



North East Local Health Integration Network

Annual Business Plan 2015/16

June 10, 2015

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Cover photo:

Danielle Bélanger-Corbin (left), Chair of the NE LHIN Board of Directors, and Jennifer Wallenius (right), Senior Officer, Algoma Hub, spoke at a NE LHIN/Change Foundation Patient Engagement Forum in Sault Ste. Marie in February 2014. Close to 100 people attended and offered their thoughts on how to build a more patient-focused system of care in Algoma, as well as across Northeastern Ontario. Patients actively participated in the day and provided examples of positive changes underway to ensure patients are included in health care transformation.

TRANSMITTAL LETTER FROM THE NE LHIN BOARD CHAIR

June 24, 2015

Kathryn McCulloch
Director, LHIN Liaison Branch, Health System Accountability and Performance Division
Ministry of Health and Long-Term Care

Dear Ms. McCulloch,

The North East Local Health Integration Network (NE LHIN) is pleased to provide you with our 2015/2016 Annual Business Plan (ABP), as required by the *Local Health System Integration Act, 2006*, the Ministry/LHIN Memorandum of Understanding, and the Ministry-LHIN Performance Agreement (MLPA).

This ABP focuses on the third year of our 2013-2016 Integrated Health Service Plan (IHSP) and builds on the progress made to date. It speaks to our vision to provide “*Quality Health Care When Northerners Need It.*” It builds on our previous years’ successes and enables continued transformational change in Northeastern Ontario health care. It aligns with *Patients First: Ontario’s Action Plan for Health Care* (February 2015) and the desired outcomes of the *Excellent Care for All Act, 2010*.

The four priorities of our current IHSP are as follows:

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

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

We continue to proactively engage with fellow Northerners to begin the discussion on setting priorities for 2016-2019. We will continue to solicit Northerners’ ideas and opinions on all aspects of their regional health care system with a focus on strengthening home and community based care, the valued role of our community hospitals in system transformation, and models of care to improve patient-centred care and system sustainability.

We continue to align our efforts with provincial commitments to a health care system that puts patients first. With 20% of our population age 65 and over (projected to increase to 26% by 2025), high rates of chronic disease and complex medical issues, the need to strengthen and expand home care and community services, as expressed to us by fellow Northerners in engagements, will continue to guide our LHIN efforts and decisions.

Please do not hesitate to discuss this ABP with either myself or our Chief Executive Officer, Louise Paquette.

Sincerely,



Danielle Bélanger-Corbin
Chair, NE LHIN Board of Directors

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.

The NE LHIN supports the four key objectives of Ontario's *Patients First: Action Plan for Health Care*:

1. **Access:** Improve access – providing faster access to the right care.
2. **Connect:** Connect services – delivering better coordinated and integrated care in the community, closer to home.
3. **Inform:** Support people and patients – providing the education, information and transparency they need to make the right decisions about their health.
4. **Protect:** Protect our universal public health care system – making decisions based on value and quality, to sustain the system for generations to come.

The NE LHIN's 2013-2016 IHSP sustains and aligns well with Ontario's 2015 Action Plan for Health Care and with the needs of Northerners as voiced through ongoing and robust engagements. The outcome of NE LHIN engagements with fellow Northerners will continue to have an impact on the NE LHIN's decision making and priority setting.

OVERVIEW OF CURRENT AND FORTHCOMING PROGRAMS/ACTIVITIES

The NE LHIN funds about 145 health services providers (HSPs) across six sectors (some delivering services in more than one sector), including:

- Hospitals (25)
- Community Health Centres (CHCs) (6)
- Community Mental Health & Addictions Providers (46)
- Community Support Services (CSS) (67)
- Long-Term Care Homes (LTCHs) (40)
- Community Care Access Centre (CCAC)

The NE LHIN continues to work in collaboration with HSPs to move our health system from provider- to patient-centred, and to ensure outcomes and evidence drive the delivery of quality care to Northerners. System realignment and enabling technologies are key to this shift, as are the commitment to maintain and further develop strong relationships with community partners.

NE 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

NE LHIN Priorities

Increase
Primary Care
Coordination

Enhance Care
Coordination
and Transitions
to Improve the
Patient
Experience

Make Mental
Health and
Addictions
Services More
Accessible

Target the
Needs of
Special
Population
Groups -
Aboriginal and
Francophone

By 2016, the NE 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

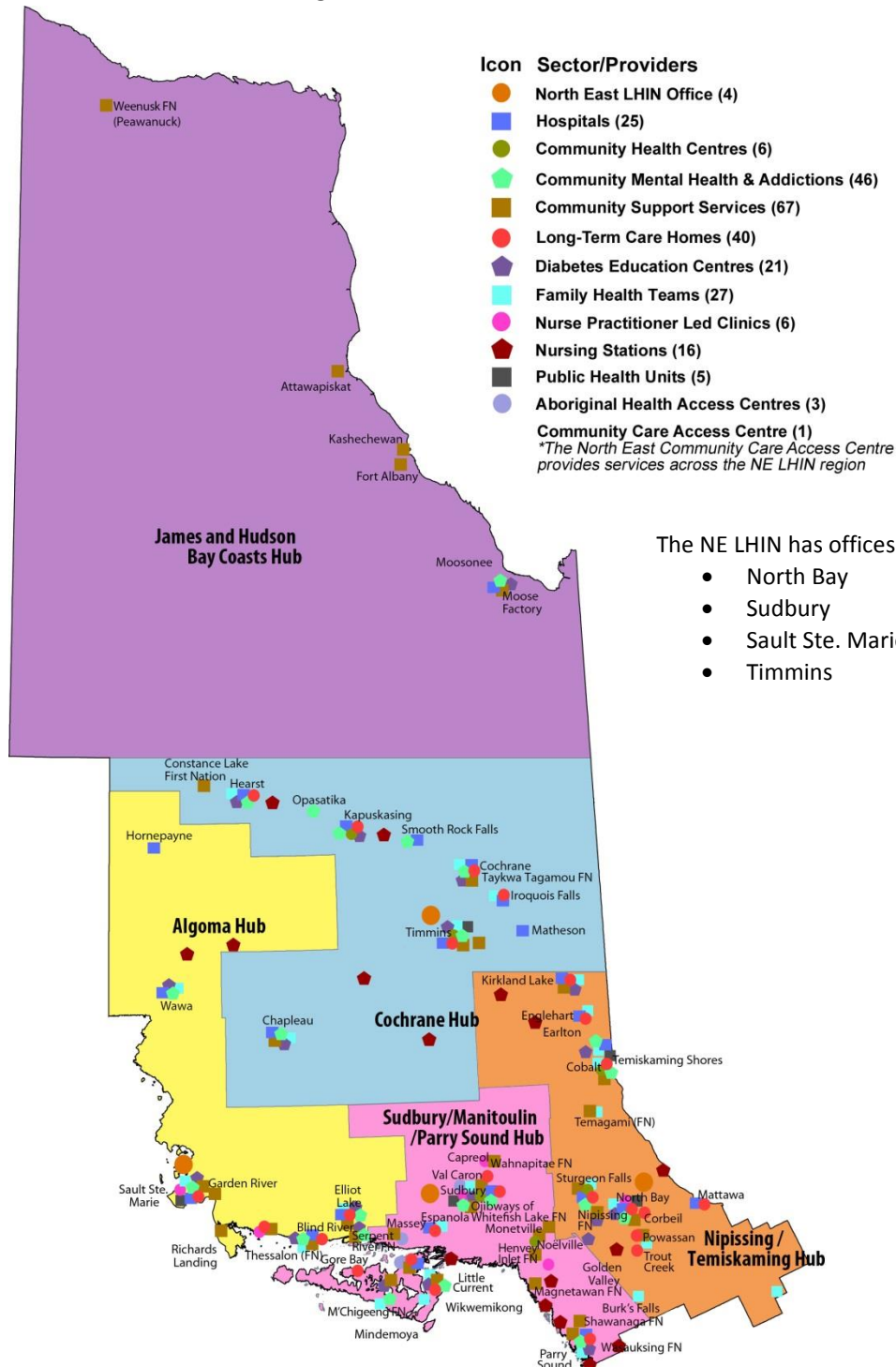
Enhance care
supports for people
with complex issues
through increased
collaboration

Increase access to
mental health
and substance
abuse services

ENVIRONMENTAL SCAN

In 2015, the NE LHIN has about 167 accountability agreements which hold HSPs accountable to deliver the NE LHIN's \$1.4 billion annual investment in front-line health care. These agreements include: 109 Multi Sector Service Accountability Agreements (M-SAAs), 25 Hospital Service Accountability Agreements (H-SAAs), and 33 Long-Term Care Service Accountability Agreements (L-SAAs).

The NE LHIN has structured its large geographic area (400,000 square kilometres) into five hub planning areas which were created based on hospital referral patterns. These hubs support local planning and realignment efforts. NE LHIN staff work out of one of four regional offices and meet one-on-one with both providers and Northerners within the hub area on a regular basis.



Access to Health Services

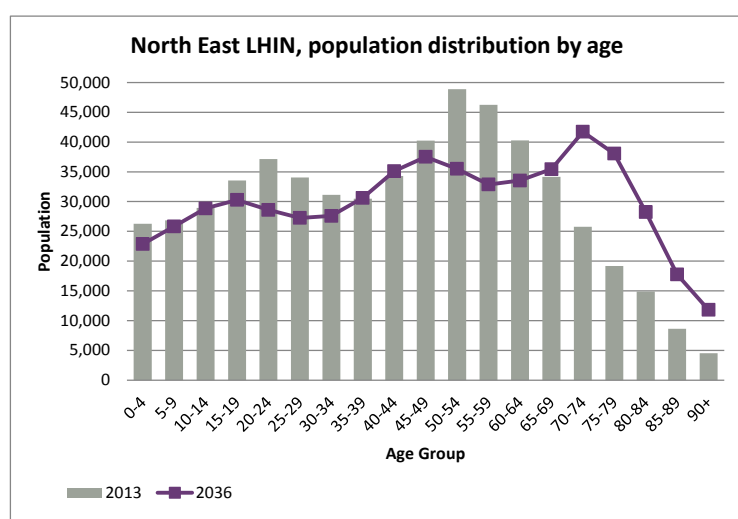
The NE LHIN has approximately 550 family physicians, one Group Health Centre in Sault Ste. Marie, 27 family health teams (FHTs), six CHCs, three Aboriginal health access centres (AHACs), six nurse practitioner-led clinics (NPLCs), and 16 nursing stations.

Life Span

Both male and female NE LHIN residents have a shorter life expectancy than residents of Ontario overall: 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 for all Ontarians, are circulatory system diseases (such as heart disease and strokes) and neoplasms (cancer). The rate of circulatory system disease 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 35% 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 two decades. The information to the left is based on Ontario Ministry of Finance projections. Only 1% overall population growth is expected by 2036 but the proportion of the population age 65 and over is projected to increase from 20% to 30%. This is an increase of 65% – a demographic shift that has major implications on the delivery of health care and the type and location of services delivered.

Health Practices and Health Status

Poor health practices are related to an increased risk of chronic disease, mortality and disability. The table below shows a number of selected health status and health practices across the region.

(The information shown below is from Statistics Canada - both the 2011 Census and the Community Health Profile 2013.)

*Ontario percentages also include Northeastern Ontario percentages.)

Indicator	NE LHIN	Ontario
Perceived health as excellent or very good	56.3%	60.4%
Perceived life stress, quite a lot (age 15+)	20.0%	22.8%
Sense of community belonging, somewhat strong or very strong	72.3%	67.5%
Smoking, daily or occasional	26.0%	19.2%
Heavy drinking (five or more drinks on one occasion, at least once a month within the last year of those who had a drink in past year)	20.8%	16.9%
Overweight or obese (adults age 18+)	59.9%	52.6%
Has a regular medical doctor	84.1%	91.1%
Contact with medical doctor in the past 12 months	79.5%	82.2%

HEALTH SYSTEM PERFORMANCE

The MLPA defines the relationship between the Ministry of Health and Long-Term Care (MOHLTC) and the NE LHIN in the delivery of local health care programs and services. The indicators that follow are those that are included in the MLPA of each LHIN. The “LHIN 2014/15 starting point” is defined as the annual results from 2013/14. Indicators are updated every quarter and housed on the NE LHIN website www.nelhin.on.ca.

