing that our region spans 40% of Ontario's land mass and is home to 4% of its population, our efforts will continue to break down silos, encourage integration and increase access to care closer to where people live. With 18% of our population age 65 and over (projected to double in 20 years), higher rates of chronic disease, and complex medical issues, the need for more care to be provided at home, in community, and centered on the needs of Northerners, will continue to guide our efforts and decisions.

Please do not hesitate to discuss this ABP with either myself or our CEO Louise Paquette.

Sincerely,

Elaine Pitcher
Board Chair

MANDATE AND STRATEGIC DIRECTIONS

NE LHIN Vision
Quality health care, when you need it.

NE LHIN Mission
To advance the integration of health care services across Northeastern Ontario by engaging our communities.

Aligning with Ontario's action plan to make Ontario the healthiest place in which to grow up and to grow old, we have embraced the plan's three patient-centred priorities:

1. Keeping Ontario healthy
2. Faster access and a stronger link to family health care
3. Right care, at the right time, in the right place.

Using this framework, and the outcomes of extensive local community engagements, our LHIN is moving forward. The latest example is aligning our IHSP 2013-2016 with LHIN system imperatives and Ontario's Action Plan for Health Care which outlines actions to meet the challenge of managing spending growth while continuing to provide high-quality care to all Ontarians.

OVERVIEW OF CURRENT AND FORTHCOMING PROGRAMS/ACTIVITIES

The North East LHIN funds 185 health services providers across six sectors; including:

- Hospitals (25)
- Community Health Centres (6)
- Community Mental Health & Addictions (48)
- Community Support Services (63)
- Long-Term Care Homes (42)
- Community Care Access Centre (1)

In the next three years, the NE LHIN will work in collaboration with health service providers to move our health system from provider to patient-centred, and ensure outcomes and evidence drive quality care. Realignment and integration efforts will be key to this shift and our commitment to developing partnerships will continue.

Overall, the LHIN is aligning people, providers and resources to ensure that we successfully complete the projects provided in this plan, and advance our region's strategic plan for quality health care when Northerners need it. See summary on next page.

North East LHIN IHSP Summary, 2013 – 2016

Ontario's Action Plan For Health Care

- Keeping Ontario Healthy
- Faster Access and a Stronger Link to Family Health Care
- Right Care, Right Time, Right Place

LHIN System Imperatives

- Enhance Access to Primary Care
- Enhance Coordination & Transitions of Care for Targeted Populations
- Implement Evidence Based Practice to Drive Quality and Safety
- Holding the Gains

North East LHIN Priorities

- Increase Primary Care Coordination
- Enhance Care Coordination and Transitions to Improve the Patient Experience
- Make Mental Health and Substance Abuse Treatment Services More Accessible
- Target the Needs of Special Population Groups - Aboriginal and Francophone

By 2016, the North East LHIN will:

- Improve access to high quality primary care for Northerners
- Improve access and quality through greater service coordination
- Improve access and system navigation for consumers and their families
- Enhance access to health care services that are linguistically and culturally appropriate
- Increase the integration of primary care within the broader continuum of care
- Improve client transitions between service providers along the continuum of care
- Increase community capacity to provide more care options for Northerners while decreasing acute sector pressures
- Increase system navigation, service coordination and access to care
- Engage and collaborate with primary care providers to better support the patient journey
- Enhance targeted service capacity where required
- Enhance care supports for people with complex issues through increased collaboration
- Increase access to mental health and substance abuse services

ASSESSMENT OF ISSUES FACING THE NE LHIN (ENVIRONMENTAL SCAN OF OPPORTUNITIES AND RISKS)

The NE LHIN has 185 Accountability Agreements which hold health care service providers accountable to deliver $1.4 billion in front-line health care each year. These agreements include:

- 118 Multi Sector Service Accountability Agreements (M-SAAs)
- 25 Hospital Service Accountability Agreements (H-SAAs)
- 42 Long-Term Care Service Accountability Agreements (L-SAAs)

Given the geographic size and the diversity of Northeastern Ontario (approximately 22% Francophone, 10% Aboriginal/First Nation/Métis), five HUB planning areas have been created, based on hospital referral patterns. These geographic areas help to support local planning and realignment efforts, particularly in enhancing access to care as close to home as possible.

Access to Health Services

The NE LHIN has 538 Family Physicians, one Group Health Centre in Sault Ste. Marie (34 family physicians), 27 Family Health Teams, six Community Health Centres, six Nurse Practitioner-Led Clinics, 16 Nursing Stations and three Aboriginal Health Centres.

The Health Care Connect Program began in February 2009 in Ontario and has helped Northerners connect with primary care providers. Between February 2009 and January 2013, 46,982 NE LHIN residents had registered with the program and nearly 70% had been referred to a family health care provider.

In the NE LHIN, there are 108 long-term care beds for every 1,000 people aged 75 and over (2012), as compared to 86 beds per 1,000 people aged 75 and over in Ontario.

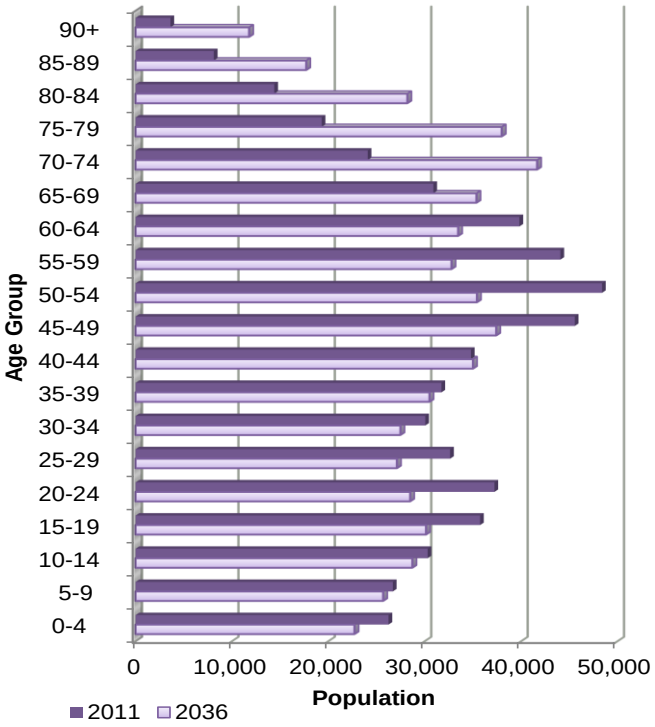
Life Span

Both male and female NE LHIN residents have a shorter life expectancy than residents of Ontario: 76.5 years for males (79.2 years in Ontario), and 81.4 years for females (83.6 in Ontario).

The leading causes of death for NE LHIN residents, as well as all Ontarians, are circulatory system diseases (such as heart disease and strokes) and neoplasms (cancer). The rate of circulatory system disease deaths (deaths per 100,000 population) is 22% higher in the NE LHIN than in Ontario; neoplasms are 16% higher.

Premature mortality, a measure of death rates (per 100,000 population) prior to age 75, is 26% higher in the NE LHIN compared to the province.

New/Emerging/Evolving Drivers of System Change



Population Change

The NE LHIN population is projected to change dramatically over the next 25 years. The proportion of the population age 65 and over is projected to increase from 18% to 30% by 2036. The estimated number of seniors (65+) is projected to increase by 72%, from just over 100,000 to over 172,000 (note the provincial average is expected to increase by about 67%). This significant demographic shift has major implications on the delivery of health care and the type and location of services delivered.

The overall NE LHIN population is projected to increase by only 1% between 2011 and 2036.

Overall, compared to the province, the North East has a higher:

	North East LHIN	Ontario*
Proportion of Aboriginal Identity	9.5%	2.0%
Proportion of Francophones	22%	4.4%
Proportion of people living in rural areas	30.2%	14.1%
Proportion of people over the age of 65	18%	14.6%
Unemployment rate for ages 15+	8.4%	6.4%
Proportion age 25 and over who do not have a post-secondary degree, diploma or certificate	18.4%	13.5%
Percentage of smokers	25.4%	19%
Percentage of drinkers reporting heavy drinking	19.9%	16.2%
Percentage of adults (age 18+) who are overweight or obese	61.7%	52.3%
Prevalence of high blood pressure	22.5%	17.4%
Percentage of residents with multiple chronic conditions	21.5%	15.2%

The North East region is also associated with a lower:

	North East LHIN	Ontario*
Proportion of the population who have a regular medical doctor	85.2%	90.9%
Proportion of the population rating their health as very good or excellent	57.9%	60.7%
Proportion of population reporting physical inactivity	44%	49%

(The information above is from Statistics Canada - both the 2011 Census and the Canadian Community Health Survey, 2010)
*Ontario percentages also include Northeastern Ontario percentages.

HEALTH SYSTEM PERFORMANCE

The MLPA defines the relationship between the Ministry of Health and Long-Term Care and the NE LHIN in the delivery of local health care programs and services. The MLPA establishes a mutual understanding between the Ministry and the LHIN and outlines performance indicators within a defined period of time. Indicators are updated every quarter; for an up-to-date status report on indicators, please contact the NE LHIN or visit www.nelhin.on.ca.

	Performance Indicator	LHIN 2012/13 Starting Point	LHIN 2012/13 Performance Target	Most Recent Quarter 2012/13 LHIN Performance	% from Target for Most Recent Quarter Result*	FY 2012/13 LHIN Annual Result
Emergency Room/Alternate Level of Care						
1	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	32.1	22	27.4	25%	22%*
2	90th Percentile Emergency Room (ER) Length of Stay for Admitted (LOS) Patients	28.3	25	31	24%	29
3	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	7.6	7	6.3	-10% (on target)	6.5
4	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	4.7	4	4.2	5% (within performance corridor)	4.1
Surgical Wait Times						
5	90th Percentile Wait Times for Cancer Surgery	61	56	54	-3.6% (on target)	59
6	90th Percentile Wait Times for Cardiac By-Pass Procedures	31	49	37	-25% (on target)	53
7	90th Percentile Wait Times for Cataract Surgery	156	155	146	-6% (on target)	148
8	90th Percentile Wait Times for Hip Replacement	306	300	275	-8% (on target)	276
9	90th Percentile Wait Times for Knee Replacement	402	300	378	26%	393
Diagnostic Wait Times						
10	90th Percentile Wait Times for Diagnostic MRI Scan	106	65	37	-43% (on target)	47
11	90th Percentile Wait Times for Diagnostic CT Scan	29	28	32	14%	34
Excellent Care for All/Quality						
12	Readmission within 30 Days for Selected CMGs**	16.1%	15%	16.7%	11%	16.9**
Mental Health and Substance Abuse						
13	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions***	18.3%	16.5%	17.6%	7% (within performance corridor)	16.7**
14	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	26%	25%	25.4%	1.6% (within performance corridor)	26.9**
Access to Community Care						
15	90th Percentile Wait Time for CCAC In-Home Services Application from Community Setting to first CCAC Service* (excluding case management)	56	48	49	2% (within performance corridor)	59*

* FY 2012/13 is based on most recent four quarters of data (Q4 2011/12 – Q3 2012/13) due to availability

** FY 2012/13 is based on most recent four quarters of data (Q3 2011/12 to Q2 2012/13) due to availability

REPORT ON MLPA PERFORMANCE INDICATORS

NE LHIN wait times improved for a number of indicators in 2012/13. Improvements were seen in Alternate Level of Care and wait times for Emergency Room, MRI, Cancer and Cataract surgeries.

