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

North East Local Health Integration Network

Annual Business Plan 2016/17

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

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Cover photo:

John Wilson, Manager, Strategy & Advocacy, Ontario Non-Profit Housing Association, chats with NE LHIN Chair, Danielle Bélanger-Corbin, and CEO, Louise Paquette (right), at the NE LHIN's first forum on housing, *Building for the Future – Meeting the North East's Housing Needs,* held in Sudbury in October 2015. Close to 150 people from a range of sectors attended the event which featured 24 speakers. As part of its Integrated Health Service Plan (2016-2019), the NE LHIN's work to continue to strengthen the continuum of care for Northerners will leverage several key areas, including **transportation and housing models** to better support people in community; the use of **technology** to strengthen the coordination of care; more **education** efforts to help Northerners more easily find the care they need; and **partnerships** that help to ensure more collaborative efforts in caring for Northerners.

TRANSMITTAL LETTER FROM THE NE LHIN BOARD CHAIR

June 10, 2016

Tim Hadwen
Assistant Deputy Minister
Health System Accountability and Performance Division
Ministry of Health and Long-Term Care
Hepburn Block, 5th Flr
80 Grosvenor St
Toronto ON M7A 1R3

Email: tim.hadwen@ontario.ca

Dear Mr. Hadwen,

The North East Local Health Integration Network (NE LHIN) is pleased to provide you with our updated 2016/2017 Annual Business Plan (ABP), as required by the *Local Health System Integration Act, 2006*, the Ministry/LHIN Memorandum of Understanding, and the Ministry-LHIN Accountability Agreement (MLAA).

This ABP focuses on the first year of our 2016-2019 Integrated Health Service Plan (IHSP). It builds on the progress made to date and our vision to provide "*Quality Health Care When Northerners Need It*" through transformational change in Northeastern Ontario health care. It aligns with *Patients First: Ontario's Action Plan for Health Care* (February 2015), and takes into account *A Proposal to Strengthen Patient-Centred Health Care in Ontario* (December 2015), for which more than 1,000 people submitted over 3,500 suggestions/comments to improve the system of care for Northerners.

The three priorities of our current IHSP are:

- Improving access to care and wait times to receive quality care
- Enhancing the coordination of care
- Strengthening the sustainability of the health care system so that it is here for Northerners and their families today and tomorrow.

These priorities are supported by the following enablers: technology to help strengthen programs and services; transportation and housing models to better support people in community; education efforts to help Northerners more easily find the care they need; and partnerships that help increase the coordination of health care across Northeastern Ontario.

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 27% by 2026), high rates of chronic disease and complex medical issues, the need to strengthen the full continuum of care, including a closer alignment of primary care and home and community care with the rest of the system, 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 strengthen the coordination of health care services and improve access.

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 2016-2019 IHSP aligns well with Ontario's 2015 *Action Plan for Health Care* and with the needs of Northerners as voiced through ongoing community engagements. The outcome of NE LHIN engagements with fellow Northerners continues to influence the NE LHIN's decision making and priority setting.

OVERVIEW OF CURRENT AND FORTHCOMING PROGRAMS/ACTIVITIES

The NE LHIN funds about 150 health service providers (HSPs) across six sectors (some delivering services in more than one sector), including:

- 25 Hospitals
- 6 Community Health Centres (CHCs)
- 44 Community Mental Health & Addictions Providers
- 68 Community Support Services (CSS)
- 41 Long-Term Care Homes (LTCHs)
- 1 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. Key to this shift is to leverage several key areas including: technology to help strengthen programs and services; transportation and housing models to better support people in community; education efforts to help Northerners more easily find the care they need; and of course, partnerships that help increase the coordination of health care across Northeastern Ontario.

We will continue to drive system quality, better the patient experience and improve population health, recognizing cultural diversity, particularly for Francophone and Aboriginal people.