Report on MLPA Performance Indicators (Status as of Q3, 2014/15)

	Performance Indicator	LHIN 2014/15 Starting Point	LHIN 2014/15 Target	Quarter 3 2014/15	% from Target for Quarter Result
Access to health care services (Objective: To enhance person-centred care. Expected outcomes: Persons will experience improved access to health care services identified below in alignment with best practices.)					
1	90 th percentile Emergency Room length of stay for admitted patients (hrs.)	29.57	25	30.87	22%
2	90 th percentile Emergency Room length of stay for non-admitted complex (CTAS I-III) patients (hrs.)	5.87	6.5	5.40	On target
3	90 th percentile Emergency Room length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients (hrs.)	4.0	4.0	3.85	On target
4	Percent of priority IV cases completed within access target (84 days) for cancer surgery	95%	90%	84%	9%
5	Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery	100%	90%	100%	On target
6	Percent of priority IV cases completed within access target (182 days) for cataract surgery	91%	90%	90%	On target
7	Percent of priority IV cases completed within access target (182 days) for hip replacement	71%	85%	79%	7%
8	Percent of priority IV cases completed within access target (182 days) for knee replacement	58%	75%	73%	3%
9	Percent of priority IV cases completed within access target (28 days) for MRI scans	73%	80%	43%	46%
10	Percent of priority IV cases completed within access target (28 days) for CT scans	81%	83%	69%	17%
Integration and coordination of care (Objective: To improve system integration and enhance coordination of care while ensuring better transitions to various care settings. Expected outcomes: Persons will be able to navigate the health care system and receive the care they need, when and where they need it.)					
11	Percentage of Alternate Level of Care days	24%	22%	20%	On target
12	90 th percentile wait time for CCAC in-home services – Application from community setting to first CCAC Service (excluding case management) (days)	70	48	64	30%
Quality and improved health outcomes (Objective: To implement evidence-based practice to drive quality and value and improve health outcomes. Expected outcomes: Persons will receive quality inpatient care and coordinate post-discharge care, leading to reduced admission rates that may improve survival, quality of life, and other outcomes without increasing cost.)					
13	Readmission within 30 days for selected CMGs	17.6%	15%	19.2%	28%
14	Repeat unscheduled emergency visits within 30 days for mental health conditions	17.6%	16.5%	17.6%	7%
15	Repeat unscheduled emergency visits within 30 days for substance abuse conditions	31.4%	25%	34.2%	37%

REPORT ON MLPA PERFORMANCE INDICATORS

Access to Healthcare Services

Emergency Room (ER): ER length of stay (LOS) performance is monitored for patients admitted to hospital, patients with high acuity or urgent issues and patients with low acuity needs or non-urgent issues who are not admitted to hospital.

- **Admitted patients:** Overall, patients visiting the ER requiring admission are waiting longer than the target of 25 hours. A key driver of this performance is the number of Alternate Level of Care (ALC) patients on medical units at the Sault Area Hospital. High bed occupancy on medical units and the delay in being able to quickly move patients to their next level of care (e.g. home care or long-term care (LTC)) are factors. The NE LHIN continues to work in these areas to help increase capacity outside of the hospital and to strengthen the continuum of care.
- **High acuity non-admitted patients:** High acuity refers to patients presenting themselves to the ER for urgent health care issues and who are categorized as "CTAS 1 to 3." ER LOS performance has improved for these patients and is consistently below target.
- **Low-acuity non-admitted patients:** Low acuity refers to patients presenting themselves to the ER for non-urgent health care issues and who are categorized as "CTAS 4 and 5." Overall, ER LOS performance is below the four-hour target for these patients.
- **Strategies to improve ER LOS performance** include the participation of the four larger urban hospitals (Health Sciences North, North Bay Regional Health Centre, Sault Area Hospital and Timmins and District Hospital) in the provincial Emergency Department "Pay For Results" program. Improving the connection rate to primary care providers is a key strategy to reduce the use of ERs. The development of new models of care such as Health Links is working to ensure complex patients who often have to use ERs are provided with comprehensive care plans by a team of care providers to better meet their health needs and reduce reliance on ERs. The deployment of Rapid Response Nurses in the four large urban communities is also helping to support patients with complex health issues upon discharge from hospital and is contributing to reduced reliance on ERs. The NE LHIN continues to work with the North East Community Care Access Centre (NE CCAC) and CSS agencies to increase the availability of assisted living services and supports that allow people to live at home longer. In addition, the NE LHIN's investment in 50 new interim beds, which opened in May 2015, will greatly assist with relieving ALC pressures at the Sault Area Hospital.

Improving Access to Surgery and Diagnostics

Patients are prioritized for surgery based on an assessment by their surgeon. Each surgery has an access target based on the priority expressed as the percentage of completed cases within the access target (days).

- **Cancer Surgery:** For patients assessed as Priority IV, 84% completed their surgery within the access target of 84 days, falling just short of the NE LHIN's target. Addressing data quality issues in the wait times information system, working with surgeons' office staff and enhancing operating room time for specific cancer surgeries are all part of improving performance.
- **Cardiac Surgery:** For patients assessed as Priority IV, 100% completed their surgery within the access target of 90 days, meeting the NE LHIN's target.
- **Cataract Surgery:** For patients assessed as Priority IV, 90% completed their surgery within the access target of 182 days.

- **Hip Replacement Surgery:** For patients assessed as Priority IV, 79% completed their surgery within the access target of 182 days. This represents a marked improvement since Q1 (70%). Service demand in the NE LHIN is 2.5 patients requiring surgery for every surgery completed. The NE LHIN is pursuing opportunities to improve surgical throughput including: (1) capacity enhancement to enable additional surgeries in 2014/15; (2) reallocating surgical volumes between hospitals, as appropriate; and (3) reviewing opportunities to “repatriate” surgeries completed on NE LHIN residents outside of the NE LHIN. The NE LHIN is also working with hospitals to improve their performance reporting. The NE LHIN has provided funding to hospitals to reduce the list of patients with long wait times. In addition, the NE LHIN’s five Joint Assessment Centres (JACs) provide comprehensive assessments by Advanced Practice Physiotherapists who advise patients on options, including the need for a consultation with a surgeon in anticipation of joint replacement, as well as other options, such as physiotherapy, to manage at home. The JACs are ensuring the right patients are getting to surgery, surgeons are being utilized efficiently to treat people who are candidates for surgery, and people are promptly informed of the opportunity to see the next available surgeon. Further to a successful pilot project, the NE LHIN has expanded the role of NE JAC to include the assessment of shoulders.
- **Knee Replacement Surgery:** For patients assessed as Priority IV, 73% completed their surgery within the access target of 182 days. This represents a marked improvement since Q1 (62%). Service demand in the NE LHIN is 3.5 to 4 patients requiring surgery for every surgery completed. The NE LHIN is pursuing the same opportunities for knee surgery as employed to improve hip surgical throughput.
- **MRI Scans:** For patients assessed as Priority IV, 43% received their MRI scan within the access target of 28 days. Overall, the NE LHIN has the second best wait time for MRI in the province when access is assessed against all patients. High demand across the four hospitals providing MRI is a key factor, especially at Health Sciences North in Sudbury.
- **CT Scans:** Patients assessed as Priority IV, 69% received their CT scan within the access target of 28 days. High demand across the four large urban hospitals is contributing to longer waits for Priority IV patients. At the regional teaching hospital (Health Sciences North), programs such as neurosurgery, trauma, cardiovascular surgery and advanced cancer diagnostics contribute to high demand for CT scans in Sudbury.

Integration and Coordination of Care

- **Percentage of ALC Days:** Extended hospital stays for patients who require an alternate care setting occur as a result of delays in discharge to their next destination (e.g. LTC or community-based care). At 20%, the NE LHIN is below target. While fluctuations in the number of patients designated as ALC are inevitable (typically higher in winter months), ALC remains an area of focus for the NE LHIN. A wide array of strategies is in place to improve the transition of hospitalized patients to their next destination. As discussed under ER performance above, these strategies range from building community capacity to support seniors in their homes (e.g. assisted living, Telehomecare) to supporting HSPs who ensure that “Home First” is the priority for all patients. ALC is addressed at local and regional planning tables and the NE LHIN is working with partners to ensure local solutions are in place to assist with strengthening the continuum of care.
- **Wait Time for CCAC In-Home Services:** At 64 days, the amount of time that homecare clients are waiting for their first service is above target (48 days) but reflective of a 30% improvement. The NE CCAC is working to reduce wait times by focusing first on people who have been waiting the longest. Analysis of NE CCAC operations (Collaborative Capacity Analysis) identified clients who are waiting for therapy services, such as occupational therapy, as some of the longest “waiters” on client lists. The CCAC has focused on offering different approaches to providing services, such as group settings in varied locations. The CCAC has emphasized recruitment of its own therapy staff, especially in locations which have historically been underserved. These efforts have paid off with 100% employment of previously existing vacancies. Some

parts of the NE LHIN, particularly more remote small communities, remain underserved with respect to some CCAC services. Innovations, such as engaging with the local hospital to provide an “integrated” therapy service, have been deployed (Hornepayne) and are being considered for other communities. In August 2014, the NE CCAC committed to implementing the 16 recommendations arising out of the joint NE LHIN/NE CCAC Collaborative Capacity Analysis. The implementation of the recommendations is expected to result in enhancements in the way CCAC services are delivered to Northerners across the region.

Quality and Improved Health Outcomes

- **Readmission within 30 Days for Selected Case Mix Groups:** Hospital readmission rates for select chronic conditions remain above target at 19%. Initiatives across the NE LHIN will contribute to reducing unnecessary hospitalizations and include: Congestive Heart Failure (CHF) Clinic (Sudbury), ER CHF initiatives (Sault Ste. Marie), Chronic Obstructive Pulmonary Disease (COPD) Clinic (North Bay), Rapid Response Nursing (North Bay, Sault Ste. Marie, Sudbury, Timmins), Telehomecare and others. Integrated Models of Care such as Health Links are wrapping comprehensive care plans around complex patients who often require hospitalization. Fully operational Health Links are in place in Timmins and Temiskaming. A NE LHIN-wide Clinical Services Review linked closely to Health System Funding Reform and the roll-out of Quality Based Procedures (QBPs) is ensuring more standardized quality care across all hospitals in the region. Many hospital Quality Improvement Plans (QIPs) have identified hospital readmissions as a priority.
- **Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions:** Repeat ER visit rates for mental health are above target at 17.6%. Revisit rates mean that each quarter there are approximately 500 repeat visits to NE LHIN ERs within 30 days related to mental health conditions. NE LHIN investments in crisis support in downtown Sudbury are providing an alternative location for mental health supports for those in crisis. North Bay has implemented a similar model with the goal of enabling intervention without requiring a visit to the ER. Across the NE LHIN, a regional “Warm Line” provides after-hours telephone access for individuals seeking assistance. The Ontario Psychiatric Outreach Program (OPOP), a pilot initiative with FHTs which started in January 2014, is enhancing service access for patients with mental health conditions. Transitional supportive housing (eight units) has been implemented in Sudbury to enable the transition from hospital to community for patients with complex mental health needs.
- **Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions:** Repeat ER visit rates are above target at 34%. These rates mean that each quarter there are approximately 250 repeat visits within 30 days to NE LHIN ERs for substance abuse conditions. Data analysis has confirmed that a small number of patients contribute to high revisit rates related to substance abuse and more specifically to alcohol related conditions. NE LHIN investments such as addictions counselling in hospital ERs, addictions subsidized housing and supports to addiction recovery homes have been deployed to support patients and clients with substance abuse conditions. In addition, the NE LHIN is supporting the development of a managed alcohol program with community partners in Sudbury.

NE LHIN Priority- 2013-2016

Increasing Primary Care Coordination

More than 4,000 Northerners contributed to the NE LHIN's 2013-2016 Strategic Plan.