Emergency Room/Alternate Level of Care

Alternate Level of Care (ALC): Good progress was made in 2012/13 with the percentage of ALC days in acute care decreasing from over 30% to 20% through Q2 and increasing to 27.4% by Q3 due to planned hospital discharges. The NE LHIN continues to support a number of initiatives to help bring down ALC rates including: home first, assisted living, integrated discharge planning, assess and restore beds, behavioural supports for seniors in long-term care facilities, case managers in selected family health teams, and more.

Emergency Room (ER): ER length of stay (LOS) performance for admitted patients was below target for most of the year but increased above target in Q4 consistent with trends in the province and due largely to inpatient flow challenges related to ALC. Nine of 11 monitored sites maintained an ER LOS below 25 hours. ALC patient challenges in Sudbury, North Bay, and Timmins were a factor in patient flow from the ER to inpatient beds.

- For high acuity non-admitted patients: ER LOS performance improved. High acuity refers to people presenting themselves to the ER for urgent health care issues and who are categorized as "CTAS 1 to 3". Consistently 9 of 11 reporting sites maintained ER LOS below 7 hours and overall NE LHIN performance was below target at 6.5 hrs.
- For low-acuity non-admits: ER LOS performance improved from 4.7 to 4.2 hours. Eight of 11 monitored sites maintained ER LOS below provincial target of 4 hours.
- Strategies to reduce ER LOS include: the four HUB hospitals participating in the provincial ED Pay for Results program, introduction of community support system navigators, NE CCAC Care Coordinators in primary care settings, and others.

Surgical Wait Times

Cancer Surgeries: Cancer surgery wait times improved and were within target in Q3 and Q4. New surgeons (urology, ear nose and throat) in Sault Ste. Marie, where previously none existed, resulted in wait times increasing in this community as patients were previously sent out of town to receive specialized care. Improvement in wait times were realized by surgeons working together to ensure data quality for the wait times information system and addressing efficiencies. It is anticipated that wait times for cancer surgery will continue to improve in 2013/14.

Cardiac Surgeries: Wait times for cardiac by-pass surgery continued to stay below target in 2012/13. As the regional provider of cardiac by-pass surgery, Health Sciences North in Sudbury continued to demonstrate high performance in this area. A temporary surge in patient volume in the spring-summer months resulted in a temporary increase in wait times that was addressed with additional operating room time and a reduction in wait time by Q3. At Q4, wait time was 37 days, well below target (49) and is anticipated to remain so in 2013/14.

Cataract Surgeries: Wait times for cataract surgeries improved and at Q4 were below target. It is anticipated that wait times will remain below provincial target in 2013/14.

Hip Replacements: Wait times for hip replacement surgery improved by 10% and was below target. All surgical sites were able to complete volumes. The *NE LHIN's Integrated Orthopaedic Capacity Plan (IOCP)* establishes targets for quality and wait time performance, as well as an aggressive strategy to repatriate surgeries completed on residents outside of the region. Over 50% of referrals have been redirected to conservative management or other care

options enabling surgeons to focus on those patients requiring surgery. This is possible because of the standardized approach to assessment implemented by advanced practice physiotherapists who have received specialized training from orthopaedic surgeons in each of the five NE LHIN funded joint assessment centres (JACS). JACs provide the opportunity for patients to review surgeons' wait lists and opt to select the next available surgeon. Expanding the role of the JACs to other procedures will be explored in 2013/14.

Knee Replacements: Wait times for knee replacement improved by 6%, however still remained above target. (See related information above under Hip Replacements.) The *NE LHIN's Integrated Orthopaedic Capacity Plan* will assist in improving wait times in 2013/14, as will the increased use of joint assessment centres.

Diagnostic Wait Times

MRI Scans: Wait times for MRI scans improved in 2012/13. The marked decrease (from 106 days to 37 days) is due to the commitment of each site to MRI-PIP (Performance Improvement Program) which enabled hospitals to improve the efficiency of MRI scanning and increase patient flow. The first MRI scanner at the North Bay Regional Health Centre in May 2011 has assisted in lowering wait times. It is anticipated that wait time for MRI will continue to be in the 35-40 day range in 2013/14.

CT Scans: Wait times for CT scans increased modestly in 2012/13 from 29 to 34 days at Q4. Very high demand for this modality, particularly in Sudbury (regional trauma centre, regional cancer centre), has contributed to the increase in wait times. Local experience in MRI-PIP is being applied similarly to CT scanning in Sudbury to improve efficiencies.

Excellent Care for All/Quality

Excellent Care for All/Quality (Readmission for Selected Case Mix Groups): Performance varied modestly from the set target for this indicator. Initiatives in Sudbury, such as the Congestive Heart Failure Clinic and Care Transitions Unit, are addressing this patient population and should have an impact on reducing readmissions to hospital. Case Managers in selected family health teams will contribute to earlier identification and treatment for frail elderly care. Deployment of Rapid Response Nurses (13) in Q1 will focus on the frail elderly with complex conditions and high risk of readmission to hospital. Telehomecare has engaged over 100 clients with heart failure or chronic obstructive pulmonary disease and will assist in keeping these residents healthier and reducing their risk of readmission to hospital. It is also anticipated that two Health Links will become operational in 2013/14 and will contribute to reduced hospital admissions for chronic conditions.

Mental Health and Substance Abuse

Repeat Unplanned ER visits for Mental Health and Substance Abuse: Overall, repeat visits within 30 days to the emergency room for mental health and substance abuse conditions were within acceptable performance range. Initiatives deployed include: addictions counseling resources in Health Sciences North ER, enhanced Community Crisis Support in downtown Sudbury, Peer Support Counsellor in North Bay Regional Health Centre ER, Case Manager in the ER at Sault Area Hospital, and access to more hours for "safe" beds for detox patients in Timmins. It is anticipated that rates will improve in 2013/14.

Access to Community Care

The wait time improved markedly in 2012/13 for North East Community Care Access Centre (NE CCAC) services for clients receiving home care in the community. Early in 2012/13, the NE CCAC identified the core client group that contributed to the longer wait time for the receipt of home care services in the community. These improvements will continue in 2013/14.

PRIORITY DETAILS, PLANS AND METRICS

Increase Primary Care Coordination

Priority Description

Primary care is essential to a truly integrated, patient-centered system of care. Primary care providers play a central role in helping patients navigate the system and improve transitions between care settings, particularly for seniors or people with complex needs. Providers are essential to the transformation of our health system, whether it's taking more responsibility for keeping people well, screening them appropriately for chronic diseases or managing their care when they are sick.

Greater involvement of primary care providers to improve system integration contributes to a more appropriate use of other care settings by helping people get the right care, in the right place, at the right time. Collaboration between primary care and other providers helps people living with chronic health conditions and places an emphasis on prevention, coordination and support for self-care.

In the past year alone, the NE LHIN engaged with more than 500 primary care providers including physicians, nurse practitioners, pharmacists and others in order to seek input on how to strengthen primary care access in Northeastern Ontario. Feedback from engagements outlined the need for a more effective and integrated system that uses health care resources more effectively while focusing more on the needs of people and patients. There was consensus around the need for local (sub-LHIN) partnerships or networks based on geography that would help to deliver better value for money, ensure higher quality of care, and improve access.

Engagement sessions also highlighted the need for a renewed primary care focus on post-acute and transitions of care beyond the hospital. This is important given the aging of the NE LHIN population and the fact that seniors tend to be high users of the health care system.

Having a strong and integrated post-acute system of care is pivotal to enabling seniors to convalesce in the comfort of their own home or preferred setting and to live independently longer, with the proper care supports around them. When patients have faster access to care, they stay healthier, get connected to the right care provider more quickly, and are less likely to require treatment in hospital.

Current Status

The Health Care Connect Program, administered by Community Care Access Centre (CCAC), helps patients connect with primary care providers. From the Health Care Connect Program, we see (as of December 2012) the NE LHIN:

- has the most total patients registered as a rate per 1,000 population (ranked #1 for reporting period March 2012 to December 2012)
- has the most total patients referred as a rate per 1,000 population (ranked #1 for reporting period March 2012 to December 2012)
- has the most Complex-Vulnerable (CV) patients registered as a rate per 1,000 population (ranked #1 for reporting period March 2012 to December 2012)
- has the most Complex-Vulnerable (CV) patients referred as a rate per 1,000 population (ranked #1 for reporting period March 2012 to December 2012)
- has the most Total Patients Registered Per Month (ranked #1 every reporting period month August 2012 to December 2012)
- has the most Total Patients Referred Per Month

We continue to work with the North East CCAC to determine how to better link Primary Care Providers with CCAC

Care Coordinators. These efforts include a pilot in which care coordinators are located within Primary Care practices.

Other initiatives aimed at supporting the integration of practice between primary care providers and the NE CCAC include a dedicated CCAC physician phone line, standardized communication protocols with primary care providers, emergency department notification of patients over 80 years, and improved communication through both print and website.

Other NE CCAC initiatives that will impact primary care include:

- the Telehomecare Program
- Rapid Response Nursing Program
- Mental Health and Addictions Nurses in Schools Program
- Palliative Care Nurse Practitioner Program
- Direct Care Providers
- Integrated Hospital Discharge Planning

Key issues identified during the primary care engagement sessions held in the fall of 2012 highlighted a need for better integration of primary care providers into the continuum of care, and for patients to have better access to their primary care providers.

In the fall of 2012, Dr. Alan McLean was hired as the North-East LHIN's Primary Care Physician Lead. One of his main objectives is to develop a Primary Care Advisory Council that can help shape and direct opportunities for more coordinated care in the primary care sector. He will also work with primary care providers on the topic of Advanced Access. We are currently recruiting for a second primary care physician lead who will assist with these efforts in addition to efforts within the diabetes education programs.

On December 1, 2012, the NE LHIN assumed the operational mandate of the diabetes Regional Coordinating Centres (RCCs) and the funding and accountability for 22 adult and four pediatrics diabetes education programs. As part of the RCC mandate to improve the quality of care related to pre-diabetes and diabetes services, the NE LHIN expanded the medical leads by including an additional primary care physician lead and an endocrinologist that will assist the LHIN to build and establish strong collaborative relationships between service providers and relevant stakeholders. This will help to drive quality improvement and adoption of best practice in diabetes care and management.

The NE LHIN Physician Office Integration (POI) project provides hospital reports (discharge summaries, lab, diagnostic imaging) that are electronically transferred from hospitals to the primary care providers' Electronic Medical Record. The project team continues to work with all hospitals within the NE LHIN, all EMR vendors and providers, OntarioMD and eHealth Ontario to ensure successful solutions and implementation.