North East LHIN Strategic Plan Summary, 2016 – 2019

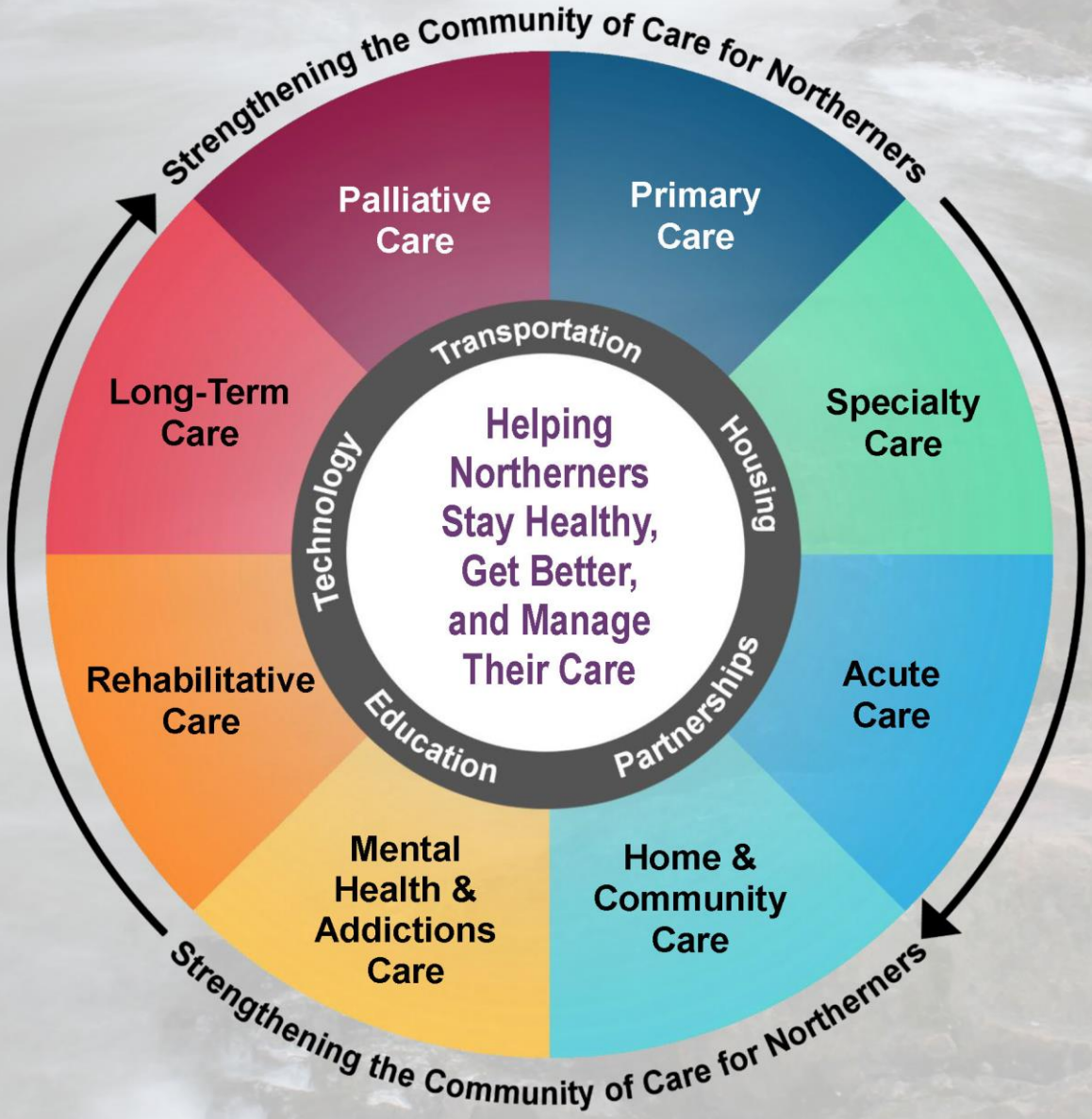
Provincial Directives

Access	Connect	Inform	Protect
Improve System Integration And Accessibility	Modernize Home and Community Care	Increase the Health and Wellness of Ontarians	Ensure Sustainability and Quality