One of the four health care priorities identified by fellow Northerners is **Increasing Primary Care Coordination.**

Primary care is the point of entry to the health care system. The NE LHIN is working to strengthen access to primary care across the region to ensure high quality care when and where it's needed.



Increase Primary Care Coordination

Priority Description

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.

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 all providers helps people living with chronic health conditions and places an emphasis on prevention, coordination and self-care.

The NE LHIN acknowledges the need for a comprehensive, system-wide strategy to establish a sustainable primary care system that is capable of meeting the growing and changing needs of Northeastern Ontario. A strong plan is required to support sustainable models of care.

The central role played by primary care providers is valuable for the LHIN to develop new, creative models of care delivery, improve system integration and achieve efficiencies. Primary care provider involvement in priority setting, strategy development and health system planning is critical for an integrated, patient-centred system of care.

Primary care work in the NE LHIN focuses on improving access, increasing the integration of primary care within the broader continuum of care, and engaging primary care providers.

Current Status

The following is a summary of initiatives underway to move this priority forward. Engagements have highlighted a need for better integration of providers for a stronger continuum of care, and for better patient access to providers.

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

1. **Leverage Health Care Connect, administered by the NE CCAC, which connects patients with primary care providers. Data from February 12, 2009 to April 30, 2015 provides a clear picture of the program's successes and areas for improvement:**
 - The most total patients registered in Ontario (74,690), and the most total patients referred in Ontario (60,101)
 - The most complex-vulnerable (CV) patients registered in Ontario (7,888), and the most CV patients referred in Ontario (5,672)
 - The most total senior patients registered in Ontario (11,267), and the most total senior patients referred in Ontario (9,153)
 - The most total senior CV patients registered in Ontario (2,229), and the most total senior CV patients referred in Ontario (1,914)
 - The largest wait list in Ontario (14,589)
 - Improved percentage of patients connected with a primary care provider from 66.2% as of December 31, 2012 to 80.5% as of April 30, 2015
2. **Maximize scope of practice opportunities and strategies**
 - This is a discussion item with the NE LHIN's Primary Care Advisory Council. The Council was formed in the summer of 2012 and is comprised of nurse practitioners (NPs) and family physicians who provide leadership and advice on issues related to primary care across the region.
3. **Promote advanced access and after hours care**
 - QIPs for FHTs, CHCs, and NPLCs that include advanced access work are underway.

- The NE LHIN's Primary Care Advisory Council is working to promote the advanced access concept to other primary care practitioners and develop solutions to increase access for patients.

4. Continue to expand Telemedicine within primary care settings

- The Ontario Telemedicine Network (OTN) adopted the expansion of telemedicine in primary care settings as a priority.
- The NE LHIN is working with OTN and FHTs, CHCs, AHACs and NPLCs to promote patient-site activities.
- 300 sites in total in the North East are OTN enabled, including CHCs, AHACs, and NPLCs. All but one FHT are on OTN. All nursing stations but one utilize OTN.

5. Promote opportunities for inter-disciplinary collaboration

- The role and function of Diabetes Education Programs (DEP) are promoted to primary care organizations. One DEP has relocated to a FHT from the hospital in order to promote better interdisciplinary collaboration, with plans for a second DEP transition in 2015/16.
- The Canadian 2013 Clinical Practice Guidelines are presented to primary care providers to promote evidence-based practice and collaboration.
- Funding for pilot projects will include inter-disciplinary collaboration: Inter-Professional Health Provider Funding, the Medically Complex Patients Demonstration Project, Physiotherapy in Primary Care Settings, and the Primary Care Low Back Pain Pilot Project.
- The role and function of the North East Specialized Geriatric Services (NE SGS) are promoted to primary care organizations.
- The Health Professionals Advisory Committee (HPAC) of the NE LHIN serves as a collective voice for health professionals and provides the NE LHIN with advice related to the implementation of the IHSP, the LHIN's ABP and strategic initiatives as requested by the LHIN. Members represent different health professions, health sectors and geographic areas of the NE LHIN.

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

1. Support and strengthen the role of primary care in chronic disease prevention and management (particularly for diabetes care)

- The NE LHIN has a Primary Care Diabetes Nurse Practitioner Lead and a Physician Diabetes Specialist (endocrinologist) working alongside a dedicated LHIN Officer on Chronic Disease and Diabetes.
- Work is being done to facilitate collaboration between DEPs and primary care providers.
- DEPs provide outreach to primary care organizations.

2. Ensure primary care providers receive timely patient information upon hospital discharge and appropriate patient follow up (particularly for high-risk patients)

- Technology enabled initiative – Physician Office Integration (POI) – is underway with more than 300 providers signed up as of December 2014.
- The Complex Centre for Diabetes Care is developing a computerized charting system, including ER notifications.
- Rapid Response Nurses from the NE CCAC are available to meet with patients being discharged from the hospital.
- Three approved Health Links are underway, with three more in the planning stages. Work is being done to ensure all primary care providers (including CHCs) involved in Health Links receive information on Health Link patients (e-notification and POI).

3. Facilitate linkages between primary care and community services (e.g. through the liaison of CCAC care coordinators and/or system navigators within primary care practices)

- We continue to work with the NE CCAC to determine how to better link primary care providers with CCAC Care Coordinators. These efforts include Care Coordinators being located within primary care practices.
- Physiotherapy reform for people requiring physiotherapy services one-on-one at home has the CCAC as the single point of entry for these services.

- 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 the age of 80, Home First program support and access for primary care providers to the CCAC Electronic Client Record.

Goal (3) – Engage and collaborate with primary care providers to better support the patient journey

1. Establish a North East Primary Care Advisory Council

- The Primary Care Advisory Committee held its first meeting in April 2013 and meets 6-8 times per year.
- The terms of reference and a work plan are complete.

2. Explore the development of Health Links as models of care, particularly for high users of the system

- Temiskaming and Timmins are early adopters of Health Links in the province.
- North Cochrane has been approved to complete a business case; a Sault Ste. Marie business case has been submitted to MOHLTC.
- A readiness assessment has been submitted to the MOHLTC for Sudbury and Nipissing.
- Community Networks or a unique community model are in discussion in a number of other rural communities.

3. Focus on quality improvement initiatives to ensure providers are equipped with current best practice guidelines that improve patient outcomes

- QIPs have been received from CHCs and most FHTs.
- An analysis of QIPs is underway.
- The NE LHIN continues its collaboration with Northeastern Ontario DEPs to promote the Canadian Diabetes Association 2013 Clinical Practice Guidelines to primary care providers.

Consistency with Government Priorities

Current legislation requires LHINs to engage the primary care sector. The legislation relating to Ontario's LHINs specifies three "communities" to be engaged by the LHINs: (1) Patients and other individuals in the geographic area of the network; (2) HSPs and any other person or entity that provides services in or for the local health system; and (3) employees in the local health system.

Ontario's Action Plan for Health Care 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; Patients First: Action Plan for Health Care; Living Longer, Living Well, Dr. Samir Sinha, March 2013; and Health Links.

The MOHLTC has identified five strategic directions for primary care (Strategic Directions for Strengthening Primary Care in Ontario, 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	2015/16		2016/17		2017/18	
	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	20%	In Progress	20%
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.	Complete	100%	Complete		Complete	
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	60%	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%
How will we measure success?						
Goal 1: Improve access to high quality primary care for Northerners - Increased usage of Health Care Connect by residents and primary care providers <i>The percentage of patients connected with a primary care provider increased from 66.2% as of December 31, 2012 to 80.5% as of April 30, 2015.</i> - Reduced 30-day hospital readmission rates for select conditions <i>MLPA target = 15%. Current MLPA Performance = 19.2% (status as of Q3, 2014/15).</i>						
Goal 2: Increase the integration of primary care within the broader continuum of care - Increased access to more integrated diabetes programs and services <i>Information for this is currently under development. There are 21 adult diabetes programs and four pediatric diabetes programs active in Northeastern Ontario. Self-referrals to DEPs are supported in order to ensure that people living with diabetes have access to primary care related to their illness.</i> - Increased primary care visits within seven days for patients upon discharge from hospital <i>The percentage of patients who visited a primary care practitioner within seven days of discharge from hospital in Northeastern Ontario in Q3 2013/14 was 33.7%.</i> - Reduced ALC rates in acute care <i>MLPA Target = 22.33%. MLPA Current Performance = 20.4% (status as of Q3, 2014/15).</i>						
Goal 3: Engage and collaborate with primary care providers to better support the patient journey The Primary Care Advisory Council has been established and is active.						

- Increased number of operational Health Links Networks
The Temiskaming and Timmins Health Links are early adopters in Ontario and are active. North Cochrane has been approved to complete a business case; a Sault Ste. Marie business case has been submitted to MOHLTC. A readiness assessment has been submitted to the MOHLTC for Sudbury and Nipissing.
- Reduced acute care admissions for chronic conditions
Reduced 30-day hospital readmission rates for select conditions. MLPA target = 15%. Current MLPA Performance = 19.2% (status as of Q3, 2014/15).

Risks/Barriers to Successful Implementation

Potential lack of human resources in the primary care sector.

To mitigate the shortage of human resources in the primary care sector, tactics the NE LHIN is deploying include:

- Active membership by our Chief Executive Officer (CEO) on the provincial Primary Care Health Human Resources Planning Group
- Collaboration with HealthForceOntario to determine how best to support physicians transitioning out of practice
- Ensuring interprofessional health providers (IHPs), including NPs, are able to work to their full scope of practice
- Through efforts of the NE LHIN's Primary Care Physician Leads, better understand the current state of primary care
- Continued advocacy for rigorous data that goes beyond 'head counts' of primary care providers and towards practice volumes and patterns in order to identify areas of high need

Key Enablers

- An expanded LHIN role and responsibility for primary care.
- The development of primary care QIPs through Health Quality Ontario (HQO), expanded to all primary care patient enrolment models.
- Expanded and enhanced electronic health record solutions to support clinical information sharing.



In the NE LHIN, there are approximately 550 family physicians, such as Dr. Jean Anawati, who work in a variety of settings, including 27 FHTs, one Group Health Centre, six CHCs, three AHACs, community group practices, community walk-in clinics, and LTC facilities, as well as in our 25 hospitals.

NE LHIN Priority- 2013-2016

Enhancing Care Coordination and Transitions to Improve the Patient Experience

More than 4,000 Northerners contributed to the NE LHIN's 2013-2016 Strategic Plan. Their voices, combined with provincial reports, pointed to the need to improve the patient journey throughout the health care system – particularly for the frail elderly and people with complex medical conditions.

While enhanced care for our growing seniors' population can be found in all our priorities, this one in particular focuses on ways to create easier access to services, and seamless transitions between points of care.



Enhance Care Coordination and Transitions to Improve the Patient Experience

Priority Description

The care of seniors is an area of focus in the NE LHIN's efforts to enhance coordination and transitions of care. The NE LHIN, in partnership with community stakeholders, has made significant investments to enhance community capacity, such as PATH (Priority Assistance to Transition Home program), more assisted living services, integrated discharge planning in our four large hospitals, assess and restore programs, geriatric emergency management nurses and system navigators in hospital emergency departments, additional CSS, and more LTC 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 population of those 65 and older in the NE LHIN is 20%, compared to 16% for Ontario as a whole (Populations, Ontario Ministry of Health and Long-Term Care: IntelliHEALTH ONTARIO). By 2036, the number of individuals age 65 and over in the North East is projected to grow to 30% of the population, or 172,000 people, up from 100,000 at present.

In NE LHIN-led engagements, Northerners strongly express 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 HSPs, such as hospitals, when required.

Current Status

The NE LHIN has shown significant progress in reducing the ALC rate in acute care over the past few years. From a high of nearly 41% in Q4 10/11, the LHIN rate dropped to just under 20% in Q1 12/13. At Q3 14/15, ALC rates in the region were 20%, which is below the NE LHIN target of 22%. Nonetheless, the work continues to ensure ALC rates remain stabilized and Northerners are being cared for in their place of choice.

In order to address the ongoing needs of our growing elderly population, the NE LHIN is engaged in a number of initiatives to build capacity and ensure residents receive coordinated services and are able to move smoothly between providers.