For more information, please see the Electronic Health Records section of this plan.

Consistency with Government Priorities:

Ontario's Action Plan for Healthcare calls for a primary care system with faster and more convenient access to care including: same-day and next day appointments, after-hours care, and when necessary, house calls. The vision is for a more integrated system that puts primary care at the centre of the continuum. The Action Plan also signals a stronger role for LHINs in primary care to improve integration and accountability for outcomes.

Key policy directions and strategic reports also direct our goals including:

- Enhancing the Continuum of Care, Dr. Ross Baker, November 2011

- Care for our Aging Population and Addressing Alternative Level of Care, Dr. David Walker, June 2011
- Ontario's Action Plan for Health Care, January 2012
- Living Longer, Living Well, Dr. Samir Sinha, March 2013
- Health Links

The MOHLTC has identified five strategic directions for primary care in Ontario (Strategic Directions for Strengthening Primary Care in Ontario, Susan Fitzpatrick, September 13, 2012):

1. The need for strategically aligned goals, measures and priorities
2. The need for improved integration supported by governance
3. Patient-centred primary care
4. Improved accountability levers and alignment of incentives
5. Quality improvement

Action Plans	**2013/14**		**2014/15**		**2015/16**	
	Status	%	Status	%	Status	%
Goal 1: Improve access to high quality primary care for Northerners						
Promote Health Care Connect and work to increase patient rostering	In Progress	20%	In Progress	20%	In Progress	20%
Maximize scope of practice opportunities and strategies	In Progress	10%	In Progress	20%	In Progress	20%
Promote Advanced Access and after-hours care	In Progress	20%	In Progress	2%	In Progress	2%
Continue to expand telemedicine within primary care settings	In Progress	30%	In Progress	30%	In Progress	30%
Promote opportunities for interdisciplinary collaboration	In Progress	20%	In Progress	20%	In Progress	20%
Goal 2: Increase the integration of primary care within the broader continuum of care						
Support and strengthen the role of primary care in chronic disease prevention and management	In Progress	20%	In Progress	20%	In Progress	20%
Ensure primary care providers receive timely patient information upon discharge	In Progress	20%	In Progress	40%	In Progress	40%
Facilitate linkages between primary care and community services	In Progress	20%	In Progress	20%	In Progress	20%
Goal 3: Engage and collaborate with primary care providers to better support the patient journey						
Establish a North East Primary Care Advisory Council	In Progress	100%	Completed		Completed	
Explore the development of Health Links as a model of care, particularly for high users of the health care system	In Progress	20%	In Progress	20%	In Progress	20%
Focus on Quality Improvement initiatives that will ensure providers are equipped with current best practice guidelines that will improve patient outcomes	In Progress	20%	In Progress	20%	In Progress	20%

Metrics

Goal 1: Improve access to high quality primary care for Northerners

- Increase usage of Health Care Connect by residents and Primary Care Providers.

- Decrease in the number of CTAS IV/V ED visits.
- Reduced 30-day hospital readmission rates for select conditions.
- Increase in the number of Ontario Telemedicine Network (OTN) connections and consultations in primary care settings across the North East.

Goal 2: Increase the integration of primary care within the broader continuum of care

- Increase access to more integrated diabetes programs and services.
- Decrease in the number of CTAS IV/V ED visits.
- Reduced acute care readmission rate for high-use patients.
- Primary care visits within seven days for high-risk patients upon discharge from hospital.
- Reduction in the ALC rate in acute care.

Goal 3: Engage and collaborate with primary care providers to better support the patient journey

- Establishment of Primary Care Advisory Council and implementation of the l annual work plan.
- Number of operational Health Links Networks.
- Reduction in acute care admissions for chronic conditions.

Risks/barriers to successful implementation

- Lack of policy to support a shift of accountability for primary care to the LHINs
- Potential lack of Human Resources in the Primary Care Sector

Key enablers

- Expanded LHIN role and responsibility for primary care
- The development of Primary Care Quality Improvement Plans through Health Quality Ontario
- Expanded and enhanced electronic health records solutions to support clinical information sharing

Enhance Care Coordination and Transitions to Improve the Patient Experience

Priority Description

Over the past several years, the NE LHIN, in partnership with community stakeholders, has made significant investments to build community capacity. Some investments include: more assisted living services, Home First and integrated discharge planning in four large hospitals, assess and restore programs, geriatric emergency management nurses and system navigators in hospital emergency departments, additional community support services, and additional long-term care bed capacity.

While these investments have increased community capacity, notably for seniors and the frail elderly, they alone are not enough to support the increasing numbers of elderly people projected for Northeastern Ontario. The care of seniors is an area of focus in the NE LHIN's efforts to enhance coordination and transitions of care.

According to a 2010 study by the Canadian Health Services Research Group, about one per cent of Ontario's population accounts for 49 per cent of hospital and home care costs; 10 per cent of the population accounts for 95 per cent. This high-user group reflects a population that accesses care in a largely uncoordinated and fragmented manner. Evidence has shown that initiatives undertaken outside of an acute care setting, aimed at providing intensive case management support, help this high-user group navigate the system in a more efficient and effective manner.

In our engagements, Northerners strongly expressed a need for enhanced transportation services. This includes moving and supporting patients – including the elderly who no longer drive – from home to medical appointments, as well as between health service providers, such as hospitals, when required.

Current Status

The population 65+ in the NE LHIN is 18% compared to 14.6% for Ontario as a whole (Census 2011). By 2036, the population 65+ in the North East is projected to grow to 30% of the population or 172,000 persons from the current 100,000 individuals 65+.

The North East LHIN has shown significant progress in reducing the ALC rate in acute care over the past 2.5 years. From a high of nearly 41% in Q4 10/11, the LHIN is just over 20% in Q2 12/13 (per the most recent Stocktake Report of February 2013). Nonetheless, the NE LHIN continues to have the highest rate of ALC among LHINs in Ontario.

In a MOHLTC analysis of high users based on 2009/10 data:

- Of the 10% top high users in Ontario, 23,695 high users or 6% of Ontario were in the North East
- The overall NE LHIN population represents 4% of Ontario
- Total expense of $640 million in the NE for the top 10% high users (this group alone utilize 75% of NE LHIN health resources)

Efforts to reduce ALC long stay cases in acute care in the four large HUB hospitals are showing an impact which is beneficial for overall patient flow. On August 31, 2012, there were 112 ALC patients in acute with ALC LOS greater than 30 days. On February 8, 2013 there were 59 patients in acute with ALC LOS > 30 days at these four referral centres.

The North East is the highest user of Health Care Connect (HCC) in Ontario. From February 2009 to December 2012, the NE LHIN accounted for nearly one fifth of both total HCC registrations and complex vulnerable

registrations. Thirty thousand NE LHIN residents have been referred to a primary care provider through HCC. This demonstrates a significant need for access to primary care in the region particularly for complex cases.

The lack of service options in many communities in the North East poses a challenge (e.g. alternate settings for assisted living, transition/restorative care and end of life care). In 2010/11, the North East had the highest mortality rate of all regions in the province at 882 deaths/100 000 population while the province as a whole was at 633 deaths/100 000 (the lowest LHIN was Central West at 395 deaths/100 000). 56% of NE deaths occur in hospital which is the third highest of any region in the province. This points to a lack of community based alternatives along the continuum of end of life services available in the region.

Until 2009, the North East did not have a single resident geriatrician or specialized geriatric programming based within the region. As of 2012 there are two geriatricians and a developing North East Specialized Geriatric Services (NE SGS which is an associate member of the five Regional Geriatric Programs of Ontario). Given the current and projected seniors' population in the North East, the LHIN is working to develop specialized geriatric service capacity and linkages both at local and regional levels. This will facilitate and support the critical role of primary care providers as they address the needs of their complex frail elderly patients.

Care transitions at a clinical level must be supported by timely information sharing, particularly upon hospital discharge. Approximately 20 of the 25 NE LHIN hospitals are at a point where health record, diagnostic imaging and lab information can be sent electronically to physicians as part of the Physician Office Integration (POI) project. The LHIN is now working with EMR vendors to address compatibility requirements.

In 2012, CSS Navigators were introduced into the four NE LHIN HUB hospitals. Their role is to facilitate successful ED and inpatient discharges, particularly for the frail elderly population needing multiple supports. The key responsibilities for this position are: system coordination, supporting interdisciplinary service delivery, and knowledge care team and capacity building.

Since 2011, the NE CCAC has been piloting efforts by which Care Coordinators are located either within or adjacent to existing group practices. Care Coordinators are currently located part time in the following three primary care venues within the region: The Community Health Centre (Sudbury East), The Superior Family Health Team (Sault Ste. Marie) and the City of Lakes Family Health Team (Sudbury, multiple locations). This model has been implemented within the offices of North East Specialized Geriatric Services as well.

In addition to collocation efforts, the NE CCAC has also implemented primary care matching with its care coordinators. As per the direction of the North East LHIN, all 500+ family physicians and nurse practitioners within the region will be offered a single point of contact within the North East to facilitate planning and treatment of their patients. These care coordinators are all registered nurses or registered practical nurses with extensive experience in planning care in the primary care givers' community.

The development of the North East BSO sustainability plan has provided the North East LHIN with an opportunity to engage stakeholders on the Behavioural Supports Ontario (BSO) system of care in the region, solicit input on its future direction, identify potential gaps, and inform stakeholders on its progress so far. Stakeholder engagements for this plan included visits to three of our hub areas (Sudbury, Sault Ste. Marie and Timmins) reaching 81 individuals from a variety of sectors. In addition, a formalized sustainability assessment process was initiated with our BSO health service providers. The assessment highlighted the success of the efforts to date and indicated the need to communicate the BSO successes to internal Long Term Care home staff. In addition, more front line staff need to be involved in order to sustain the program. The stability of our current infrastructure would be enhanced by increased leadership participation.

Senior and clinical leadership from North Bay Regional Health Centre in partnership with all BSO health service

providers, will serve as the cornerstone of the implementation of a sustainability action plan. The transfer of the quality improvement functions has been considered in this plan and will build on the current planning and implementation of the BSO action plan.

Continued commitment from the NE LHIN to support and monitor the implementation of the action plan, improvement projects and funding for BSO will be essential to the ongoing success of this system change.

Elements of the BSO sustainability plan include: leadership and structure, quality improvement, measures and accountability, and gaps in service.

The four HUB hospitals and NE CCAC have implemented the Home First philosophy supported by Integrated Discharge Planning (IDP) processes between the hospitals and CCAC. Since September 2010, over 1,200 patients have been sent home using enhanced Home First services with 70% remaining in the community for 90+ days. Home First and IDP remain a key care coordination priority moving forward in terms of continued process improvement and expansion across hospital inpatient units as appropriate.