NE LHIN Priorities

- Improve Access and Wait Times
- Increase Care Coordination
- Strengthen System Sustainability

Areas of Care

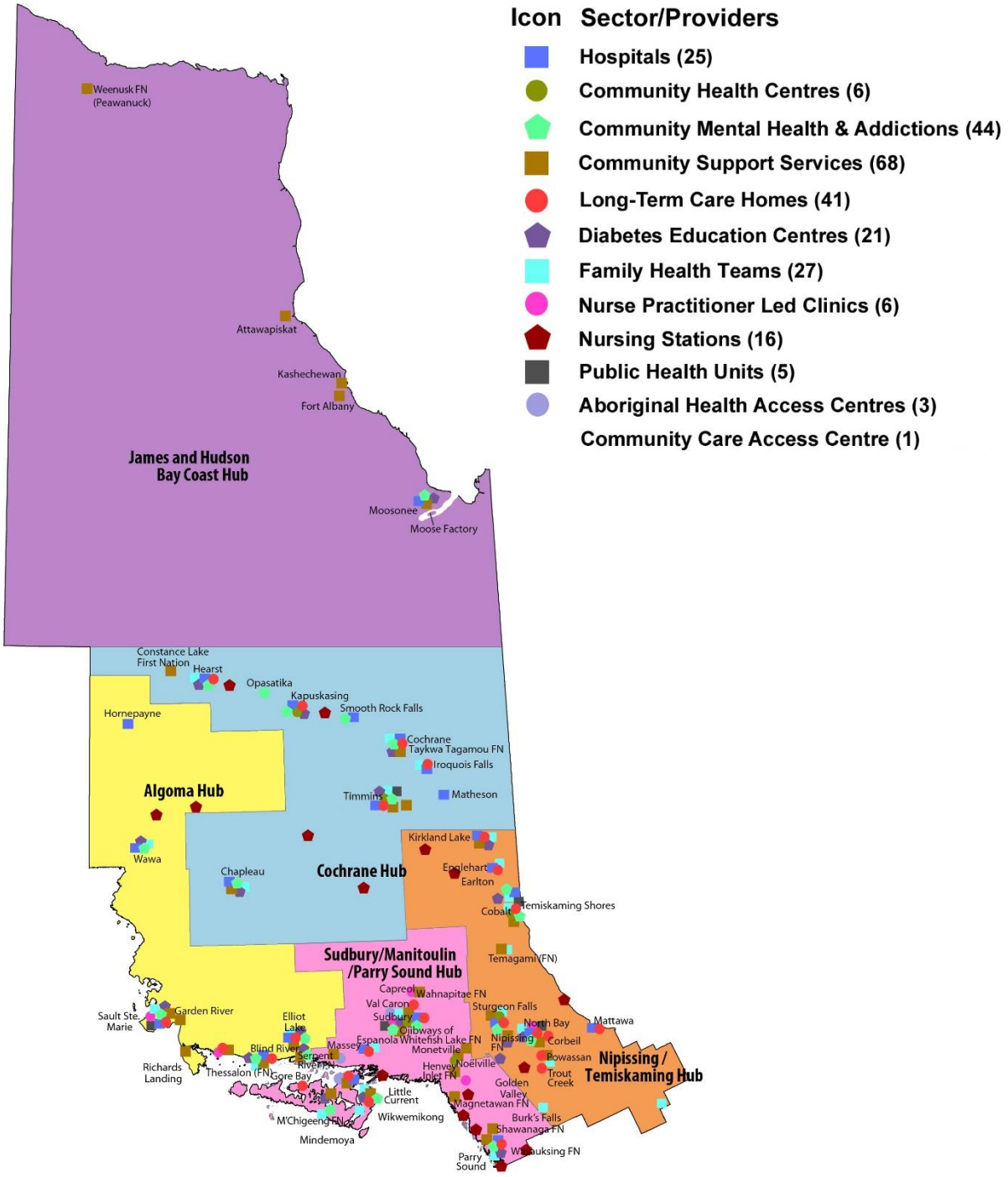


The NE LHIN will work with partners to drive system quality and value, enhance the patient experience, and improve population health while recognizing cultural diversity, particularly for Francophone & Aboriginal people.