Rehabilitation – Much work has been done under the leadership of the Provincial Rehabilitative Care Alliance on inpatient and community-based rehabilitative care. The NE LHIN has been analyzing the current rehabilitative care delivery model in relation to the bedded level of care framework developed by the Alliance, and identified opportunities to strengthen our system to better meet the needs of patients. Some of this work focuses on frail seniors living in the community who have experienced loss of functional ability, are at risk of hospitalization or LTC placement, and have restorative potential. The Provincial Assess and Restore Guideline was released in December 2014 and implementation will be one of the priorities in rehabilitative care in the coming fiscal years.

Physiotherapy – Improving access and continuity for patients requiring in-home and outpatient community based physiotherapy through Physiotherapy Reform remains a priority. The community clinics which had been allocated episodes of care funding for the 14/15 fiscal year continue to receive funding to deliver quality care to patients who meet the eligibility criteria. Evaluation is ongoing and work continues to seek opportunities to leverage these investments to support future QBP pathways for rehabilitation (i.e. total joint replacement, hip fracture, stroke).

Outpatient Laboratory Services –The NE LHIN undertook a review of Outpatient Lab Services in the region. Four key priorities were identified: data accuracy and consistency; test repatriation; access to phlebotomy services; and enhanced communication. Planning for the second phase includes identifying key objectives to move the project forward. With membership at the MOHLTC Ontario Laboratory Services Advisory Forum, the NE LHIN will identify opportunities to leverage work being done at a provincial level to move regional work forward, as well as to provide insight and raise awareness to the provincial expert panel regarding the provision of outpatient laboratory services in the North East.

NE LHIN Clinical Services Review – The Health System Funding Reform was introduced in 2012/13 across the province. This included funding for key procedures in an effort to improve quality of care. The NE LHIN, NE CCAC and the region's 25 hospitals worked with the Hay Group to develop a plan to achieve best practice models of care for the delivery of QBPs across the region. The plan focused on the following QBPs: Congestive Heart Failure; COPD; total joint replacement; hip fracture; cataract; vascular surgery; endoscopy and chemotherapy. The hospitals decided to focus on hip fracture and COPD for 2014/15, with the intent to implement the recommendations for the remaining QBPs in 2015/16. The goal is to ensure hospitals are following the QBP Clinical Handbooks, which will provide consistency across the North East while improving the quality of care. All hospitals are implementing common patient order sets and a data working group is developing a scorecard to measure our success.

Health Human Resources (HHR) – HHR strategies to support increased community capacity for community-based care, such as opportunities to provide funding or support activities that increase the number of front-line providers in CSS, are being applied. Further, the NE LHIN will work with partners to develop a recruitment and retention strategy and develop a common workforce planning mechanism with more coordinated recruitment efforts.

Primary Care Linkages – To improve patient transitions from primary care to community, the NE LHIN is creating formalized linkages between the CCAC and all primary care providers to ensure better communication and patient care. In addition, the development of Health Links and Community Networks across the region is well underway and is creating individualized care plans to assist primary care providers in managing the top users of the health care system. The relationship between the NE LHIN and the NE CCAC is key given that the CCAC is providing primary care to unattached clients/patients through Primary Care NPs, keeping patients out of hospital, and supporting transition back into the community.

Long-Term Care Home Capacity – The NE LHIN continues to assess and evaluate the capacity for LTC homes to incorporate Short Stay Restorative and Convalescent programs. The desired distribution of Short Stay Respite Beds will be determined to ensure adequate placement/availability to allow for caregiver relief. In addition, through engagement with the LTC Sector, the NE LHIN will identify opportunities for LTCHs to utilize space for the delivery of alternative programs (e.g. Day Programs, Chronic Disease Management clinics, Meals on Wheels). LTCHs will be empowered to identify residents with the potential to safely return to the community and maximize their independence through cooperative collaboration between LTCHs, CCAC and CSS for a safe and effective transition back to the community.

Hospice/Palliative Care – Increasing availability and access to palliative care is being achieved through work with community health care partners and Shared Care Teams (a team of experts available to support primary care physicians and palliative NPs in caring for dying people in their home). A regional strategy for hospice palliative care education to ensure standardized education for all sectors and disciplines is being designed.

Specialized Geriatric Services – Until 2009, the North East did not have a resident geriatrician or specialized geriatric programming based within the region. As of 2013, there are two geriatricians, a number of Care of the Elderly physicians and a developing NE SGS. Given the current and projected seniors' population, the LHIN is working to develop specialized geriatric service capacity and linkages at local and regional levels. The goal is to reverse frailty where possible through an interdisciplinary approach in order to optimize functioning and allow seniors to remain in their homes.

Paramedicine – Six community paramedicine pilot projects have been funded in the North East (out of 30 provincially). The goal is to leverage paramedic capacity to support older Ontarians and other patients with chronic conditions to stay healthy and independent at home for as long as possible through activities such as home visits and community clinics/education.

Non-Urgent Transportation – With the completion of the Non-Urgent Patient Transportation project and Evidence-Based Third Party Review & Restructuring Plan, the NE LHIN is working with hospital and Emergency Medical Services (EMS) partners to implement a new non-urgent transportation model for the region. The North East Non-Urgent Patient Transportation Leadership Working Group has been established to support the implementation process that includes, for example, undertaking a Request for Proposals process for the dedicated routes in the region, implementing new hospital business processes and establishing a central dispatch coordination mechanism.

Falls Prevention – This past fiscal year (2014/15) saw the implementation of a Falls Prevention model called *Stay On Your Feet*. In this initiative, the NE LHIN engaged all stakeholders to implement programs to prevent falls, including:

- educating health and social service providers regarding the scope of the problem and ways to reduce risks through the Canadian Falls Prevention Curriculum;
- engaging primary care providers in annually assessing falls risk and making appropriate referrals;
- focusing interventions on older adults and their families so they can age safely at home (e.g. removing hazards in home);
- increasing physical activity among older adults; and
- expanding “Age Friendly Communities” across the North East by working with municipalities.

Community Support Services – With the amendments to the *Home and Community Care Services Act* (HCCSA) that came into effect on July 1, 2014, the NE LHIN established an infrastructure to support the implementation of HCCSA changes. Stakeholders include the NE LHIN, the NE CCAC, and the CSS Regional Network. The group will facilitate dialogue between the CCAC and CSS to define roles, adopt common standards and support implementation. The working group is collecting data on the current state of personal support services delivered by the CCAC and by CSS (costs vs. funding, volumes, clients). The data will help to determine where capacity does and does not exist to meet current state levels post-implementation.

In June 2014, the NE LHIN announced the outcome of broad consultations with CSS agencies regarding the sector’s Information Communication and Technology (ICT) needs. A report outlined 10 recommendations to improve the information flow to and from CSS and the following three priorities were identified.

1. **ALC Resource Matching & Referral Business Transformation Initiative** – Across the spectrum of CSS organizations and services, a variety of referral methodologies exist. While most identify similar information requirements from clients, there are key differences based on a variety of factors. The goal of this project is to streamline the referral process in key pathways: acute care-to-CSS; CCAC-to-CSS; CSS-to-CSS; mental health and addictions-to-CSS; and primary care-to-CSS. The working group identified the following objectives: a standardized referral form for all LHIN-funded CSS services; a standardized referral work flow process; and an electronic tool to support the referral work flow process.
2. **Coordinated Access** – Consultations supported multiple entrance points to services, following the concept of “every door is the right door.” Individuals wanting to make a referral should be able to with the assistance of any provider. The system must work towards coordinated access to ensure that clients don’t fall through the cracks. Activities that will support this priority include leveraging www.thehealthline.ca and 310-2222 (English)/310-2272 (French) for access points for CSS services, and ensuring that correct and current CSS information is available for the web and phone line services.
3. **Leveraging the Integrated Assessment Record (IAR)** – Leveraging the Integrated Assessment Record (IAR) – Implementation of the various assessment tools is contributing to a growing number of client assessments that are available to health service providers. This presents the CSS and CCAC sectors with an opportunity to reduce duplication of effort by leveraging completed assessments on a client by another provider, allowing a provider to connect its clients with services without delay.

Consistency with Government Priorities

This IHSP priority and its goals are aligned with key policy directions and strategic advice provided to the Government of Ontario. 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; Patients First: Action Plan for Health Care; Living Longer, Living Well, Dr. Samir Sinha, March 2013; Health Links; Minister Hoskins Mandate Letter; MOHLTC 2014 Framework for Strategic Action.

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

Action Plans	2015/16		2016/17		2017/18	
	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	66%	Completed	100%
Develop strategies to minimize avoidable (re-) hospitalization for high-risk/high-use patients.	In Progress	20%	In Progress	40%	In Progress	60%
Implement best practices in patient risk assessments and integrated discharge planning.	In Progress	30%	In Progress	60%	In Progress	90%
Develop coordinated access for CSS.	In Progress	30%	Completed	100%		
Goal 2: Improve client transitions between service providers along the continuum of care						
Streamline client assessments between providers.	In Progress	40%	In Progress	80%	Completed	100%
Ensure timely sharing of patient information as high-risk clients/patients are discharged from hospital.	In Progress	33%	In Progress	33%	Completed	33%
Partner with primary care providers on continuity of care post-hospital discharge.	In Progress	20%	In Progress	20%	In Progress	20%
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	20%	In Progress	20%	In Progress	20%
Continue to implement initiatives to support more senior friendly hospitals.	In Progress	20%	In Progress	20%	In Progress	20%
Goal 3: Enhance targeted service capacity where required						
Expand regional NE SGS and support local geriatric service expertise.	In Progress	20%	In Progress	20%	In Progress	20%
Create new service delivery models to better meet the needs of seniors in their own homes.	In Progress	20%	In Progress	20%	In Progress	20%
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	20%	In Progress	20%	In Progress	20%
Implement a model for non-urgent inter-facility patient transportation across region.	In Progress	50%	In Progress	75%	Completed	100%
Continue to implement BSO Action Plan.	In Progress	33%	In Progress	66%	Completed	100%
How will we measure success?						
Goal 1: Improve access and quality through greater service coordination						
- Increased number of CCAC care coordinators linked to primary care providers - Increased number of unplanned hospital admissions screened for risk of readmission using a standard risk assessment tool - Decreased 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 the IAR - Standardized electronic hospital patient discharge summaries to primary care providers - Increased linkages to primary care providers for patients discharged from hospital - Increased primary care visits within seven days for high-risk patients						

- Reduced hospital LOS
- Increased availability of medication reconciliations for all patients being discharged from hospital
- Health Care Connect linkages for unattached patients leaving hospital
- Reduced ALC rates 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 CSS
- Increased numbers of end-of-life cases occurring in settings other than hospitals
- Reduced 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.) As 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.

Planned intervention / risk mitigation efforts:

- The NE LHIN is continuing to invest in assisted living opportunities and to identify unique partnerships (including small hospitals) to enhance options for Northerners to live independently in the community. Collaborative planning with the municipal sector and District Social Services Administration Boards (DSSABs) will ensure that affordable housing options also include greater access to health services. The NE LHIN is also working with Northeastern Ontario communities to ensure an ongoing focus on assess and restore, convalescent, and palliative care options across the region.
- Issues of human resources recruitment and retention present a risk to address additional needs, especially for Personal Support Workers (PSWs).

Planned intervention / risk mitigation efforts:

- Continued work with partners to implement and expand 'made in the North' strategies to increase capacity for community-based care such as the PSW Fast Track Program in Parry Sound and the James Bay Coastal Region PSW Training Program.
- The change management and time required for the process improvement initiatives are greater than anticipated.

Planned intervention / risk mitigation efforts:

- The NE LHIN will continue to leverage the resources, expertise and evidence provided by HQO and encourage HSPs to adopt the HQO Quality Improvement Framework. Additionally, the NE LHIN has developed a North East Rural Communities Framework for Health System Improvement (which is currently being piloted in six communities) to help stakeholders at the community level determine an appropriate service delivery model to enhance patient care and transitions between hospital and community.
- There are 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 seniors' population in the NE, social determinants of health).