Consistency with Government Priorities:

These goals both stem from, and are aligned with, key policy directions and strategic advice provided to the Government of Ontario in the last year and a half. These include:

- Enhancing the Continuum of Care, Dr. Ross Baker, November 2011
- Caring for Our Aging Population and Addressing Alternative Level of Care, Dr. David Walker, June 2011
- Ontario's Action Plan for Health Care, January 2012
- Living Longer, Living Well, Dr. Samir Sinha, March 2013
- Health Links

Care coordination (particularly for complex patients) will reduce ED visits and hospitalizations leading to ALC, strengthen the role of primary care and ensure the right care is provided at the right time in the right place.

Actions Plans	**2013/14**		**2014/15**		**2015/16**	
	Status	%	Status	%	Status	%
Goal 1 - Improve access and quality through greater service coordination						
Expand patient navigation in hospital and community.	In Progress	33%	In Progress	33%	Completed	33%
Develop strategies to minimize avoidable (re-) hospitalization for high-risk / high-use patients.	In Progress	33%	In Progress	33%	Completed	33%
Implement best practices in patient risk assessments and integrated discharge planning.	In Progress	33%	In Progress	33%	Completed	33%
Develop one point of access for community support services per HUB.	In Progress	70%	In Progress	15%	Completed	15%
Goal 2 - Improve client transitions between service providers along the continuum of care						
Streamline client assessments between providers.	In Progress	20%	In Progress	50%	Completed	20%
Ensure timely sharing of patient information as high-risk clients/patients are discharged from hospital.	Not Yet Started	33%	In Progress	33%	Completed	33%
Partner with primary care providers on	In	20%	In	20%	In Progress	20%

continuity of care post-hospital discharge.	Progress		Progress			
Educate patients/clients/caregivers on service availability and options.	In Progress	20%	In Progress	20%	In Progress	20%
Continue to build on Resource Matching and Referral work to use LEAN techniques to efficiently move people throughout the health system.	In Progress	25%	In Progress	25%	In Progress	25%
Continue to implement initiatives to support more senior friendly hospitals.	In Progress	25%	In Progress	25%	In Progress	25%
Goal 3 - Enhance targeted service capacity where required						
Expand regional North East Specialized Geriatric Services (NE SGS) and support local geriatric service expertise.	In Progress	25%	In Progress	25%	In Progress	25%
Create new service delivery models to better meet the needs of seniors in their own homes.	In Progress	25%	In Progress	25%	In Progress	25%
Expand affordable seniors' assisted living services.	In Progress	20%	In Progress	20%	In Progress	20%
Develop the range and capacity of end of life services (hospice palliative care) across the North East.	In Progress	25%	In Progress	25%	In Progress	25%
Implement a model for non-urgent inter-facility patient transportation across region.	Not Yet Started	25%	In Progress	50%	Completed	25%
Continue to implement BSO Action Plan.	In Progress	80%	In Progress	10%	Completed	10%

Metrics

Goal 1: Improve access and quality through greater service coordination

- Increase in number of CCAC care coordinators linked to primary care providers.
- Increase in number of unplanned hospital admissions screened for risk of readmission using a standard risk assessment tool.
- Decrease time from referral to CCAC to acute care discharge.
- Reduced acute care readmission rate for high-use patients.

Goal 2: Improve client transitions between service providers along the continuum of care

- Roll out of integrated assessment record.
- Standardized electronic hospital patient discharge summaries to primary care providers.
- Increase linkages to primary care providers for patients discharged from hospital.
- Increase primary care visit within seven days for high-risk patients.
- Reduced length of stay in hospital.
- Availability of medication reconciliations for all patients being discharged from hospital.
- Health Care Connect linkage for unattached patients leaving hospital.
- Reduction in the ALC rate in acute care.

Goal 3: Enhance targeted service capacity where required

- Local geriatric networks established in the four HUB communities (and linked to the NE SGS).
- More clients served in their homes by the NE CCAC and community support services.
- Increase in the number of end-of-life cases occurring in settings other than hospitals.
- Reduction in ALC days due to patient transfer delays.

Risks/barriers to successful implementation

- Critical services in the community do not have the capacity to make the necessary impact i.e. insufficient resources to address seniors assisted living needs. Per NE LHIN Seniors' Residential Housing Options – Capacity Assessment and Projections, March 16, 2009, in order for the supply of seniors' housing to simply keep pace with projected growth in seniors' population, an increase of 8,409 beds or units over the next 25 years, or an average of 336 per year, would be required across the NE LHIN.

- HR recruitment and retention issues to address additional needs especially for Personal Support Workers.

- The change management and time required for the process improvement initiatives are greater than anticipated.

- Factors that are outside the control of the health system that impact on the level and intensity of health services required by seniors (I.e. rate of growth of senior's population in the NE, social determinants of health).

- At the community level, many of the interventions rely on partnerships with primary care providers who are, for the most part, outside of the current LHIN mandate. As noted in Enhancing the Continuum of Care: Report of the Avoidable Hospitalization Advisory Panel, November 2011, these partnerships, as well as increased accountability between partners, are critical to keep medically complex patients out of the ED and hospital.

Key enablers

- Continued e-health solutions to support clinical information sharing between providers.
- Expanded LHIN role and responsibility for primary care.

Make Mental Health & Substance Abuse Services More Accessible

Priority Description

The report "Mental Health and Addictions in Ontario LHINs" – 2008, indicates that nearly 20% of Ontario residents are affected by mental health (or mental illness) during their lifetime, however as few as one-third of these individuals seek help. The NE LHIN funds 21 addiction health service providers and 31 mental health service providers who offer a range of treatment and prevention programs throughout the region.

Mental Health and Addictions issues have a significant impact on the delivery of health care and the quality of life for those living in North East Ontario. As well, frequent readmissions and presentations to emergency departments often leads to longer wait times and increased demands on community and hospital services. Through the implementation of innovation initiatives, realignments, integrations and decentralization of some services as well as improved use of new technologies the NE LHIN hopes to have a significant impact in improving access to service for consumers.

Current Status

The NE LHIN is responsible for a full continuum of community and hospital based mental health and substance abuse services with 28 Substance Abuse organizations and 37 Mental Health Programs with an overall budget of $74,714,098. To reduce demand in order to improve access, the NE LHIN has implemented a number of initiatives throughout the region aimed at diverting referrals, decreasing readmissions, and improving access to/and capacity of community services. The NE LHIN also has been working with district Mental Health and Substance Abuse planning tables to implement "on the ground" changes that will have a positive impact on decreasing hospitalizations.

Consistency with Government Priorities:

The NE LHIN priorities are consistent with Ontario's Comprehensive Mental Health and Addictions Strategy "Open Minds, Health Minds" and will contribute to the Province's guiding goals:

- Improving mental health and well-being for all Ontarians
- Creating healthy, resilient, inclusive communities
- Identifying mental health and addictions problems early and intervene
- Provide timely, high quality, integrated, person-directed health and other human services

Action Plans	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Goal 1: Expand system realignment initiatives by HUB to improve access and system navigation for consumers and their families.						
Leverage the use of new technologies and improved communication processes	In progress	30%	In progress	30%	In progress	30%
Support expansion of OTN technology to substance abuse treatment services	In progress	90%	In progress	10%	In progress	
Use a "tiered" approach to service provision that places consumer needs at the centre as per the provincial ten year strategy	Not yet started					
Explore and implement models that streamline processes for access to services	In progress	20%	In progress	20%	In progress	20%

Implement Mental Health CritiCall in hospitals	In progress	80%	In progress	20%		
Hold a mental health Forum to inform how to move collaboratively forward with priority	In progress	100%				
Decentralize 12 children's mental health specialized tertiary beds/program	In Progress	100%				
Goal 2: Increase community treatment capacity to provide more care options for consumers and their families while decreasing pressures on the acute sector.						
Work with our Mental Health partners to develop programs that incorporate the use of peer support workers, where possible	In progress Ongoing	20%	Ongoing	20%	Ongoing	20%
Realign resources to enhance community Mental Health capacity	In progress	35%	In progress	35%	In progress	30%
Implement the use of new quality of service indicators to monitor client/consumer treatment experience	Pending release of monitoring tool					
Engage with primary care physicians to find effective ways to integrate mental health and substance abuse treatment services into their practice	In progress					
Implement the opiate treatment strategy	In Progress	80%		20%		
Goal 3: Enhance care supports for individuals with complex issues by working closely with health community sectors, ministries and governments.						
Implement provincial guidelines for individuals with dual disorders	Pending review of guideline implementation by MOHLTC					
Work collaboratively with partners - including Education, Ministry of Children and Youth Services, and children's mental health services - to implement best approaches to helping transitional aged youth	Not yet started					
Work with partners to implement BSO plan	In progress		On going		On going	
Work with the Regional Human Service Justice Coordinating Committee and implement initiatives to assist individuals with mental health and substance abuse issues at risk of coming into conflict with the criminal justice system	In progress	30%		35%		35%
Implement initiative placing nurses with mental health expertise with school boards across the region	In progress	100%				
How will we measure success?						
Goal 1: Expand system realignment initiatives by HUB to improve access and system navigation for consumers						

and their families:

- 90 % Implementation of IAR across NE LHIN mental health & addiction sector
- 100% OTN sites established in all WMS programs and Opiate case management programs
- Tiered model implemented in 60% newly integrated substance abuse/mental health services in NE LHIN (Anchor Agency, Cochrane services etc.)
- Implementation of offsite crisis centres in 4 hub hospital communities
- 100% Implementation of bed registry across the region
- Successful implementation of forum with next steps emanating from consultation
- Two Tertiary beds operational SSM & Timmins and 4 beds operational in Sudbury & North Bay

Goal 2: Increase community treatment capacity to provide more care options for consumers and their families while decreasing pressures on the acute sector:

- Continue to work with CSI programs and providers to ensure that there are a minimum of 4 initiatives across the region that incorporate the use of paid peer support workers
- Implementation of the Anchor Agency realignment, Cochrane, Sudbury and North Bay system realignments
- Implementation of New CAMH Clients experience of treatment experience in all substance abuse/mental health providers in NE LHIN
- Implementation of Store Forward pilot in Sault Ste. Marie & evaluation report completed
- 6 Opiate case managers placed in agencies across the region and programs operational

Goal 3: Enhance care supports for individuals with complex issues by working closely with health community sectors, ministries and governments.

- Once available the LHIN will work with HSPs to implement the DD guidelines
- The LHIN will participate on MCYS/MCSS committees looking at transitional youth issues
- Decentralize and monitor the 12 children's mental health tertiary beds
- BSO initiatives ongoing an active throughout the region
- Implementation of one drug court in the NE LHIN by 15/16
- 17 nurses will be placed in 17 boards of education in NE LHIN and managed by the NE CCAC

Risks/barriers to successfully implementation

Risks include:

- Lack of resources for implementation
- Current demands on health service providers which could result in processes being slower to implement
- Some projects are contingent upon multi-ministry/multi-community buy in and participation
- MOHLTC 10 year strategy might dictate LHIN attention be directed into other project areas.

In light of these potential risks and in an effort to ensure full implementation of these action items, the NE LHIN's mitigation strategy will include: well defined metrics for each initiative, monitoring, and evaluation. Internal LHIN and other system resources will also be garnered to support certain project pieces. The NE LHIN will also work closely with the MOHLTC to be fully aware of MOHLTC strategy directions prior to them being implemented.