ENVIRONMENTAL SCAN

In 2016, the NE LHIN has 168 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 34 Long-Term Care Service Accountability Agreements (L-SAAs).

Currently, the NE LHIN structures its large geographic area (400,000 square kilometres) into five hub planning areas. 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

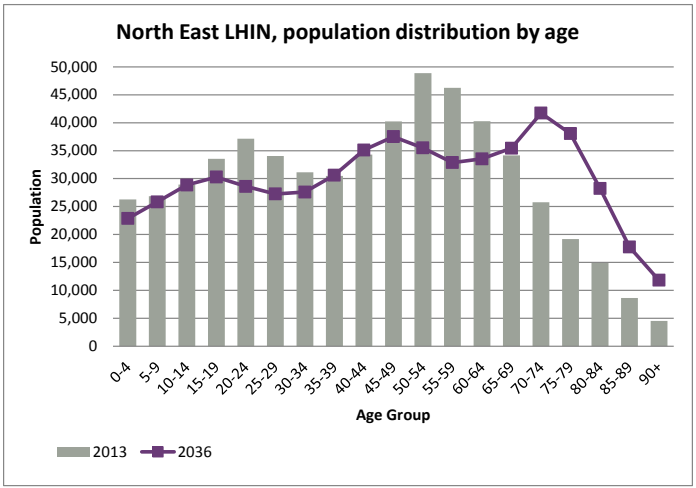
The NE LHIN has approximately 420 physicians delivering comprehensive primary care, one Group Health Centre in Sault Ste. Marie, 27 family health teams (FHTs), six community health centres (CHCs), three Aboriginal health access centres (AHACs), six nurse practitioner-led clinics (NPLCs), and 16 nursing 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. An overall decline of 2.5% is expected over the next two decades but the proportion of the population age 65 and older is projected to increase from 20.5% to 31.2%. The number of seniors will increase by 48.4% - 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.

(Source: Statistics Canada. Table 105-0502 - Health indicator profile, two year period estimates (2013-14), by age group and sex, Canada, provinces, territories, health regions (2013 boundaries) and peer groups, occasional, CANSIM (database). (accessed: March 2, 2016). *Ontario percentages also include Northeastern Ontario percentages.)

Indicator	NE LHIN	Ontario
Perceived health as excellent or very good	54.9%	59.5%
Perceived life stress, quite a lot (age 15+)	20.7%	22.9%
Sense of community belonging, somewhat strong or very strong	69.3%	68.0%
Smoking, daily or occasional	23.2%	17.7%
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)	21.9%	16.7%
Overweight or obese (adults age 18+)	61.7%	53.9%
Has a regular medical doctor	85.3%	91.8%
Contact with medical doctor in the past 12 months	77.2%	80.0%

NE LHIN Priority

Improve access and wait times to receive quality care

Overwhelmingly, when Northerners are asked how their experience with the health care system can be improved, access is their top word of choice.

Accessible health care means getting the quality care you and your family need, where you need it, and in a timely manner. This could include help from a family doctor or nurse practitioner, an Aboriginal or Francophone community health centre, a family health team, an integrated health care team, a specialist, mental health and addiction counsellor, long-term care home, or a home and community care provider. Sometimes we need the services of several of these providers, particularly as we age.

Priority: Improve Access and Wait Times to Receive Quality Care

Goal – Faster access to the service you need with shorter wait times.