Planned intervention / risk mitigation efforts:

- Continued implementation, monitoring and evaluation of strategies related to the recommendations of the province's *Living Longer, Living Well* report.

- 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 emergency department and hospital.

Planned intervention / risk mitigation efforts:

- The NE LHIN will continue to collaborate with primary care providers, as well as contracted Primary Care Clinical leads dedicated to championing physician engagement, enhanced collaboration and integration of healthcare providers.

Key Enablers

- Continued eHealth solutions to support clinical information sharing between providers
- An expanded LHIN role and responsibility for primary care
- The finalization of province-wide non-urgent patient transportation standards



Efforts continue to improve the transportation of non-urgent patients across the North East, with a permanent non-ambulance solution in the works for long-distance inter-hospital transfers. This NE LHIN supported project has people working together from the region's four large hospitals, referring community hospitals, EMS, and Central Ambulance Communication Centres, as well as the NE LHIN.

NE LHIN Priority- 2013-2016

Making Mental Health and Addictions Services More Accessible

More than 4,000 Northerners contributed to the NE LHIN's 2013-2016 Strategic Plan. One of the four health care priorities identified by fellow Northerners is Making Mental Health and Addictions Services More Accessible.

It is estimated that 20% of Ontario residents are affected by a mental health issue during their lifetime; however, as few as one-third of these individuals seek help.

The NE LHIN is working to help streamline the delivery of mental health and addictions services so that people can get the help they need in a timelier manner and as close to where they live as possible.



Make Mental Health & Addictions Services More Accessible

Priority Description

There can be no health without mental health. Mental health and addictions issues have a significant impact on the delivery of health care and on an individual's and their family's quality of life. Frequent readmissions and presentations to emergency departments often lead to longer wait times, increased stigma and increased demands on community and hospital services. Through innovative initiatives, realignments, integrations and decentralization of some services, as well as improved use of new technologies, the NE LHIN anticipates a significant impact on improving access to service for consumers.

Improved system navigation, increased community treatment capacity and enhanced supports for individuals with complex treatment issues will continue to improve service access and treatment outcomes. Addressing social determinants of health is also key to the success of individuals with mental health and addictions issues recovering and sustaining recovery.

Current Status

The NE LHIN is responsible for a full continuum of community and hospital supported mental health and addictions services, with a total of 46 funded organizations, of which 26 provide addictions services and 34 provide mental health services. To reduce demand and improve access, the NE LHIN has implemented a number of initiatives across the region aimed at diverting referrals, decreasing readmissions, and improving access to and capacity of community services.

Key issues facing this client group include difficulty navigating the system, challenges with general determinants of health (including housing, financial security, social isolation, employment etc.), stigma, prescription drug use, and access to mental health assessments and psychiatric consultations.

A number of diversion initiatives to decrease re-visits to emergency departments are showing success, including placing substance abuse professionals and peer workers in emergency departments, expanding opiate programs for pregnant and parenting moms, increasing addictions housing and case management options, centralized access programs, and centralized crisis pilots. The overall number of individuals involved in the high number of revisits remains relatively few; however, the frequency of their visits remains high, making it necessary to double our efforts at finding innovative solutions to decreasing the demand for services. The pending implementation of a managed alcohol program and working with other ministries, municipalities and the private sector to expand housing options, are just two of these innovations.

The NE LHIN continues to work with the OTN, the Centre for Addictions and Mental Health (CAMH) and others to increase access to psychiatric resources to FHT patients and to expand the reach of the telepsychiatry program to more FHTs across the region. The NE LHIN continues to support pilot projects that utilize technology to improve access to remote communities to expert mental health and addictions professionals.

In keeping with the NE LHIN mental health and addictions work plan, the LHIN will focus on areas which may be supported, based on a determination of need. Investments will build community capacity ranging from prevention to acute care, including housing and housing supports, improved access (early intervention, dual diagnosis, centralized access, community mobilization, health links, OTN), addressing demographic changes (aging population, decreasing population), transitional age youth (in collaboration with appropriate ministries, youth and adult service providers), First Nations mental health issues (including suicide, addictions/substance abuse, and culturally safe services), and employment of peer support workers.

Consistency with Government Priorities

This priority fits well within the second phase of the MOHLTC's 10-Year Mental Health and Addictions Strategy, which sets out five pillars for achieving better mental health and addictions recovery: promote resiliency and well-being in Ontarians; ensure early identification and intervention; expand housing, employment supports and diversion and transitions from the justice system; right service, right time, right place; and fund based on need and quality.

Action Plans	2015/16		2016/17		2017/18	
	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.	Ongoing	10%	Ongoing	10%	Ongoing	10%
Use a “tiered” approach to service provision that places consumer needs at the centre as per the provincial 10-year strategy.	In Progress	50%	In Progress	50%	Complete	100%
Explore and implement models that streamline processes for access to services.	Ongoing	50%	Ongoing	10%	Ongoing	10%
Implement Mental Health CritiCall in hospitals.	TBD	50%	In Progress	100%	Complete	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.	Ongoing	25%	Ongoing	25%	Ongoing	25%
Realign resources to enhance community mental health capacity.	Ongoing	35%	Ongoing	35%	Ongoing	30%
Implement the use of new quality of service indicators to monitor client/consumer treatment experience.	Pending release of new tool	10%	In Progress	50%	Complete	100%
Goal 3: Enhance care supports for individuals with complex issues by working closely with health community sectors, ministries and governments						
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.	Ongoing	10%	Ongoing	20%	Ongoing	50%
Work with partners to implement BSO plan.	Complete	100%	Complete	100%	Complete	100%
Work with DSSABs, municipalities, housing partners and mental health and addictions partners, as well as various ministries to build housing opportunities for mental health and addictions clients.	In Progress	5%	Ongoing	25%	Ongoing	100%
Implement initiative placing nurses with mental health expertise within school boards across the region. Also work with NBRHC psychiatry to support RNs in schools.	In Progress	90%	Ongoing	95%	Complete	100%
Work with Ministry of Community and Social Services/City of Greater Sudbury, and MOHLTC, Northern Ontario School of Medicine and mental health partners to implement a managed alcohol program.	In Progress	15%	In Progress	75%	Complete	100%
Implement the Rebound Program in two additional communities in the NE LHIN.	TBD					

How will we measure success?
Goal 1: Expand system realignment initiatives by Hub to improve access and system navigation for consumers and their families • 10 FHTs connected to consulting psychiatry via OTN • New version of Mental Health CritiCall is 100% implemented and operational Goal 2: Increase community treatment capacity to provide more care options for consumers and their families while decreasing pressures on the acute sector • 50% increase in the number of Peer Support workers hired across the region • Evaluation of Sudbury mental health services is completed and recommendations implemented • Client's perception of care tool implemented and operational in all NE LHIN mental health and addictions treatment services • Store forward pilot completed and phase two implementation completed Goal 3: Enhance care supports for individuals with complex issues by working closely with health community sectors, ministries and governments • Rebound program implemented in an additional two communities • 100 additional mental health and addictions housing options by 16/17 (including rent supplements, assisted living, etc.) • Establishment of training and consultation supports for RNs (two sessions yearly with ongoing consultation) • 15 individuals housed in a managed alcohol program in Sudbury (reduced repeat emergency department visits)
Risks/Barriers to Successful Implementation
• Lack of resources for implementation • Current demands on HSPs result in processes being slower to implement • Some projects are contingent upon multi-ministry/multi-community buy-in and participation • The MOHLTC's 10-Year Strategy may dictate that 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 over the next fiscal year, the NE LHIN's mitigation efforts include: • the realignment of resources where necessary and appropriate; • the identification of timelines to ensure initiatives are completed at a strategically manageable rate; • engagement with providers and user groups to ensure participation and support; and • management of expectations and outcomes to ensure goals are completed in a coordinated fashion.
Key Enablers
• Technology (OTN, eHealth, OPOP) • The MOHLTC's 10-Year Mental Health and Addictions Strategy directions/pillars • Increased telepsychiatry in FHTs • Increased available housing stock • Increased collaboration with key partners in housing • Implementation of Health Links and community mobilization tables

NE LHIN Priority- 2013-2016

Targeting the Needs of Culturally Diverse Population Groups

More than 4,000 Northerners contributed to the NE LHIN's 2013-2016 Strategic Plan. One of the four health care priorities identified was Targeting the Needs of Culturally Diverse Population Groups.

For people whose mother tongue is not English, expressing their health care symptoms to a care provider can be a barrier to accessing the health care system.

The NE LHIN works closely with our Local Aboriginal Health Committee to improve access to care for Aboriginal/First Nations/Métis people living in Northeastern Ontario, as well as the Réseau du mieux-être francophone du Nord de l'Ontario, to help identify and meet the health care needs of Francophones across Northeastern Ontario.



Aboriginal/First Nation/Métis People

Priority Description

The NE LHIN continues to focus on building meaningful relationships with Aboriginal/First Nations/Métis people in an effort to improve the services and health status of this population. The NE LHIN works collaboratively with its Local Aboriginal Health Committee (LAHC), which acts as a vehicle for knowledge exchange between the LHIN and Aboriginal HSPs. The LAHC provides the LHIN with much needed on-the-ground intelligence on the needs and best practices in Aboriginal health care. As such, the LAHC plays a large role in the implementation of the goals of the plan.

The main objective for targeting the needs of this population group is to improve health status and health outcomes; however, the following goals have been identified as broader action items that will move this priority forward:

- Access to health services that reflect and recognize cultural and linguistic needs
- Aligning the 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
- Increasing access to mental health and addictions services

Current Status

The Aboriginal/First Nations/Métis population:

- conservatively represents 11% of the overall NE LHIN population;
- is dispersed over a vast geography in urban, rural and isolated remote communities, including 41 First Nations and 14 urban and rural communities that speak various Aboriginal languages such as Cree, Ojibwa, and Odawa;
- has more people who are aging faster than the rest of the population due to high rates of chronic disease; and
- continues to have a lower life expectancy, a higher rate of infant mortality, higher rates of suicide and higher rates of infectious disease.

The NE LHIN funds 38 Aboriginal HSPs, including one hospital, one LTCH, 32 CSS agencies, nine agencies delivering mental health and addictions services, and one CHC.

The NE LHIN has made significant progress in meeting the goals and objectives of this priority through various investments and collaborative efforts with provider partners, including the following:

- Indigenous Cultural Competency training was made available to NE LHIN employees and HSPs. Over 120 participants completed the training in 2014.
- Culturally sensitive PSW training was delivered in Fort Albany and Moose Factory through a partnership with the Red Cross. In late summer 2014, there were 15 graduates who are now working in their communities. There are plans to roll out this training in Attawapiskat, Peawanuck and Kashechewan in 2015/16.
- Assisted Living for High Risk Seniors, supported by the NE LHIN in Nipissing First Nation, will allow 10 seniors from that community to remain safely at home.
- A new delivery site for Telehomecare was initiated with the Baawaating Family Health Team.
- There has been continued involvement and collaboration with four Health Canada Health Service Integration Fund projects in the areas of prescription drug abuse (the Weeneebayko Area Health Authority (WAHA), Mamaweswen North Shore Tribal Council, United Chiefs and Councils of Mnidoo Mnising) and diabetes (Nipissing First Nation). The aim of these projects is to integrate federal and provincial programs and services to create seamless care and service delivery.
- The Timmins Native Friendship Centre has been designated as a HSP, which will allow for access to LHIN funding to serve the urban Aboriginal/First Nations/Métis community of Timmins.
- A tri-party working group was established in November 2014 with Health Canada, MOHLTC and the LHIN to evaluate the Weeneebayko Area Health Integration Framework Agreement (WAHIFA).
- The continued involvement of two Community Wellness Development Teams that support First Nations communities will create capacity and allow for the development of strategies to address mental health and addictions issues.
- Support to the Fetal Alcohol Spectrum Disorder assessment clinic has allowed for a reduction in the wait list for

Aboriginal/First Nations/Métis children waiting for assessment, referral and treatment.