Key enablers

Electronic Health Record Opportunities:

- The increased use of telemedicine services and sites will enhance access to primary care, mental health and addiction and specialty services (psychiatry) in the North East and will improve equity of access.
- This will also allow for more frequent training and consultation between mental health and substance abuse treatment professionals.

Realignment and System Transformation:

- The roll-out of realignment plans and the implementation of health links will help mental health and substance abuse services to have a positive impact on decreasing readmission rates and provide a more consumer centred approach.

Target the Needs of Culturally Diverse Population Groups – Aboriginal/First Nation/ Métis People

Priority Description

The NE LHIN continues to focus on building meaningful relationships with Aboriginal/First Nation/Métis communities in an effort to improve the services and health status of this population. In order to inform this IHSP priority, community engagements were held in four communities – Sudbury, Sault Ste. Marie, Timmins and North Bay. A special engagement with Dr. Samir Sinha, Provincial Seniors' Strategy Lead, was also held with Aboriginal health leaders.

In late February 2013, Dr. Sinha, NE LHIN CEO Louise Paquette, Geriatricians Dr. Jo-Anne Clarke, Dr. Janet McElhaney, and NE LHIN Primary Care Lead, Dr. Alan McLean, made a historic and informative visit to the James and Hudson Bay Coast. With a special focus on senior care, discussions with community leaders, community members and health facility tours provided a greater understanding of the challenges in delivering health care services to our most northerly communities.

The health needs of Aboriginal communities across the region continue to be significant and that the needs of culturally diverse population groups, particularly Aboriginal/First Nation/Métis, must remain a priority of the NE LHIN.

The main objective for targeting the needs of this population group is to improve health status and health outcomes; however, through recent engagements, other goals emerged:

- Access to health services that reflect and recognize the cultural and linguistic needs of this population group.
- Aligning existing Aboriginal/First Nations/Métis regional, provincial and federal health planning, program and service delivery structure.
- Coordinating services and access to care through formalized collaboration and partnerships within and across sectors.
- Increase access to mental health and substance abuse services.

Current Status

- The Aboriginal/First Nation/Métis population conservatively represents 10% of the overall North East LHIN population.

- The Aboriginal/First Nation/Métis population is dispersed over a vast geography in urban, rural and isolated remote communities throughout the NE LHIN, including 41 First Nations, 14 urban and rural communities that speak various Aboriginal languages such as Cree, Ojibwa, and Odawa.

- Aboriginal/First Nation/Métis people have higher rates of chronic disease and co-morbidities and at a younger age than their non-Aboriginal counterparts.

- Aboriginal/First Nation/Métis people continue to have a lower life expectancy, a higher rate of infant mortality, higher rates of suicide, and higher rates of infectious disease.

- Among our Aboriginal population, many people are aging faster than the rest of the population, due to high rates of chronic disease.

- The NE LHIN funds 36 Aboriginal health service providers at a total of $36,880,816 including one hospital, one long-term care home, 32 community support service agencies, seven agencies delivering mental health and addiction services, and one community health centre.

Consistency with Government Priorities:

The identified goals are aligned with key government priorities including:

- Ontario's Action Plan for Health Care, January 2012
- Living Longer, Living Well - Dr. Samir Sinha, December 2012

Action Plans	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Goal 1: Enhance access to health care services that linguistically and culturally appropriate and deemed culturally safe for Aboriginal/First Nation/Métis population.						
Determine the location and number of health service providers (HSPs) who have participated in cultural safety training or are experiencing language barriers and would benefit from training.	Not yet started	75%	Completed	25%	Completed	100%
Work with partners to develop an indicator to include in HSP 2014/15 accountability agreements that measures HSP participation in education of culturally safe services and sharing of best practices.	Not yet started	50%	In Progress	50%	Completed	100%
Work with providers to determine and implement methods of providing cultural safety training.	Not yet started	20%	In Progress	20%	In Progress	20%
Include and monitor indicator in S-AAs.	Not yet started	0%	In Progress	50%	Completed	50%
Goal 2: Increase service coordination, system navigation and access to care for Aboriginal/First Nation/Métis population.						
Formalize partnerships between Aboriginal health service providers and non-Aboriginal providers within and across sectors.	Not yet started	20%	In Progress	20%	In Progress	20%
Initiate efforts to collaborate and create protocols between the provincial/federal governments to increase coordination of transportation services.	Not yet started	20%	In Progress	20%	In Progress	20%
Monitor and maximize the availability and usage of telemedicine locations and services, particularly for remote and isolated communities.	Not yet started	25%	In Progress	25%	In Progress	25%
Goal 3: Increase access to mental health and substance abuse services for Aboriginal/First Nation/ Métis population.						
Implement recommendations of the	In Progress	10%	In Progress	40%	In Progress	50%

NE LHIN Aboriginal Mental Health and Addiction Strategy with particular attention to traditional healing and cultural treatment methods.						
Align Aboriginal/ First Nation/Métis mental health and substance abuse treatment services, as outlined in the NE LHIN Mental Health & Addiction strategy decision making framework.	In Progress	20%	In Progress	40%	In Progress	40%

Metrics

Goal 1: Enhance access to health care services that are linguistically and culturally appropriate and deemed culturally safe for Aboriginal/First Nation/Métis population.

Year One:

- Complete inventory of HSPs participating in culturally safety training and/or experiencing language barriers.
- Indicator developed to include in service accountability agreements in 2014/15.

Year Two:

- Indicator included in SAAs

Year Three:

- HSP participation in linguistic and culturally sensitive training is increased by at least 25%.

Goal 2: Increase service coordination, system navigation, and access to care for Aboriginal/First Nation/ Métis population.

- Increase each year in the number of formal partnerships between Aboriginal and non-Aboriginal health service providers.
- Relationships built with federal government yielding protocols that result in additional transportation services.
- Increased use of telemedicine locations and services, particularly for remote and isolated communities.

Goal 3: Increase access to mental health and substance abuse services for Aboriginal/First Nation/ Métis population.

- Improved wait times and access to mental health and addictions/substance abuse services.
- Implement Mental Health and Addiction Strategy recommendations.
- More streamlined and realigned mental health and substance abuse treatment services.

Risks/barriers to successful implementation

The vast geography of the NE LHIN and remoteness of some communities poses a challenge to planning strategies and access to health care for Aboriginal communities. There is recognition of the disadvantaged circumstances under which many Aboriginal communities exist compared to mainstream Northern Ontario, especially in terms of health status and care. The high degree of health disparities, poverty, low to poor socio-economic conditions and high unemployment are factors that hinder the advancement of Aboriginal peoples overall health status.

Another notable barrier is the multi-level governmental funding mechanisms and the complex jurisdictional and governmental relationships that direct First Nation policy, governance and health care delivery.

Key enablers

Electronic Health Record Opportunities:

- Increase utilization of OTN service and capacity for our remote and rural communities to ensure access to primary care and mental health and addictions services.
- Innovative solutions include the use of OTN to ensure culturally safe service delivery through the use of interpreters via OTN. OTN services can also be leveraged among our urban and non- aboriginal health service providers to reduce transportation needs.

Realignment and System Transformation:

- Include Aboriginal health service providers in the roll out of realignment plans and the implementation of Health Links to enhance access to health services, close gaps and remove barriers to service for the Aboriginal/First Nation/Métis population.

Recruitment and Retention of Health Human Resources:

- The recruitment and retention of Aboriginal people in all sectors of health care, and increasing on-going partnerships with Aboriginal service providers, will increase access to culturally safe care to our Aboriginal/First Nation/Métis population.
- In order to improve access to health services, the current resources must be utilized in an innovative way such as through sharing of human resources and increased partnership and collaboration.

Additional comments

The Local Aboriginal Health Committee (LAHC) and the NE LHIN work collaboratively on targeted issues and engagement activities. The LAHC act as a vehicle for knowledge exchange between the LHIN and Aboriginal health service providers and provides the LHIN with much-needed on-the-ground intelligence of the needs and best practices in Aboriginal health care. Revised terms of reference and renewed LAHC membership will ensure that the LAHC continues to play an important role in the successful delivery of this priority.

Target the needs of culturally diverse population groups: Francophones

Priority Description

In the past two years, the NE LHIN and the Réseau du mieux-être francophone du Nord de l'Ontario (RMEFNO) – the French Language Health Planning Entity – engaged with hundreds of Francophones across the region, either in person or through an on-line survey. Participants confirmed that French-language services (FLS) need to remain an integral priority in 2013-2016 and must be reflected in all LHIN activities to meet the needs of Francophones living in Northeastern Ontario.

During engagement sessions, participants were asked questions about access needs and solutions relating to French-language services. The main themes that arose in engagements, and which are reflected in the goals and actions for this priority involve issues related to:

- a need for more focus on a culturally and linguistically sensitive local health care system
- primary care
- community support services
- mental health and substance abuse services, especially in rural and remote areas
- challenges to receiving services in French across the continuum of care
- the need for improved coordination of care among providers capable of offering services in French
- the shortage of French-speaking health human resources.

Current Status

- There are 40 health service providers in the North East, across all sectors, which are officially designated under the *French Language Services Act* to provide services in French, and 63 who are working towards the planning and delivery of French language services.
- In 2012-2013, 6 HSPs in the North East (included in the 40) were newly designated by the government through an Order-in-Council. Two more requests for FLS designation were approved by the NE LHIN Board, including the NE CCAC's designation plan, and are now pending approval at the MOHLTC level.
- In 2013-2014, the NE LHIN will continue to work with other HSPs, including the North Bay Regional Health Centre, on more FLS designation requests.

Consistency with Government Priorities:

The identified goals are aligned with key government priorities outlined in Ontario's Action Plan for Health Care, January 2012.

- Sixty-two percent of Francophones in Northeastern Ontario say that they have one or more chronic disease (RRASFO, 2012). Enhancing access to primary health care services in French for this population, including chronic disease management and prevention services, will keep Francophones in the North East healthy.
- Enhancing access to primary health care services for Francophones also means looking at ways of integrating French-language services in family health care, without undue wait times for services in French. It means increasing the use of telemedicine services to provide access to French-speaking family health care providers.

- By improving system navigation and service coordination across the continuum of care for Francophones, we are ensuring culturally and linguistically appropriate patient-centred care, provided when Francophones need it, in the setting that best meets their needs. Thus, we will improve access to

community support and long-term care services in French, and ensure an easy transition for Francophones to these services.