Objectives

1. Support primary and specialty providers to ensure more timely access to services.
2. Improve wait times for surgical / diagnostic procedures and emergency department visits.
3. Enhance the availability of coordinated home and community care services and programs.
4. Improve older adults' access to falls prevention strategies.
5. Enhance dementia/behavioural support services for seniors and their caregivers.
6. Work with partners to increase housing opportunities and associated supports for older adults, people with mental health and addiction issues, and other vulnerable populations.
7. Improve access to mental health and addiction services with a focus on implementing a standardized referral form, an on-line health information site, a provincial bed registry, and programs targeting the Aboriginal population.
8. Work with the French Language Health Planning Entity to increase access to services in French with a focus on increasing the number of health service providers developing designation plans and implementing an Active Offer approach.
9. Increase access to community support services, diabetes outreach models, and traditional health and healing services for Aboriginal Northerners, particularly people living with complex chronic conditions.
10. Increase timely access to rehabilitative care in home and community.
11. Improve access to long-term care beds.

Current Status

The NE LHIN works with Northerners to increase both the availability of, and access to, care. This is especially important in our region, knowing that about 20% of our population is already age 65 or older, and this number will climb to 31% in the coming two decades. We also place emphasis on increasing access for Francophone and Aboriginal people, which comprise 23% and 11% of our population respectively.

We now have 42 LHIN-approved providers under the French Language Service Act, with 57 others in the designation planning stage. In our region, 72% of non-designated providers have professionals who can provide services in French. NE LHIN efforts have consistently focused on improving access to services and the health status of Aboriginal people living within our geographic boundaries. The Aboriginal population is the fastest growing population in the region. Aboriginal people have higher rates of chronic disease and co-morbidities and at a younger age than their non-Aboriginal counterparts.

A few examples of how the LHIN is working to improve access to primary care include: 82% of family physicians use electronic medical records for their patients' information; 82.7% of people registered with Health Care Connect have a primary care provider; more than 285 critically ill patients have been cared for through Virtual Critical Care, and close to 2,000 people have benefited from Telehomecare to better self-manage their COPD or heart failure. Over the past three years, the NE LHIN has invested in many projects and programs to improve access and wait times for people suffering from mental health or addiction related illnesses and more than 7,500 people have received specialized Behavioural Supports Ontario (BSO) training to care for older adults with challenging and complex behaviours. Additionally, more than 22,000 people have accessed care through the regional mental health Warm Line.

Consistency with Government Priorities

Improved access to quality health services is a central component of the government's transformation of the health care system, as noted in *Patients First: Ontario's Action Plan for Health Care (February 2015)*, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario (December, 2015)*, the Ministry's *10-Year Mental Health and Addictions Strategy* which sets out five pillars for achieving better mental health and addictions recovery, and *Bringing Care Home*: Report of the Expert Group on Home & Community Care (March 2015).

Objective 1: Support primary and specialty providers to ensure more timely access to services.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Work with North East Specialized Geriatric Services (NESGS) to implement its 2015-18 Strategic Plan which includes expanding SGS capacity and coordination in communities across the region.	In progress	33%	In progress	33%	In progress	33%
Action 2: Continue to monitor and address issues related to the implementation of CCSO's (Critical Care Services Ontario) Critical Care Life or Limb policy in the NE LHIN.	In progress	50%	In progress	50%	Complete	100%
Action 3: Continue to expand telemedicine opportunities to primary care providers and patients. (i.e. eConsult, tele-dermatology /wound care, tele-psychiatry, OTN telemedicine visits for patients).	In progress	33%	In progress	33%	In progress	33%
Action 4: Improve access to primary care services by promoting both Health Care Connect (for unattached patients), and the adoption of HQO's (Health Quality Ontario) Advanced Access information.	In progress	33%	In progress	33%	In progress	33%

How will we measure success?

Action 1: Expansion of the NESGS team in Sudbury and implementation of multi-disciplinary SGS team in Timmins and Sault Ste. Marie. Service volume targets will be identified based on the magnitude and nature of the investments. Research has shown that SGS programs reduce ED, acute care and ALC utilization for the population age 75+.
Action 2: Reduction or elimination of critical care life or limb consultation refusals by sub-specialists in the North East.
Action 3: 80 primary care providers (physicians and NPs) provisioned to make referrals utilizing eConsult (175% increase); average of 80 eConsults established per month by NE providers (150% increase); increase number of physicians utilizing tele-dermatology, and 20% increase in total consultations annually; 10% increase in number of physicians utilizing tele-psychiatry, and 15% increase in total number of consultations annually; 10% increase in all OTN visits annually.
Action 4: Increase percentage of patients referred to a primary care provider through Health Care Connect. Increase percentage of people who are attached in the NE LHIN (Health Care Experience Survey). Increase percentage of people who were able to see a primary care provider when they were sick on the same or next day (Health Care Experience Survey).