- Planning, in conjunction with our LAHC, took place to host the annual joint LHIN CEO-Provincial Aboriginal LHIN Network meeting in May 2015 on Manitoulin Island.
- Several NE LHIN supported eHealth advancements have helped WAHA reach major milestones, increasing access to and quality of patient care, including:
 - An integrated Electronic Health Record (iEHR): WAHA is now part of the North Eastern Ontario Network (NEON). NEON is a partnership of 22 hospital corporations in Northeastern Ontario sharing a single financial and clinical information system (Meditech). This install included the sites at Moose Factory, Moosonee, Attawapiskat and Fort Albany. These shared systems support a regional iEHR that increases electronic health record adoption and clinical benefits. As well, being part of NEON will now allow WAHA access to provincial interfaces.
 - WAHA is also part of the network that allows for the electronic sharing of diagnostic images throughout the LHIN and other parts of the province.
 - Implementation of Electronic Patient Order Sets: The NE LHIN provided funding for the implementation of widespread use of electronic patient order sets, a key enabler in implementing QBPs and part of the North East Clinical Services Review. WAHA is part of this regional implementation.
 - Shared service for abstracting software: WAHA is now part of a northern shared service that offers common abstracting software for the hospitals in the North East.
 - Multi-Infrastructure support for WAHA's Wide Area Network.
 - POI: WAHA is now part of the North East POI initiative. POI allows hospitals to send their discharge summaries, diagnostic imaging and lab reports to a secure regional repository, where the reports remain till picked up by the care provider.
 - OTN: Access to OTN is vital for WAHA's provision of health services. The NE LHIN has supported WAHA with funding for equipment, as well as telemedicine coordinators.

Consistency with Government Priorities

The identified goals are aligned with key government priorities including: Patients First: Action Plan for Health Care; and Living Longer, Living Well, (2012).

Action Plans	2015/16		2016/17		2017/18	
	Status	%	Status	%	Status	%
Goal 1: Enhance access to health care services that are linguistically and culturally appropriate and deemed culturally safe for Aboriginal/First Nations/Métis population						
Determine the location and number of HSPs who have participated in cultural safety training or are experiencing language barriers and would benefit from training.	In Progress	50%	In Progress	75%	Completed	100%
Work with partners to develop an indicator to include in HSP accountability agreements that measures HSP participation in education of culturally safe services and sharing of best practices. *(To coincide with provincial efforts)	In Progress	10%	In Progress	25%	In Progress	50%
Work with providers to determine and implement methods of providing cultural safety training.	In Progress	25%	In Progress	50%	In Progress	75%
Include and monitor indicator in SAAs. *(To coincide with provincial efforts)	In Progress	10%	In Progress	25%	In Progress	50%

Goal 2: Increase service coordination, system navigation and access to care for Aboriginal/First Nations/Métis population						
Formalize partnerships between Aboriginal and non-Aboriginal HSPs within and across sectors.	In Progress	10%	In Progress	25%	In Progress	50%
Initiate efforts to collaborate and create protocols between the provincial/federal governments to increase coordination of transportation services.	In Progress	10%	In Progress	25%	In Progress	50%
Monitor and maximize the availability and usage of telemedicine locations and services, particularly for remote and isolated communities.	In Progress	25%	In Progress	50%	In Progress	75%
Goal 3: Increase access to mental health and addictions services for Aboriginal/First Nations/Métis population						
Implement recommendations of the NE LHIN Aboriginal Mental Health and Addictions Strategy with particular attention to traditional healing and cultural treatment methods.	In Progress	10%	In Progress	25%	In Progress	50%
Align Aboriginal/First Nations/Métis mental health and addictions treatment services, as outlined in the NE LHIN Mental Health and Addictions strategy decision making framework.	In Progress	25%	In Progress	50%	Completed	100%
How will we measure success?						
Goal 1: Enhance access to health care services that are linguistically and culturally appropriate and deemed culturally safe for Aboriginal/First Nations/Métis population - Completed inventory of HSPs participating in cultural safety training and/or experiencing language barriers - Development of an indicator for service accountability agreements - Increased HSP participation in linguistic and culturally sensitive training						
Goal 2: Increase service coordination, system navigation, and access to care for Aboriginal/First Nations/Métis population - Increased formal partnerships between Aboriginal and non-Aboriginal HSPs - More relationships with federal government, yielding protocols that result in more coordinated services - Increased use of telemedicine locations and services, particularly for remote and isolated communities						
Goal 3: Increase access to mental health and addictions services for Aboriginal/First Nations/Métis population - Improved wait times and access to mental health and addictions/substance abuse services - Implementation of Mental Health and Addictions Strategy recommendations - More streamlined and realigned mental health and addictions treatment services						
Risks/Barriers to Successful Implementation						
- The vast geography and remoteness of some communities pose a challenge to planning strategies and access to health care. <i>Planned intervention / risk mitigation efforts:</i> - Increase utilization of OTN to reduce the amount of travel to primary care and specialist appointments where appropriate - 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.						

Planned intervention / risk mitigation efforts:

- Ongoing collaborative work with the NE LHIN's LAHC to ensure solutions are implemented across the region to better meet the needs and increase access to health care services for Aboriginal people living within the NE LHIN
- The reality of the multi-level governmental funding to Aboriginal populations, and the complex jurisdictional and governmental relationships that direct First Nation policy, governance and health care delivery.

Planned intervention / risk mitigation plan:

- Ongoing collaboration with Health Canada and provincial ministries to improve communication between varying government bodies and ensure a more concerted planning and service delivery approach
- The lack of data and baseline information to conduct effective health planning, understand needs and ensure gaps have been identified. Comprehensive data collection would allow a greater understanding of the challenges and allow for a more strategic and effective approach to health care.

Planned intervention / risk mitigation plan:

- Improve the use of the InterRAI CHA and IAR screening assessment tools by Aboriginal providers to better capture data that will increase the understanding and identification of needs.

Key Enablers

- Increased utilization of OTN service and capacity for remote and rural communities to ensure access to primary care and mental health and addictions services
- Increased utilization of OTN service to ensure culturally safe service delivery through the use of interpreters, as well as to reduce transportation needs, by leveraging OTN services among our urban and non-Aboriginal HSPs
- Active involvement of Aboriginal HSPs in the roll-out of realignment plans and the implementation of Health Links to enhance access to health services, close gaps and remove barriers
- Recruitment and retention of Aboriginal people in all sectors of health care and increasing on-going partnerships with Aboriginal service providers to access culturally safe care
- Utilization of current resources in an innovative way, such as through sharing of human resources and increased partnership and collaboration



NE LHIN CEO Louise Paquette (left) and Dr. Gordon Green, WAHA Chief of Staff, stopped for a photo during a tour of the Moosonee Health Clinic in February 2015. Paquette and senior staff from both the MOHLTC, and Health Canada, met with WAHA's senior team and took part in several discussions about ways and means to continue to increase access to health care services for people living in coastal communities.

Francophones

Priority Description

With 23% of the NE LHIN's population self-identifying as Francophone, ensuring equal access to care in a person's language of choice is important. The NE LHIN and the Réseau du mieux-être francophone du Nord de l'Ontario (RMEFNO) – the French Language Health Planning Entity (FLHPE) – have engaged with hundreds of Francophones across the region to help inform this priority.

During community engagement sessions, participants were asked questions about access needs and solutions relating to French-language services (FLS). 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 a more concerted focus on culturally and linguistically appropriate services; a sensitive local health care system; primary care; CSS; mental health and addictions 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; and the shortage of French-speaking HHR.

Current Status

There are 41 HSPs in the North East, across all sectors, which are officially designated under the *French Language Services Act* to provide services in French; two are awaiting their designation and 57 are working towards the planning and delivery of FLS.

In 2013/2014, two HSPs 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 and North Bay Regional Health Centre, and these requests are now pending approval at the MOHLTC level.

A new process to evaluate designated HSPs was developed in 2014/2015 and is aligned with the new provincial strategy developed by the Office of Francophone Affairs. The goal is to ensure that providers continue to meet designation criteria and provide quality services in French. In 2015/2016, the goal is to evaluate approximately 12 designated HSPs.

In 2015/2016, the NE LHIN, in collaboration with the FLHPE, will continue to support five HSPs to complete a FLS designation plan. The NE LHIN's partnership with the FLHPE will help identify and meet the health care needs of Francophones across the region. In the coming year, the NE LHIN will help celebrate 400 years of French presence in Ontario by highlighting health care services available in French across the region.

Additional initiatives that have led to continued progress with this priority include the following:

- Increased awareness of Active Offer guidelines through a Virtual Coffee Break held in April 2014 with the FLHPE and the FLS Commissioner, as well as through the distribution by the FLHPE of Active Offer toolkits to approximately 10 HSPs
- Representation by the FLHPE on all new Health Link planning tables
- Francophone representation secured on the Regional Chronic Disease Management Advisory Committee
- Chronic Disease Self-Management peer leader training provided in French by North East Living Health to North East residents
- The sharing of Francophone patient stories during a Patient Engagement session, increasing awareness of the importance of language in patient-centred care
- An HSP-completed FLS report that provides information on FLS capacity, therefore assisting in effective planning of FLS

Consistency with Government Priorities

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

- 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 FLS 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.
- Improving system navigation and service coordination across the continuum of care for Francophones helps to ensure culturally and linguistically appropriate, patient-centred care, provided when Francophones need it, in the setting that best meets their needs. Access to community support and LTC services in French, and facilitating an easy transition for Francophones to use these services, will be continued.

Action Plans	2015/16		2016/17		2017/18	
	Status	%	Status	%	Status	%
Goal 1: Enhance access to primary care services that are linguistically and culturally appropriate						
Continue to work in partnership with providers to increase access to primary care services in French.	Ongoing		Ongoing		Ongoing	
Include the needs of Francophones and FLS in the local planning of primary care, health promotion/prevention and chronic disease services.	Ongoing		Ongoing		Ongoing	
Improve service coordination among primary care providers.	In Progress	40%	Completed	100%		
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 FLS.	In Progress	80%	In Progress	20%	Completed	100%
Increase access to day programs for Francophone seniors, to respite programs for their families, and to transportation programs offering services in French.	In Progress	40%	In Progress	40%	In Progress	20%
Review FLS capacity in LTCHs and increase the number of designated LTC providers.	In Progress	50%	In Progress	50%	Completed	100%
Goal 3: Increase access to mental health and addictions services for Francophones						
Review the availability of FLS in the mental health and addictions sector.	Completed	100%				
Increase coordination and integration of mental health and addictions services in French.	In Progress	20%	In Progress	20%	In Progress	20%
Continue to work in partnership with providers to increase access to mental health and addictions services in French.	In Progress	20%	In Progress	20%	In Progress	20%
How will we measure success?						
An increase in: • The use of telemedicine sites to maximize access to care in French • Diabetes and other chronic disease programs offering services in French • The number of HSPs designated under the <i>French Language Services Act</i> (from 41 to 45) • The number of HSPs who implement active offer guidelines for FLS • Access to CSS in French, (i.e. day, respite and transportation for seniors) • The capacity for services in French in LTC facilities. A decrease in: • Repeat visits to designated hospital ERs for Francophones presenting mental health and addictions issues						

Risks/Barriers to Successful Implementation

- HSPs may not achieve expected FLS indicator targets in their accountability agreements due to challenges with recruitment and retention of French-speaking staff.

Planned intervention / risk mitigation efforts:

- Monitor HSPs' FLS capacity through yearly FLS reports and, in collaboration with the FLHPE, share strategies for recruitment and retention

- Due to staff turnover in HSPs, new staff may not have received the necessary FLS training and education on FLS requirements and active offer.

Planned intervention / risk mitigation efforts:

- In collaboration with the FLHPE, develop an Active Offer tool kit that is shared with providers

- Integration activities, especially between providers, must reflect the needs of Francophones as new integrated models of care are implemented (Health Links, Health Hubs).

Planned intervention / risk mitigation efforts:

- Develop internal LHIN process for FLS consideration within integration initiatives
- Include the FLHPE in the new models of care to represent the needs of Francophones and ensure more coordination/integration of those needs

Key Enablers

- Increased use of telemedicine services and sites will enhance access to primary care, mental health and addictions and specialty services in French.
- The implementation of integrated models of care for rural communities will help consolidate services in French for Francophones and build on best practices.
- A continued partnership with the FLHPE is key in advancing the LHIN priority of meeting the needs of the Francophone communities.