Action Plans	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Goal 1: Enhance access to primary care services that are linguistically and culturally appropriate						
Continue to work in partnership with health service providers (HSPs) to increase access to primary care services in French.	In progress	In progress	In progress	In progress	In progress	In progress
Consider and include the needs of Francophones and French-language services in the local planning of primary care, health promotion/prevention and chronic disease services.	In Progress	In progress	In progress	In progress	In progress	In progress
Improve service coordination among primary care providers.	In progress	20%	In progress	20%	Completed	60%
Goal 2: Improve system navigation and service coordination across the continuum of care for Francophones						
Work with regional providers to include the needs of Francophones in local community care planning and to ensure greater access to French-language services.	In progress	40%	In progress	40%	Completed	20%
Increase access to day programs for Francophone seniors, to respite programs for their families, and to transportation programs offering services in French.	In progress	20%	In progress	20%	In progress	20%
Review French-language service capacity in long-term care (LTC) homes and increase the number of designated LTC providers.	In progress	20%	In progress	40%	Completed	40%
Goal 3: Increase access to mental health and substance abuse services for Francophones						
Review the availability of French-language services in the mental health and substance abuse sector.	completed	100%				
Increase coordination and integration of mental health and substance abuse services in French.	In Progress	20%	In Progress	20%	In progress	20%
Continue to work in partnership with HSPs to increase access to mental health and substance abuse services in French.	In progress	20%	In progress	20%	In progress	20%

Metrics

- Francophone high users are identified by HSPs.

- Increase use of telemedicine sites to maximize access to care in French.
- Diabetes and other chronic disease programs offer services in French.
- Increase the number of HSPs designated as providers of French language services (under the FLS Act) from 40 to 45.
- Increase number of HSPs who implement active offer guidelines for French language services.
- Increase access to community support services in French, such as: day, respite and transportation programs for seniors.
- Increase the capacity for services in French in long-term care facilities.
- Decrease repeat visits to designated hospital ERs for Francophones presenting mental health and substance abuse issues.

Risks/barriers to successful implementation

- HSPs may not achieve expected FLS indicator targets in their SAAs due to challenges with recruitment and retention of French-speaking staff.
- Due to staff turnover in HSPs, new HSP staff may not have received the necessary FLS training and education on FLS requirements.
- Integration activities, especially between HSPs, must reflect the needs of Francophones in each hub area or health link.

Key enablers

Electronic Health Record Opportunities:

- The increased use of telemedicine services and sites will enhance access to primary care, mental health and addiction and specialty services in French for Francophones in the North East.

Realignment and System Transformation:

- The roll-out of realignment plans and the implementation of health links will help consolidate services in French for Francophones and build on best practices.

Recruitment and Retention of Health Human Resources:

- The development of a regional recruitment and retention strategy will reduce the shortage of French-speaking health human resources. It will help identify existing health human resources in French including vacancies, and establish a common mechanism for recruiting and sharing Francophone health care professionals in all sectors.

Additional comments

The NE LHIN's continued partnership with the Réseau du mieux-être francophone du Nord de l'Ontario will help identify and meet the health care needs of Francophones in the North East.

Enablers

Electronic Health Record Opportunities

Priority Description

The overarching goal of the NE LHIN electronic health record effort is: one patient, one record. This means a single point of access for services, patients tell their story only once, and service providers can securely access and share health information electronically while upholding patient privacy. Electronic health records and ICT are key enablers to achieve goals within the 2013-2016 IHSP – technology and information can: support patients to become healthier; provide faster access and a stronger link to family health care; and provide information to the right care, at the right time, in the right place.

ICT solutions are key enablers for each of our priorities and will be leveraged to support service integration and the delivery of quality care. As with most health care initiatives, ICT projects reap the greatest benefit when they:

- Enhance patient care services or access to services
- Are part of a broader regional strategic ICT plan
- Use a multi-LHIN, multi-agency or multi-sector partnership approach
- Have a sound business case
- Can be used as foundational elements in the creation of an electronic health record

Current Status

Scope of services currently provided

- Electronic Health Records and ICT impacts all health services including: hospitals, primary care providers, FHT, FHN, FHG, FHO, Nurse Practitioners, community support services, independent health facilities (lab & diagnostic imaging), public health, pharmacy, community health centres, CCACs, mental health, addictions and long-term care.

Number of providers providing service

- Electronic Health Records and ICT impacts all health service providers including: hospitals, primary care providers, FHT, FHN, FHG, FHO, Nurse Practitioners, pharmacies, Independent Health Facilities, Community Health Centres, community support services, CCAC sites, hospitals, public health units, long term care, FHTs, mental health and addictions.

Number and type of clients serviced annually

- Electronic Health Records and ICT assists health service providers, patients and clients through the whole continuum of care as Electronic Health Records initiatives are piloted, implemented and adopted.

Successes of the Past Year

- We expanded the scope of the Physician Office Integration (POI) project. EHealth Ontario funded a proposal to allow the West Parry Sound Health Centre (a non-Meditech site) to join POI, which brings our total to 24 hospitals. The funding also allows the LHIN to expand the project to Nurse Practitioners and Community Health Centres. POI allows hospitals to send discharge summaries, lab and diagnostic imaging reports directly to the Primary Care Provider's EMR.

- Over 200 Telemedicine coordinators attended an Ontario Telemedicine Network Education

Conference hosted by the NE, NW and OTN.

- The NE LHIN established an IT/eHealth Integration and Alignment Council (IAC) that includes the participation of all 25 hospital CEO's and CIO's. The purpose of the IAC is to provide advice and recommendation of proposed solutions and deployment strategies for the region thereby increasing efficiency, standardization, shared purchasing/procurement and interoperability of systems.

- The NE LHIN participated in the ALC Resource Matching and Referral project, as part of Cluster 3 with the North West, South East, and Champlain LHINs. As a cluster, we agreed to future state work flows for acute in-patient to complex continuing care, Rehab, long-term care and home care. As a LHIN we also participated in provincial standardization and achieved provincial minimum data set standardization for referral forms. The NE LHIN also compiled future state maps for discharge to community support services and mental health and addiction services.

- 49,069 patients served using Telemedicine across 273 sites in the NE LHIN, a 42% increase from 2011/12 and remains the highest user of Telemedicine among Ontario's 14 LHINs.

- We are participating in the Telehomecare program. The goal is to provide remote access/care to patients with congestive heart failure and chronic obstructive pulmonary disease. The NE CCAC provides the project management support for this initiative. We are one of three LHINs in this initial roll-out.

- We are supporting the rollout of Ontario Lab Information System within the hospital sector.

Consistency with Government Priorities:

This enabler aligns with:

- Ontario's Action Plan for Health Care
- EHealth Ontario 2015 Blueprint

Action Plans	**2013/14**		**2014/15**		**2015/16**	
	Status	%	Status	%	Status	%
Goal 1: To deploy common assessment systems, back office system and integrated assessment record in community sector.	In progress	100%				
Goal 2: To expand the Physician Office Integration project which allows the sharing of client profiles among the community and hospital sectors.	In progress,	100%				
Goal 3: To support the implementation of the Alternate Level of Care Resource Matching and Referral Business Transformation Initiative within the NE, NW, SE and Champlain cluster.	In progress	30%	In progress	30%	In progress	40%
Goal 4: To increase the use of Telemedicine in the NE LHIN.	In progress	30%	In progress	30%	In progress	40%
Goal 5: To expand the Telehomecare program for patients with chronic obstructive	In progress	80%	In progress	20%		

pulmonary disease and congestive heart failure.						

Metrics

- # of Telemedicine visits
- # of COPD/CHF patients enrolled
- % of PCPs receiving electronic reports (i.e. discharge summaries) and # of hospital reports
- % of HSPs that have implemented common assessment tools

Risks/barriers to successful implementation

- Flow-through of provincial funds in 2013/14.
- Flow-through of funding and deliverables from eHealth Ontario to LHINs and/or Transfer Payment Agencies.

Key enablers

- Funding received on time to initiate/complete project deliverables.
- ICT governance that is agreed upon with the LHINs and amongst cluster projects.
- Recognition of rural, northern geography issues and extra costs to operate eHealth initiatives given these factors.

Realignment and System Transformation

Priority Description

The North East LHIN continues to work with health-care partners to focus care and investment where there is the greatest need – realigning resources to create a truly integrated health care system. Each year, the NE LHIN engages with fellow Northerners to ensure that we identify, fund and promote local initiatives that improve health care services. Overwhelmingly, Northerners have agreed, status quo of the local health care system is not an option and change, through more patient-centred and realigned health care services, is needed.

Current Status

In 2013/14, the North East LHIN will continue to work in partnership with health service providers to achieve successes in transforming and realigning the North East region through the following projects:

Collaboration and integration between three hospitals and health service providers in the district of Temiskaming. The North East LHIN Board approved a Temiskaming Realignment Plan in 2012/13 with the goal of transitioning toward an improved patient focused local system, fewer pressures on system providers, and increased access and care across the district. Projects include (not limited to):

- Integration of three hospitals: Englehart, Kirkland, and Temiskaming Hospitals.
- Integration of mental health and substance abuse providers.
- Adoption of Health Links model for coordinating rural care.

Collaboration and integration between rural hospitals and health service providers in the district of Cochrane. The North East LHIN Board approved a Cochrane Realignment Plan in 2012/13 with the goal of transitioning toward an improved patient focused local system, fewer pressures on system providers, and increased access and care across the district. Projects include (not limited):

- Integration of Timmins Mental Health Cluster.
- Integration of addictions agencies in Hearst, Kapuskasing, Smooth Rock Falls.
- Integration of hospitals: Hôpital Notre Dame, Sensenbrenner and Hôpital Smooth Rock Falls.
- Integration discussions with Timmins Alzheimer's Society.
- Adoption of Health Links model for coordinating rural care.

Collaboration and integration between rural hospitals and health service providers in the district of Algoma. Projects include (not limited too):

- Integration of Sault Area Hospital's - Matthew's Memorial and Thessalon Hospital to Blind River District Health Centre.
- Continuing support of the Algoma Anchor Agency, whereby, 13 health service providers are integrating their mental health and substance abuse services into the Anchor Agency.
- Integration of three hospitals: Hornepayne, Chapleau, and Lady Dunn Health Centre.
- Integration discussions regarding Sault Ste. Marie Alzheimer's Society.
- Adoption of Health Links model for coordinating rural care.

Collaboration and integration of hospital services and health service providers in the district of Sudbury and Parry Sound / Nipissing. Projects include (not limited):

- Integration of the North East Specialized Geriatric Services from the City of Sudbury to North Bay Regional Health Centre.
- Integration of the Sudbury addictions agencies.
- Integration between WarmHearts and Mason Vale Hospice.
- Integration of Sudbury and North Bay Alzheimer's Societies.

- Adoption of Health Links model for coordinating care.

Consistency with Government Priorities:

This enabler is aligned with the:

- Local Health System Integration Act, 2006 – which demonstrates that integration is a key driver in transforming and realigning the North East LHIN region, between health service providers and the MOHLTC.
- Ontario's Action Plan for Health Care (2012).