Risks/barriers to successful implementation

- Primary care physician accountability.

NE LHIN risk mitigation efforts

- New NESGS consolidated regional program sponsorship and governance will support increased coordination and oversight.
- The new NE LHIN Critical Care Network will provide a neutral table to address and manage life or limb related issues, with an escalation process to the LHIN CEO.
- Primary care engagement and alignment of work with NE LHIN.

Key enablers

- Closer alignment of primary care with the full continuum of care.
- Continued support for Primary Care Clinical Leads in hub communities.
- Support and alignment with OTN.
- Integration of NESGS with HSN and formation of Specialized Geriatric Services committee of the NE LHIN.

Objective 2: Improve wait times for surgical/diagnostic procedures and emergency department visits.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Conduct value for money assessment of Pay for Results funding to inform the utilization strategy for future initiatives.	In progress	75%		25%		
Action 2: Support efforts to secure a second MRI scanner in Sudbury to improve access and reduce wait times.	In progress	50%		50%		
Action 3: Complete population-based analysis of QBP Cataracts to inform volume allocation to surgical hospitals.	In progress	100%				
Action 4: Complete a population-based analysis of QBP Hip and Knee to inform volume allocation to surgical hospitals.	In progress	50%	In progress	50%	Complete	100%

How will we measure success?

Action 1: ED length of stay for complex patients will improve to meet 8 hour target.
Action 2: Diagnostic imaging (MRI) will improve patient access by increasing the percentage of scans completed within access targets to meet 90% target.
Action 3: Cataract surgery performance will be maintained at/above the target of 90%.
Action 4: Hip and knee replacement surgeries will improve patient access and wait time by increasing the percentage of surgeries completed within access targets to meet 90% target.

Risks/barriers for successful implementation

- Achieving performance improvement in ED length of stay for complex patients is driven by the length of stay of patients admitted to hospital. High ALC (Alternate Level of Care) rates are impeding patient flow to medical floors in some NE LHIN hospitals. ALC rates will challenge performance improvement for ED length of stay.
- Both cataract, and hip and knee replacement, surgical volumes allocated to local hospitals should address population needs and if not allocated appropriately the risk is that some NE residents do not receive necessary surgery.

NE LHIN risk mitigation efforts

- ALC performance improvement strategies will improve patient flow and mitigate risk of inability to improve ED length of stay for complex patients.
- A second MRI scanner in Sudbury.
- A population-based allocation of cataract, and hip and knee replacement surgeries, enables the best access to care.

Key enablers

- NE LHIN's ED Network will support ongoing monitoring of ED performance.
- NE LHIN's Health System Advisory Committee supports LHIN ALC performance improvement efforts.
- NE LHIN's Wait Time and Volumes Subcommittee and the Local Partnership monitor and hold hospitals accountable for volume completion and wait time performance.

Additional comments

Operation and deployment of Health Links ensures that the most complex patients are supported with coordinated care plans. Rural health hubs will integrate care in rural communities improving access and timeliness to care. These efforts will assist in ensuring timely access to care for patients and improved management of their health conditions. Improving access to and timeliness of care may assist in reducing reliance on ED visits and hospitalizations.

Objective 3: Enhance the availability of coordinated home and community care services and programs.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Develop and implement IT tools that improve flow across the planning area.	In progress	40%	In progress	30%	In progress	30%
Action 2: Collaborate on health human resource initiatives to strengthen capacity and service coordination.	In progress	30%	In progress	35%	In progress	35%
Action 3: Work to identify caregiver/respite processes and models that support seamless and equitable access to services across the planning area.	In progress	10%	In progress	45%	Complete	45%

How will we measure success?