Marc and Flore Côté participate in a new French seniors' day program in Verner. Across the region, more than 125,000 people are Francophone and look to receive their health care services in French. As part of the health service planning process, the NE LHIN engages with and requests advice from the RMEFNO on the needs and priorities of French-speaking communities.

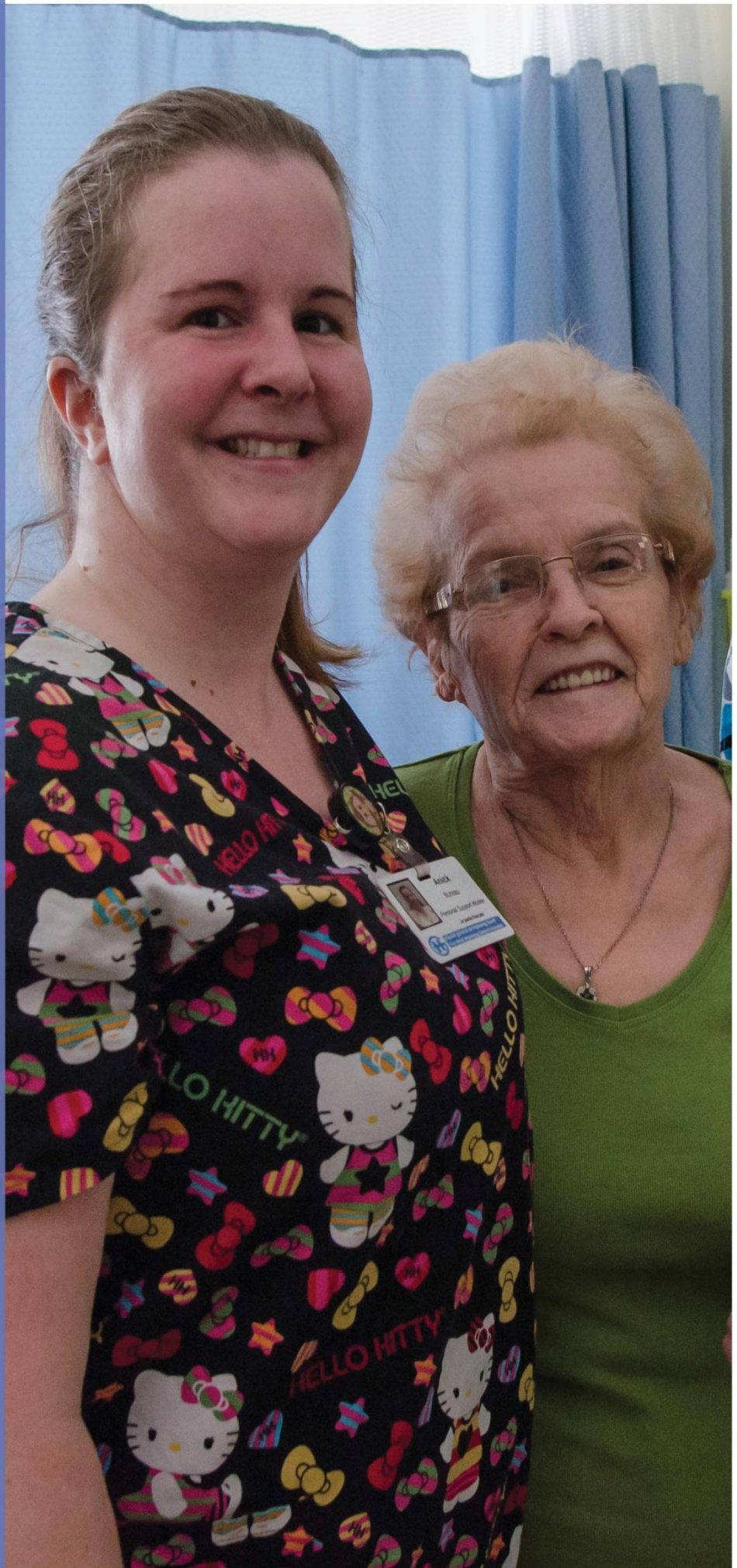
NE LHIN Enablers- 2013-2016

Supporting the Successful Achievement of Health Care Priorities

More than 4,000 Northerners contributed to the NE LHIN's 2013-2016 Strategic Plan and helped to identify the plan's four priorities.

Each of the priorities is enabled by: technology (electronic health records), health system realignment efforts, and the recruitment and retention of health human resources.

The NE LHIN works closely with our advisory committee partners to build a stronger system of patient-centred care for Northerners who want to be cared for at home or in community for as long as possible.



Electronic Health Record Opportunities

The overarching goal of NE LHIN electronic health record (EHR) efforts is: one patient, one record.

This means a single point of access for services, patients telling their story only once, and service providers securely accessing and sharing health information electronically while upholding patient privacy. EHRs and ICT are key enablers to achieve goals of all LHIN priorities.

Technology and information:

- ensure that care is appropriately coordinated around the person receiving it;
- support patients in becoming healthier;
- provide faster access to health care services; and
- provide information for the right care, at the right time, in the right place.

ICT solutions are leveraged to support service integration and the delivery of quality patient-focused care. ICT projects reap the greatest benefit when they enhance patient care services or help those who are transitioning through and across systems and sectors; 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; and are used as foundational elements in the creation of an EHR.

More than 76% of physicians in Northeastern Ontario are using EHRs to more quickly access patient files. The NE LHIN continues to work with partners on ways and means to use technology to strengthen health care in Northeastern Ontario.

Select Updates:

Pharmacy Medication Management – All 25 of our hospitals (and their patients) will benefit from this regional hospital pharmacy initiative in 2015. This project will enable hospitals across the region to work towards addressing hospital pharmacy issues and leveraging opportunities to ultimately improve the quality of care to inpatients.

Electronic Patient Order Sets – The NE LHIN has provided funding for our regional hospitals to implement widespread use of electronic patient order sets, a recommendation of our 2014 Clinical Service Review, as we recognize that these order sets are a key enabler in implementing QBPs. These are now being used in 24 of our hospitals. Patient order sets offer a standard approach for the region and consistency of care no matter what the hospital size. Hub hospitals can work more effectively with smaller community hospitals when patient transfers occur.

OTN Telemedicine – The NE LHIN continues to rank first of all LHINs for clinical use with 300 sites in the Northeast and over 70,000 clinical events (provider treatments or consultations with one or more patients) hosted in 2013/14. More than 146 million kilometres of travel were avoided in Northern Ontario in 2013/14 thanks to the use of telemedicine, and an estimated \$62 million in Northern health travel grants were not paid out because those patients had a telemedicine consultation.

Telehomecare for COPD and CHF – To date, more than 1,400 Northerners have benefited from this home-monitoring method of supported care. Telehomecare uses ICT to remotely link providers and patients. In combination with a team and evidence-based model of chronic disease management, Telehomecare provides remote monitoring of the patient's condition, a targeted and rapid response from the care team to an emerging health crisis, proactive patient coaching and education and coordination of care amongst multiple care providers.

NEON – 22 of our 25 hospitals are now on NEON. These shared systems support iEHR and increase iEHR adoption and clinical benefits.

Realignment and System Transformation

The NE LHIN supports realignment initiatives that demonstrate action and a renewed coordination of health services planning. While a number of integration priorities will continue to be led by the NE LHIN, additional efforts to achieve a more seamless and patient-focused approach to health care will be driven by providers and community leaders. Patient-focused integration efforts allow for a health care system that's easier for people to navigate and offers a greater possibility to maintain or enhance current service levels.

The NE LHIN will continue to work with health care partners to focus care and investments where there is the greatest need; realigning resources to create a truly integrated health care system. Some examples of realignment and system transformation being supported by the NE LHIN include:

- **Modernizing home and community care**
 - The NE LHIN is being considered as a potential site for early adoption for amendments of the *Home and Community Care Services Act* that came into effect July 1, 2014.
 - Continued monitoring and implementation of the North East Community Care Access Centre Collaborative Capacity Analysis Report will ensure that an appropriate level of service continues to be available today and into the future.
- **Ensuring sustainability and quality**
 - Efforts will continue to ensure implementation of QBPs into NE LHIN hospitals.
 - Discussions continue with the region's community hospitals to ensure transformation and sustainability of the region's 21 community hospitals and that they are delivering appropriate services for their changing population. In October 2014, the NE LHIN published *Community Hospitals and Health Care in Northeastern Ontario: Transforming the Patient Experience*, which chronicled the evolution of the region's community hospitals and encouraged Northerners to join in the conversation and help structure the next chapter.
 - The NE LHIN will continue to leverage its valued partnership with HQO to deliver quality improvement sessions with funded agencies.
- **Improving system integration, accessibility**
 - Work continues to build the most appropriate models of integrated care for communities, including: Health Links, Health Hubs, Community Networks, and other models.
 - A focus will remain on promoting advanced access in primary care settings.
- **Increasing the health and wellness of Ontarians**
 - The NE LHIN will continue to advance active aging supports, such as Community Exercise and Falls Prevention programs for seniors, as well as physiotherapy in the community.
 - Mental health initiatives such as Community Mobilization programs and a managed alcohol program are helping to better meet the needs of Northerners in community.
 - The NE LHIN will continue to ensure chronic disease initiatives such as low back pain programs, supporting patients living with chronic disease, are made available to Northerners.
- **Integrated Care Models**
 - A key enabler in helping the NE LHIN achieve its four priorities is our commitment to building the most appropriate model of integrated care for communities. The NE LHIN created *The North East Rural Communities Framework for Achieving Improved Health System Coordination*, a document designed to help communities collaborate on how to enhance patient care and transitions between hospital and community care. The framework brings community agencies together – from all sectors, including primary care, hospitals, mental health organizations, and culturally diverse populations – to help them decide on the most appropriate model of care for their community, whether it be Health Links, Health Hubs or Community Networks. Foundations for this framework include improving transitions between health care providers by breaking down silos and reducing costs, and putting patients at the centre of the local health care system by making them active participants in their care and allowing them to co-design the system.

Recruitment and Retention of Health Human Resources

People working to provide health care services are essential to the transformation of the health care system, whether they are treating people while in hospital or helping them to transition back home. Greater access to health care professionals helps to promote healthy living and support better management of chronic conditions. Access, particularly to primary care services, remains a significant issue for patients in Northeastern Ontario.

With many primary care physicians at or nearing retirement, the NE LHIN has focused its efforts in the past year on better understanding issues related to closing practices. This information will start a dialogue about how to create a system that is patient-centred, allowing patients to move seamlessly from one form of primary care to another, particularly for patients with complex needs, while at the same time meeting the needs of both new physicians and retiring physicians.

A healthy system of care also relies on professionals working to their full scope of practice. Recruitment and retention of health care professionals, such as NPs and PSWs, help to ensure a good mix of professionals across the continuum of care. The NE LHIN works with partners to decrease gaps in the mix and distribution of health care professionals and to ensure a collaborative approach to recruitment and retention strategies.

The NE LHIN will continue to work closely with HealthForceOntario, the Northern Ontario School of Medicine, and both health and educational partners to advance HHR strategies and innovative Northern solutions.



The NE LHIN and Health Sciences North (HSN) launched an innovative program in May 2014 called Virtual Critical Care (VCC) that extends the reach of expert providers to critically ill patients in community hospitals across the region. To date, with 23 sites participating, the unit has been used for 110 patients, with an additional 218 follow-up visits, for a total of more than 11,000 VCC care minutes. Consultations through the VCC allowed health care professionals to avoid medical transfers by air ambulance for 40 of those patients, at an estimated savings of approximately \$680,000 to the health care system. Members of the VCC team at HSN include (from left to right) Mike Lafontaine, RN; Steven MacNeil, RN; Renée Fillier, RN, Coordinator, VCC Program, HSN; and Dr. Derek Manchuk, Medical Director, Critical Care, HSN and Critical Care Lead for the NE LHIN.