Action Plans	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Goal 1: Promote opportunities for interdisciplinary collaboration.	In Progress	35%	In Progress	35%	In Progress	30%
Goal 2: Facilitate linkages between primary care and community services.	In Progress	25%	In Progress	25%	In Progress	50%
Goal 3: Explore the development of additional Health Links as models of care, particularly for high users of the health care system.	In Progress	35%	In Progress	35%	In Progress	30%
Goal 4: Develop one point of access for community support services per HUB.	In Progress	25%	In Progress	50%	In Progress	25%
Goal 5: Continue to implement initiatives to support more senior friendly hospitals.	In Progress	50%	In Progress	25%	In Progress	25%
Goal 6: Expand regional North East Specialized Geriatric Services and support local geriatric service expertise.	In Progress	50%	In Progress	25%	In Progress	25%
Goal 7: Explore and implement models that streamline processes for access to services.	In Progress	35%	In Progress	35%	In Progress	30%
Goal 8: Realign resources to enhance community mental health capacity.	In Progress	35%	In Progress	35%	In Progress	30%

Metrics

- Increase in the number of Ontario Telemedicine Network (OTN) connections and consultations in primary care settings across the North East.
- Reduction in acute care readmission rates for high users.
- Health Link representation in each HUB.
- Implementation of Senior Friendly Hospital indicators for Delirium and Functional Decline
- Rate of Baseline Delirium Screen / Rate of Hospital Acquired Delirium.
- Rate of ADL Function Assessment at Admission and Discharge / Rate of No Decline in ADL Function.
- Establish local geriatric networks in the four HUB communities – with linkage to the NE SGS.
- Reduction in repeat mental health and addictions visits to emergency departments.
- Increase in mental health and substance abuse resources reallocated to community treatment programs.

Risks/barriers to successful implementation

- Resources available to implement identified integration opportunities.
- Resistance from stakeholders to move away from status quo to create a more integrated transformational health care system.
- Fear of loss of services.

- Lack of project management knowledge among hospitals and health service providers.

Key enablers

- Integrate change management training into realignment initiatives to support health service providers.
- Integrate project management training into realignment initiatives to support health service providers.
- Utilize internal North East LHIN expertise to assist organizations through the change process.
- Continue to document community engagement outcomes as a means to further communicate the need for transformational change and realignment throughout the North East region.
- Regular communication between North East LHIN and health service providers to ensure a clear understanding of realignment expectations are conveyed, accompanied by timelines.
- Continue to promote Section 27 integrations throughout the North East region.

Additional comments

Health service providers must understand that in accordance with Section 24 of LHSIA, every health organization has an obligation to pro-actively pursue integration opportunities and comply with the realignment and transformational models identified through the North East LHIN's extensive community engagements.

Recruitment and Retention of Health Human Resources

Priority Description

Providers are essential to the transformation of our health system, whether it's taking more responsibility for keeping people well, screening them appropriately for chronic diseases or managing their care when they are sick. Many communities in Northeastern Ontario experience ongoing shortages of health human resources, including primary care providers.

Access to health care professionals helps in promoting healthy living and supporting better management of chronic conditions, along with the participation of people in their own wellness, by taking advantage of screening and vaccination programs.

Current Status

The challenge of having the right number and mix of health care professionals, when and where they are needed, is often cited at NE LHIN engagements. There are more than 20,000 individuals who work in health care across Northeastern Ontario, including the contracted service providers of the NE CCAC.

The appropriate mix of health human resources across the region is challenged by the aging of the health service workforce and general population, an increase in high-users of the system, and fewer professionals to deliver health care services.

Many communities in Northeastern Ontario experience ongoing shortages of health human resources. A shift to community-based care, away from institutional-based, has an impact on health resources and the community support service (CSS) workforce which deliver many of the home-based services to clients. CSS providers require a well-trained workforce to effectively care for patients in community.

The NE LHIN will continue to work with educational partners, such as the Northern Ontario School of Medicine and other post-secondary institutions, to address the chronic shortage of health human professionals. Innovative approaches to the recruitment and retention of health care professionals is a pillar for a strong local health care system.

Consistency with Government Priorities:

This enabler is aligned with:

- Ontario's Action Plan for Health Care (2012)
- Enhancing the Continuum of Care (2011)
- Caring for Our Aging Population and Addressing Alternate Levels of Care (2011)
- Living Longer, Living Well, December 2012

The Ministry's Action Plan and the direction of Ontario's Seniors' Strategy support greater utilization of personal support services to ensure the shift to increased care in the home and community.

Action Plans	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Goal 1: Work with partners to develop a regional recruitment and retention strategy	In Progress	35%	In Progress	35%	In Progress	30%

Goal 2: Apply HHR strategies to support increased capacity for community-based care	In Progress	35%	In Progress	35%	In Progress	30%

Metrics

- Decrease in the number of vacancies.
- Decrease in recruitment costs.
- More coordinated recruitment efforts.
- Reduced reliance on locum coverage.
- Increase in the number of front-line care providers within the community support services sector to meet growing community-based care demand.

Risks/barriers to successful implementation

- Availability of dedicated resources, including volunteer members for HPAC of NE LHIN Board.
- Securing buy-in from the various stakeholders (locally and provincially).

Key enablers

- NE LHIN HHR Inventory and Forecasting Tool
- Assistance with the recruitment and retention of PSWs through additional support to CCAC for PSW training and mileage coverage for PSWs.
- Facilitate the collaboration between the CSS and CCAC contracted providers and other stakeholders for the advancement of the strategies found in the NE Personal Support Occupations Action Plan.
- Continued collaboration with HealthForceOntario and regional educational partners.
- The development of a NE LHIN online job board which is appropriately resourced, credible, and widely communicated to successfully link employers with health human resources.

Template B: LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2011/12 Actual	2012/13 Budget	2012/13 Forecast	2013/14 Planned Expenses	2014/15 Planned Expenses	2015/16 Planned Expenses
Salaries and Wages	3,147,545	3,071,097	2,997,634	2,998,459	2,998,459	2,998,459
Employee Benefits						
HOOPP	277,710	299,438	280,940	299,846	299,846	299,846
Other Benefits	324,458	329,382	316,553	329,831	329,831	329,831
Total Employee Benefits	***602,168***	***628,820***	***597,493***	***629,677***	***629,677***	***629,677***
Transportation and Communication						
Staff Travel	178,767	140,000	133,817	175,000	175,000	175,000
Governance Travel	18,524	30,000	9,214	15,000	15,000	15,000
Communications	66,264	50,000	86,888	84,000	84,000	84,000
Other	11,938	8,000	17,560	10,000	10,000	10,000
Total Transportation and Communication	***275,493***	***228,000***	***247,479***	***284,000***	***284,000***	***284,000***
Services						
Accomodation	195,058	190,000	207,443	177,960	177,960	177,960
Advertising	46,969	15,000	24,979	10,000	10,000	10,000
Banking	-	-	-	-	-	-
Consulting Fees	50,659	20,000	58,907	35,000	35,000	35,000
Equipment Rentals	18,997	20,000	18,695	20,000	20,000	20,000
Board Chair Per Diems	21,375	-	-	20,000	20,000	20,000
Other Governance Per Diems	17,510	-	4,100	10,000	10,000	10,000
Insurance	16,337	5,800	5,977	7,500	7,500	7,500
LSSO Shared Costs	382,525	341,520	341,520	341,520	341,520	341,520
LHIN Collaborative	26,971	47,500	47,500	47,500	47,500	47,500
Other Meeting Expenses	44,154	50,000	47,908	50,000	50,000	50,000
Other Governance Costs	36,440	24,000	8,185	10,000	10,000	10,000
Printing & Translation	55,895	60,000	70,799	60,000	60,000	60,000
Staff Development	18,896	20,000	22,695	20,000	20,000	20,000
Total Services	***931,786***	***793,820***	***858,708***	***809,480***	***809,480***	***809,480***
Supplies and Equipment						
IT Equipment	20,895	13,000	14,794	15,000	15,000	15,000
Office Supplies & Purchased Equipment	24,995	18,045	30,182	16,166	16,166	16,166
Total Supplies and Equipment	***45,890***	***31,045***	***44,976***	***31,166***	***31,166***	***31,166***
Capital Expenditures	***-***	***-***	***6,492***	***-***	***-***	***-***
LHIN Operations: Total Expenses	5,002,882	4,752,782	4,752,782	4,752,782	4,752,782	4,752,782
Diabetes RCC: Capital Expenditures			148,854	-	-	-
Diabetes RCC: Total Expenses			185,156	1,087,560	1,087,560	1,087,560
Annual Funding Target			5,294,982	5,840,342	5,840,342	5,840,342
Variance Surplus/(Deficit)			208,190	-	-	-

Template C: LHIN Staffing Plan (Full-Time Equivalents)

Position Title	2012/13 Actual as of Mar 31st	2013/14 Forecast	2014/15 Forecast	2015/16 Forecast
CEO	1	1	1	1
Senior Director	3	3	3	3
Project Coordinators	4	4	4	4
Officer	10	10	10	10
Officer, Performance & Decision Support (Data Analyst)	3	3	3	3
Executive Assistant and Board Liaison	1	1	1	1
Controller/Corporate Services Manager	1	1	1	1
Financial Analyst	2	2	2	2
Finance Clerk	1	1	1	1
Director, Communications and Community Engagement	1	1	1	1
Communications Officer	2	2	2	2
Communications & CE Coordinator	1	1	1	1
Multimedia/Web Officer	1	1	1	1
Communications Clerk	1	1	1	1
Chief Information Officer	1	1	1	1
Senior Project Manager	1	1	1	1
Project Manager	2	1	1	1
Diabetes - Outreach Officers	4	5	5	5
Chronic Disease / Diabetes Officer	1	1	1	1
Diabetes - Data Analyst	1	1	1	1
French Language Services Advisor	1	1	1	1
Aboriginal/First Nation/Métis Officer	1	1	1	1
Total FTEs	44	44	44	44

Template D: Integrated Communications Strategy

Objectives

Business Objective:
Implementing the North East LHIN's 2013-16 Integrated Health Service Plan and the initiatives contained in this Annual Business Plan, the North East LHIN and its Board will require a very strategic approach to communication and engagement. A strong communications strategy and plan are critical to support execution of the "Quality Health Care When Northerners Need It" transformation agenda. The communication strategy and plan will support efforts to:

- Increase primary care coordination
- Enhance care coordination and transitions to improve the patient experience
- Make mental health & substance abuse services more accessible
- Target the needs of culturally diverse population groups – Aboriginal/First Nation/Métis People
- Explain the priority enablers: electronic health record opportunities, realignment and system transformation, and recruitment and retention of health human resources
- Foster an understanding of the need for health system transformation both internally and externally.
- Build support for the health system model by focusing on the benefits of the health system transformation that creates an integrated sustainable healthcare system that ensures better health, better care, and better value for money.
- Align the health service providers to the shared vision, mission, values and common "Quality Health Care When Northerners Need It" direction of helping North East LHIN residents.
- Demonstrate how organizations and individuals can participate in the success of the health system transformation.
- Mitigate communications risks of negative publicity by proactive planning of risk reduction.
- Provide information on performance and progress– document successes and share them.