Action 1: Use of CSS Common Referral Form across all patient pathways including a 25% increase in traffic to the Healthline website. Public access initiated in 2016 will allow for easier access to, and information about, CSS providers.
Action 2: Delivery of PSW training to enhance workforce capacity and sustainability. Ongoing annualized program will build upon existing needs and assist with retention and quality service delivery. Sharing of best practices related to volunteer management in the areas of recruitment and retention.
Action 3: A review and inventory is initiated of respite services available to caregivers.

Risks/barriers for successful implementation

- Competing ICT (Integrated Communication Technology) priorities.

NE LHIN risk mitigation efforts

- Work collaboratively with partners to build upon current resources. Advocate locally and provincially to share access to resources as identified.
- In tandem with CSS Regional Table Work Group, advocate for resources to support a regional approach.
- Build a collaborative approach to review and ensure informed decisions/solutions are achieved.
- Investments in CSS to stabilize and enhance capacity.

Key enablers

- Partnership with CSS Regional Table.
- Technology supports.

Objective 4: Improve older adults' access to falls' prevention strategies.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Build multi-sector partnerships across the health continuum focused on fall prevention at the district and regional level.	In progress	50%	In progress	25%	In progress	25%
Action 2: Increase the fall prevention knowledge base among multi-sector service providers.	In progress	25%	In progress	25%	In progress	25%
Action 3: Increase awareness among older adults and their caregivers of the risks of falls and ways to reduce risks.	In Progress	25%	In progress	25%	In progress	25%
Action 4: Maximize the reach of exercise classes and falls prevention classes.	In progress	50%	In progress	25%	In progress	25%
Action 5: Support and build healthy public policies at the local and regional level on fall prevention and healthy aging.	In progress	50%	In progress	25%	In progress	25%
Action 6: Establish a standard fall risk screen/ assessment and community referral protocol within all primary care providers.	In progress	25%	In progress	25%	In progress	25%

How will we measure?

Action 1: Percentage of sectors engaged in Stay on Your Feet (SOYF) network across the region; percentage of sectors implementing fall prevention programming across the region.
Action 2: Percentage of service providers providing education on fall risks and prevention strategies.
Action 3: Reach of education and awareness components of SOYF.
Action 4: Percentage of the 177 exercise classes operational and number of participants per year.
Action 5: Number of policies supported; number of policies implemented.
Action 6: Percentage of primary care providers who integrate standard falls risk screen and assessment into their practice.
All actions: Monitor emergency room visits and hospitalizations due to falls among older adults.

Risks/barriers for successful implementation

- Strengthening community capacity is underway, however it will take time -- a long-term process.
- Limited capacity within the health and other sectors to engage in SOYF.
- Accountability for public health and primary care is currently not with the NE LHIN.

NE LHIN risk mitigation efforts

- Build on the strengths that exist within each district for falls prevention.
- Identify ways to incorporate fall prevention into existing practices.
- Integrate local population and public health planning with other health services and formalize linkages between LHINs and public health units.

Key enablers

- Strong SOYF Regional Network and local SOYF coalitions to ensure sustainability.
- Continued commitment of public health units to work collaboratively with the LHIN.

Objective 5: Enhance dementia/behavioural support services for seniors and their caregivers.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Realign existing BSO funding to ensure funding is distributed appropriately.	In progress	75%	Complete	25%		
Action 2: Enhance BSO investments and programs available in NE LHIN.	In progress	25%	In progress	75%		
Action 3: Align planning activities with provincial dementia strategy.	In progress	25%	In progress	75%		
Action 4: Develop behavioural management in LTC facilities to reduce ALC pressures.	In progress	20%	In progress	50%		

How will you measure success?

Action 1: Increase in number of referrals for appropriate clients to receive BSO services, in hospital, community and LTC.
Increase in number of LTC homes with embedded teams.