LHIN Operations Spending Plan

LHIN Operations Sub-Category (\$)	2014/15 YE Actual	2015/16 Allocation	2016/17 Planned Expenses	2017/18 Planned Expenses
Salaries and Wages	2,954,194	3,174,244	3,174,244	3,174,244
Employee Benefits				
HOOPP	277,759	328,918	328,918	328,918
Other Benefits	366,950	357,296	357,296	357,296
Total Employee Benefits	644,709	686,214	686,214	686,214
Transportation and Communication				
Staff Travel	141,368	121,472	121,472	121,472
Governance Travel	11,546	10,412	10,412	10,412
Communications	144,630	79,825	79,825	79,825
Other	4,050	3,471	3,471	3,471
Total Transportation and Communication	301,594	215,179	215,179	215,179
Services				
Accommodation	259,396	203,910	203,910	203,910
Advertising	6,939	3,471	3,471	3,471
Banking	-	104	104	104
Consulting Fees	80,364	21,240	21,240	21,240
Equipment Rentals	9,876	6,486	6,486	6,486
Board Chair Per Diems	9,575	8,746	8,746	8,746
Other Governance Per Diems	23,922	10,065	10,065	10,065
Insurance	6,762	4,494	4,494	4,494
LSSO Shared Costs	225,091	264,922	264,922	264,922
LHIN Collaborative	47,500	32,971	32,971	32,971
Other Meeting Expenses	27,685	22,212	22,212	22,212
Other Governance Costs	4,733	7,635	7,635	7,635
Printing & Translation	44,849	34,706	34,706	34,706
Staff Development	38,630	24,294	24,294	24,294
Total Services	785,323	645,257	645,257	645,257
Supplies and Equipment				
IT Equipment	26,102	10,412	10,412	10,412
Office Supplies & Purchased Equipment	23,804	21,476	21,476	21,476
Total Supplies and Equipment	49,907	31,888	31,888	31,888
Capital Expenditures	-	-	-	-
LHIN Operations: Total Expenses	4,735,727	4,752,782	4,752,782	4,752,782
LHIN Program Expenses				
Diabetes RCC	1,087,560	1,087,560	1,087,560	1,087,560
French Language Services	296,800	296,800	296,800	296,800
eHealth PMO	510,000	510,000	510,000	510,000
Aboriginal Planning	100,000	100,000	100,000	100,000
ER/ALC	100,000	100,000	100,000	100,000
FLS Entity	796,159	796,159	796,159	796,159
Physician Lead	225,000	225,000	225,000	225,000
Grand Total LHIN Expenses	7,851,246	7,868,301	7,868,301	7,868,301
Annual Funding Target	7,851,246	7,868,301	7,868,301	7,868,301
Variance Surplus/(Deficit)	-	-	-	-

LHIN Staffing Plan (Full-Time Equivalents)

Position Title	2014/15 Actual as of March 31/15	2015/16 Forecast	2016/17 Forecast	2017/18 Forecast
Chief Executive Officer	1	1	1	1
Senior Directors	3	3	3	3
Project Coordinators	4	4	4	4
Executive Assistant & Board Liaison	1	1	1	1
Administration Clerk	3	2	2	2
Human Resources/Corporate Services Coordinator	1	1	1	1
Controller	1	1	1	1
Analysts – Data, Finance & Performance	3	3	3	3
Senior Advisor, System Performance	1	1	1	1
Director, Communications, Community Engagement	1	1	1	1
Communications & Community Engagement Coordinator	1	1	1	1
Communications Officers	3	3	3	3
Chief Information Officer & eHealth Lead	1	1	1	1
Senior Project Manager	1	1	1	1
Senior Officer, Policy & Health System Planning	1	1	1	1
Hub Officers	4	4	4	4
Outreach Officers	4	5	5	5
Officers – CSS & Assisted Living, Chronic Disease/Diabetes Management, Rehabilitation & Complex Continuing Care, Primary Care, NE Falls Prevention, Mental Health & Addictions, Performance & Decision Support, Finance & Performance, Project Management, Long-Term Care	10	10	10	10
French Language Services Officer	1	1	1	1
Aboriginal/First Nations/Métis Officer	1	1	1	1
Total FTEs	46	46	46	46

Objectives

Business Objective:

To implement the final year of the NE LHIN's 2013-2016 IHSP and the initiatives contained in this ABP to develop a regional system of patient-centred, integrated health care across the continuum by:

- increasing primary care coordination;
- enhancing care coordination and transitions to improve the patient experience;
- making mental health and addictions services more accessible;
- targeting the needs of culturally diverse population groups;
- explaining the priority enablers: EHR opportunities, realignment and system transformation, and recruitment and retention of HHR;
- fostering an understanding of the need for health system transformation;
- focusing on health system transformation to create an integrated sustainable health care system that ensures better health, better care, and better value for money;
- aligning HSPs with the NE LHIN's mission and vision;
- encouraging Northerners to participate in health system transformation; and
- providing information on performance and progress – documenting successes and sharing them.

Communications Objectives:

We will promote opportunities for engagement and involve Northerners in helping to achieve our business objectives by:

- providing fellow Northerners with timely, accurate and useful information about the need for regional health care transformation, from a person-centred health care decision perspective;
- disseminating a shared vision of the NE LHIN related to the priorities of the IHSP for 2013-2016 and increasing awareness of transformation and integration successes in the NE LHIN;
- coordinating corporate communications and community engagement activities, particularly related to realignment and stakeholder engagement to prepare the IHSP 2016-2019;
- building awareness of the NE LHIN's role in advancing local health care priorities;
- guiding the communications and engagement activities of North East HSP partners involved in initiatives in the 2015/16 ABP;
- ensuring stakeholders understand their role to identify opportunities to integrate services of the local health system to provide appropriate, coordinated, effective and efficient services based on available funding, and to track performance against accountability agreements;
- providing accurate and timely information to all audiences; and
- being transparent and accountable.

Context

- Ontario's *Patients First: Action Plan for Health Care*, announced by the Minister in February 2015, which is consistent with the principles of the *Excellent Care for All Act (2010)*, puts LHINs at the centre of health system transformation.
- The NE LHIN's 2013-2016 IHSP and the initiatives laid out in this ABP are strategically aligned with government direction and priorities and recognize the joint accountability of the MOHLTC and LHINs to serve the public interest and effectively oversee the use of public funds.
- The *2014 Mandate letter: Health and Long-Term Care* provided the Premier's instructions to the Minister and included priorities placed on home and community care, LHINs' role in delivering more efficient and coordinated care to patients, and focus on accountability and transparency.
- *Patients First: Roadmap to Strengthen Home and Community Care* (May 2015) is the first phase of the

provincial plan to remake the home and community care sector. It outlines the steps being taken to improve the care loved ones receive, and is informed by the work of the MOHLTC's expert group on home and community care, led by Gail Donner, and its report, *Bringing Care Home*.

Target Audiences

The NE LHIN engages with many stakeholders who can be categorized into several categories:

External

- Public (taxpayers, patients/clients and family members)
- HSPs
 - LHIN-funded HSPs: Hospitals, CCAC, CSS, Community Mental Health and Addictions Services, LTCHs, CHCs
 - Non-LHIN funded HSPs: Physicians, primary care organizations, Ambulance Services, OTN, Provincial networks (i.e. Cancer Care Ontario and others), Public Health Units
- MOHLTC
- 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, Ministry of Municipal Affairs and Housing, Ministry of Northern Development, Mines and Forestry, Ministry of Children and Youth Services, Services de santé en français; Secretariat for Aboriginal Affairs; Seniors' Secretariat
- 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

- Board of Directors, Health Care Leads, Advisory Groups and Committees, Staff

Strategic Approach

Position the NE LHIN as a valued key player within the transformation of Ontario's health system.

Communication initiatives will support the priorities of both the MOHLTC's *Patients First: Action Plan for Health Care* and the NE LHIN's IHSP 2013-2016.

- We will use a combination of high-profile and low-profile communication strategies to document and share successes of system transformation, with a particular focus on patient benefit.
- Targeted communications – specific to service provision and/or geographic areas – will demonstrate how Northerners 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.

Key Messages

Our regional commitment to Ontario's health system transformation reinforces provincial health care priorities, including:

- putting people and patients first by enhancing the health care experience;
- providing information to make decisions, and tools to live healthy and stay healthy;
- providing better access to quality health services, and protecting those services for generations to come;
- providing faster access to the right care;
- providing enhanced home and community care;
- providing information to make the right decisions about your health; and
- ensuring our universal health care system is sustainable for generations to come.

NE LHIN key messages are both aligned with the above provincial directions and responsive to local voices:

People-Focused Care in Community

- The NE LHIN is enhancing care in Northeastern Ontario communities by responding to the voices of Northerners and their request for more care at home and in community.

Transforming Together

- The voices of Northerners are the bedrock of the NE LHIN's strategic plan to improve care coordination, accessibility, transition, and cultural responsiveness.

One Coordinated System

- The NE LHIN is bringing together HSPs to help build one system of quality care that is more coordinated, value-driven, accountable, and focused on the needs of Northerners, particularly our frail elderly.

By bringing together health care partners such as hospitals and community-based agencies to develop innovative, collaborative solutions that lead to improved access to high-quality care for all residents, the NE LHIN is championing system transformation.

Guided by our 2013-2016 IHSP, the NE LHIN is collaborating with health sector partners to organize the system differently and focus on medical evidence to bring about significant and positive change to ensure system sustainability and the delivery of quality care services.

Tactics

- News releases, media advisories, blast emails, newsletters, bulletins, letters to the editor, photos with captions, NE LHIN CEO blog
- Virtual Coffee Breaks with guest speakers in which Northerners can listen in to conversations on key issues, as well as send in questions to be answered by the speakers
- Healthy Change Champions – named by NE LHIN as champions of health care change in Northeastern Ontario
- Health Care Lead Columns – regular updates on their NE LHIN roles/work
- Videos to tell personalized stories of health system transformation
- Website postings/alerts, social media
- The NE LHIN has completed the implementation of the standardized LHIN Visual Identity
- Stakeholder events – presentations
- 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 NE LHIN to identify whether communication activities have been successful. These factors may include:

- The degree of public/patient participation in events, programs and engagement activities
- A comprehensive monthly media tracking analysis to measure success through output
- 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
- 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. At each engagement opportunity, feedback will track success and/or determine needed modification of information dissemination and comprehension.
- HSPs are engaged early and frequently and can see how their participation is impacting implementation/transformation

Community Engagement

A variety of best practice strategies will be employed to fulfil the NE LHIN's commitment to community engagement in 2015/16. This is a significant year for outreach to continue change management efforts included in the 2013-2016 IHSP and invite dialogue on priorities for the 2016-2019 IHSP.

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 offer 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 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, Virtual Coffee Breaks, 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 North East; and
- technology: Virtual Coffee Breaks, town hall meetings, blogs, as well as interactive social media including twitter, Facebook, YouTube.

NE LHIN Engagements

Throughout the year, the NE LHIN holds engagements with both fellow Northerners and HSPs, which include, but are not limited to:

- open meetings of the NE LHIN Board of Directors;
- HPAC meetings – members represent a wide range of professionals across the health care sector in Northeastern Ontario;
- NE LHIN LAHC meetings to share information and receive advice and recommendations on improving access to care;
- RMEFNO to support Francophone engagements;
- regional HUBs Group – CEOs and Board Chairs of four large hospitals and the NE CCAC;
- bi-monthly meetings with 21 community hospitals;
- bi-monthly engagement meetings with the region's 40 LTCHs;
- regular meetings with six CHCs;
- regular meetings with the NE LHIN eHealth Advisory Council;
- regular communication with MPPs and one-on-one meetings as needed;
- regular meetings with HSPs to discuss opportunities for collaboration;
- regular meetings with North East Hospice Palliative Care Network;
- North East Behavioural Support Working Group meetings;
- North East Regional Community Support Services (CSS) Network meetings;
- Diabetes Advisory Committee meetings;
- Regional Primary Care Council meetings;
- Regional Long Term Care Network meetings;
- meetings with the Regional Steering Committee for Stay on Your Feet;
- 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; and
- FHT meetings.