Communications Objectives:

- To build awareness of the NE LHIN's role in the following priorities and their enablers: improving primary care coordination, in enhancing care coordination and transitions to improve the patient experience, in making mental health & substance abuse services more accessible, and in helping to target the needs of culturally diverse population groups – Aboriginal/First Nation/Métis People.
- To build understanding and support regarding the rationale for, and importance of, Ontario's transformation of the health care system.
- To guide the communications and engagement activities of the North East LHIN (Board and staff) and health service provider partners involved in initiatives contained in the 2013-14 Annual Business Plan.
- To ensure that all stakeholders understand the role of the respective organizations to identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services based on funding available and tracking performance against accountability agreements.
- To provide accurate and timely information to all audiences.
- To be transparent and accountable to our shared audiences re: timelines, outcomes and opportunity for participation/feedback.

Context

- *Ontario's Action Plan for Health Care*, announced by the Minister in January 2012, which is consistent with the principles of the *Excellent Care for All Act (2010*), puts LHINs at the centre of health system

transformation.

- As such, LHINs have a critical role to play in key provincial initiatives such as Health System Funding Reform, Health Links, Seniors' Strategy and the expansion of Quality Improvement Plans into the primary and community care sectors.
- The North East LHIN's "Quality Health Care When Northerners Need It" 2013-2016 IHSP and the initiatives laid out in this Annual Business Plan are strategically aligned with government direction and priorities and recognize the joint accountability of the ministry and LHINs to serve the public interest and effectively oversee the use of public funds.
- The health care system has evolved to the point where LHINs are being recognized as the local system managers who play a central leadership role in driving health system transformation.

Target Audience

The North East LHIN engages with many stakeholder audiences with often differing understanding of the local health care system. Stakeholders can be categorized in several categories and sub-categories:

External

- Public (taxpayers, patients/clients and family members)
- Health Service Providers
    - LHIN-Funded Health Service Providers: Hospitals; Community Care Access Centre; Community Support Services; Community Mental Health, Addiction Services; Long-Term Care Homes; Community Health Centres
    - Non-LHIN Funded Health Service Providers: Physicians, Nurses and frontline care workers, Ambulance Services; Family Health Teams; Ontario Telehealth Network; Provincial networks (i.e. Cancer Care Ontario and others); Public Health Units
- Ministry of Health and Long-term Care
- Policy Makers - Northeastern Ontario MPPs; Municipal Government; Councils, Mayors, Reeves and CEOs; Ontario Office of Francophone Affairs; Office of the French Language Services Commissioner; Ministry of Health Promotion; Municipal Affairs and Housing; Services de santé en français; Northern Development, Mines and Forestry; Secretariat for Aboriginal Affairs; Seniors' Secretariat; Children and Youth Services
- Academic Institutions - Algoma University; Collège Boréal; Cambrian College; Canadore College; Laurentian University; Nipissing University; Northern Ontario School of Medicine; Northern College; Sault College of Applied Arts and Technology; University of Sudbury
- Organizations - Local advocacy groups; College of Physicians and Surgeons of Ontario; Ontario College of Family Physicians; Ontario Medical Association; Ontario Public Health Association; Unions
- Special Population Groups - Francophone, Aboriginal/First Nations/Métis
- Media

Internal to the North East LHIN

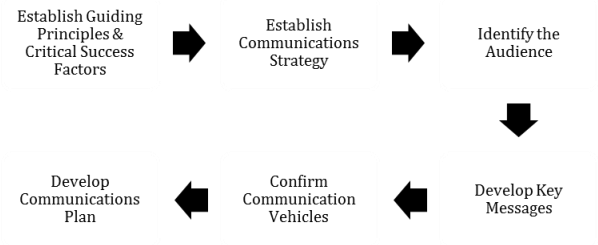
- NE LHIN Board of Directors; NE LHIN Senior Leadership Team; NE LHIN Health Care Leads; NE LHIN Advisory Groups and Committees ; NE LHIN Staff

Strategic Approach

- Communication initiatives will support the priorities of both the ministry's Action Plan for Health Care, and the NE LHIN's Integrated Health Service Plan 2013-2016.
- We will use a combination of high-profile and low-profile communication strategies to document and share successes at system transformation, with a particular focus on patient benefit.
- Targeted communications -- specific to service provision and/or geographic areas -- will be used to demonstrate how organizations and individuals can participate in the success of health system transformation.

- Major initiatives will have their own "Communications and Community Engagement Plan" documenting the context for each initiative, timelines, audiences, tools/tactics, key messages and a deliverables tracking chart. In many cases, this will be a document that will be developed and rolled out in partnership with the appropriate health care partners.

The NE LHIN will utilize the communication strategy framework depicted below for each strategic direction.



Key Messages

- LHINs are key partners in transforming the health system to provide quality care that meets the needs of Ontarians today and into the future.
- We are changing from an old system designed to treat people once they are sick, to a more coordinated, value-driven model that promotes wellness.
- Our Northeast population is aging and the rates of chronic conditions are rising. We are working with our health care partners to address these realities and enhance care coordination and transitions to improve the care experience.
- Enhanced patient care is driving the work of the NE LHIN in a time of fiscal and demographic realities.
- LHINs have already brought about significant and positive change in the way health services are delivered, and we must continue that work. In fact, we must aggressively build upon that work, because the status quo is neither acceptable nor sustainable.
- Transformation requires a collective call to action.
- Leadership is key to change – taking action to building a people-focused system of care that ensures fewer gaps in services and better coordination.
- Everyone has an important role to play in making healthy change happen, including health-service providers, the LHINs, community leaders and the public.

Tactics

To be referenced in each plan but will include:

- News releases/Blast e-mails/Newsletters/Bulletins
- Website postings/alerts/social media
- Stakeholder events
- Outreach to local government stakeholders
- Engagement with specific stakeholders –provincial associations, community groups, etc.
- Organizing and participating in information sharing events
- Board Meetings

Evaluation

Identifying and tracking critical communication success factors will enable the North East LHIN to identify more effectively whether communication activities have been successful. Critical success factors may include:

- Comprehensive monthly media tracking analysis to measure success through output (what efforts were made), outcomes (results of those efforts), and impact (including the NE LHIN's ability to influence

transformation, progress with Ontario's Action Plan, and Dr. Sinha's Seniors Strategy).

- The LHIN's ability to make quick modifications based on shifts and lessons learned as activities are carried out – including response by social media and traditional media.
- Visible senior leadership engagement and support of the ABP initiatives and related communications.
- Senior leadership and LHIN-wide committees take visible, active roles in supporting communications and change with their teams.
- Key stakeholders have a clear understanding of the "*Quality Health Care When Northerners Need It*" transformation agenda and how they will be impacted by the implementation of any related initiatives.
- Health care providers across the North East LHIN are engaged early and frequently and can see how their participation is impacting implementation/transformation.
- North East LHIN region people are engaged by the LHIN and with the LHIN via a variety of tactics including traditional media, online/social media (e.g., websites, Twitter) and LHIN communication vehicles (blast emails, bulletins).

Template E: Community Engagement

Community Engagement

Guided by the organization's vision "Quality health care, when Northerners need it" and focused on achieving its identified priorities in 2013-14, the North East LHIN will fulfil its commitment to community engagement in the following ways:

Engagement Strategies and Best Practices

A variety of best practice strategies will be employed. The objectives of community engagement will be identified in advance for priority initiatives and will vary across the following engagement continuum.

Inform and Educate: To provide accurate, timely, relevant and easy to understand information to the community. This level of engagement will provide information about the LHIN, and offers opportunities for community members to understand the problems, alternatives and/or solutions. There is no potential to influence final outcome as this is one-way communication.

Gather Input: To obtain feedback on analysis and proposed changes. This level of engagement provides opportunities for community to voice their opinions, express their concerns and identify modifications. There may be potential to influence the final outcome.

Consult: To seek out and receive the views of community stakeholders on policies, programs or services that affect them directly or in which they may have a significant interest. This level provides opportunities for dialogue between community and the LHIN. Consultation may result in changes to the final outcome.

Involve: To work directly with stakeholders to ensure that their issues and concerns are consistently understood and considered, and to enable residents and communities to raise their own issues. In this level, community stakeholders may provide direct advice as this is a two-way communication process. This level will influence the final outcome and encourage participants to take responsibility for solutions.

Collaborate: To work with and enable stakeholders to work through options/solutions to find common ground or agreement.

Empower: Delegated stakeholder decision-making where final decision-making authority, leading to action is assigned to a committee (ad hoc, standing) or other organized body (project-related work group or task).

Keeping Public Stakeholders Engaged and Informed

In a process of continuous improvement, the NE LHIN will work throughout the year to ensure that its messages are being received and understood, and that the NE LHIN as an organization is providing ample opportunity to adjust its efforts when needed to ensure that the public's interests are being met. To keep communities informed, the NE LHIN will continue to use, among others, the following communication vehicles:

- Dialogue through newsletters, communiqués, media releases, community presentations, and proactive media liaison
- LHIN 101 education sessions, presentations and round table discussions with community groups
- Web posting of public accountability reports
- Public meetings of the Board of Directors at locations across the Northeast
- Use of technology: virtual coffee breaks (audio-teleconferences), town hall meetings, blogs, as well as interactive social media including twitter, Facebook, Youtube.

NE LHIN Engagements

Throughout the year, the NE LHIN will hold ongoing engagements with both fellow Northerners and health

service providers which includes, but is not limited to:

- Open meetings of the NE LHIN Board of Directors
- Health Professional Advisory Committee meetings – members represent a wide range of professionals across the health care sector in Northeastern Ontario.
- NE LHIN Local Aboriginal Health Committee meetings to share information and receive advice and recommendations on improving access to care.
- Réseau du mieux-être francophone du Nord de l'Ontario to support Francophone engagements.
- Regional HUBs Group – CEOs and Board Chairs of four large hospitals and the NE CCAC.
- Bi-monthly meetings with 21 small and rural hospitals.
- Bi-monthly engagement meetings with the region's 42 long-term care homes.
- Regular meetings with six Community Health Centres.
- Regular meetings with the NE LHIN eHealth Advisory Council.
- Regular communication with MPPs and one-on-one meetings as needed (NE LHIN has nine MPPs).
- Regular meetings with health service providers to discuss opportunities for collaboration and integration.
- Regular meetings with End-of-Life Regional Network.
- North East Behavioural Supports Working Group meetings
- Regular meetings of the Regional Mental Health and Addiction Consultation Group
- Quarterly meetings of the North East Emergency Department Network and its small hospitals and Pay for Results sub groups.
- Meetings of the North East ED/ALC Leadership Committee
- Family Health Team meetings.

Evaluation

Participants involved in community engagement activities are asked to evaluate and offer suggestions to enhance the NE LHIN approach to community engagement. Generally, the NE LHIN issues a survey to capture vital information. Feedback, comments and suggestions received in relation to any NE LHIN community engagement activity or consultation are documented, tracked and considered by the NE LHIN.

Our website traffic is measured using sophisticated analytics that provide us with valuable insight into the health care interests of all visitors to www.nelhin.on.ca. Just as we must all hold our local health care systems accountable, we hold ourselves accountable. This is achieved in part by acting on feedback we receive.

We will continue to actively listen to the people we serve in Northeastern Ontario to ensure our vision of "quality health care, when Northerners need it" becomes a reality.