Action 2: Increase in enhanced BSO supports available in acute care, community, LTC.
Overall percentage of staff educated on GPA, PIECES, U-First and other pertinent sessions.
Action 3: Number of engagement activities that occur to align with the dementia strategy.
Outcomes from cross-sector meetings held to develop NE LHIN Dementia Strategy.

Action 4: Investments in staff in LTC homes willing to manage increased levels of care residents with behavioural challenges.

Risks/barriers for successful implementation

- Willingness of providers to incorporate BSO program into existing services.
- Ensuring providers are able to meet expectations.
- Providing adequate support in rural/remote communities.
- Need for ongoing collaboration with key stakeholders during development phase.
- Competing priorities of stakeholders.
- Coordinated Admission Review committee.

NE LHIN risk mitigation efforts

- Engage providers to ensure understanding of common goal for appropriate distribution of resources.
- Leverage expertise from providers on service provision.
- Recognize the unique needs and challenges of providing services in rural settings and ensure all partners are engaged throughout the process.
- Coordinate meetings between LHIN/Ministry to determine current state of BSO and alignment with Dementia Strategy.
- Review data and analyze gaps in current service and for early identification of partnerships that may provide services.

Key enablers

- Partnerships and engaging with various committees including (but not limited to): NE BSO Steering Committee; establishment of a NE Dementia Strategy Committee; LTC Regional and Hub Networks; development of cross-sector relationships.
- Technology including OTN/webinars for committee meetings, education sessions; websites/electronic referral systems to link sectors.
- Education sessions that include train the trainer to ensure all participants have equal access for training opportunities.

Objective 6: Work with partners to increase housing and associated supports for older adults, people with mental health and addictions issues, and other vulnerable populations.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Form Expert Housing Panel.	In progress	100%				
Action 2: Complete needs analysis and capacity assessment of housing support needs in the NE Region.	In progress	100%				
Action 3: Complete housing support model research and development.	In progress	50%	In progress	50%		
Action 4: Complete NE LHIN housing strategy to guide future housing expansion in the region.	In progress	100%				
Action 5: Market the strategy among partners: non-profit, profit, and government.	Pending		in progress	50%	In progress	50%
Action 6: Educate on formal, non-formal and informal methods for impact on social determinants of health.	In progress	25%	In progress	50%	In progress	25%

How will we measure success?

Action 1: By fall 2016, the expert panel will have completed a NE LHIN strategic housing document that provides baseline data on housing needs, gaps, capacity and opportunities for development. Based on this strategy, the NE LHIN (with its partners) will work to expand housing and housing supports to vulnerable individuals residing in the North East. This document will also provide information about housing supports needed by people currently living in social housing.

Action 2: Needs analysis completed.

Action 3: Housing support model research funded and in progress.

Action 4: Housing strategy completed.

Action 5: Housing strategy being marketed to partners.

Action 6: Education methods being planned on social determinants of health.

NE LHIN risk mitigation efforts

- The expert panel will support the strategy development and final report.
- Build momentum through broad range of partners.

Key enablers

- Technology such as OTN to facilitate panel meetings.
- Partnerships through the skills and support of NOSDA to coordinate efforts; alliances, cross committee work, education.
- Strong collaboration and engagement with all housing and support sectors.
- Realignment of existing housing and support resources will help improve access and decrease wait times for housing.

Objective 7: Improve access to mental health and addiction services with a focus on implementing a standardized referral form, an on-line health information site, a provincial bed registry, and programs targeting the Aboriginal population.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	
Action 1: Completion and implementation of a standardized MH & A referral form.	In progress	50%	Complete		50%	
Action 2: Launch and full utilization of a MH & A mini-site on the North East Healthline website.	In progress	50%	Complete		50%	
Action 3: Continued expansion of tele-psychiatry/FHT project.	In progress	50%	In progress	50%		

How will we measure success?

Action 1: 100% of MH & A treatment service providers will adopt this form; all primary care professionals will have access to and utilize this form as appropriate.
Action 2: Use of MH & A mini-site.
Action 3: Increase in the number of individuals seen; increase in the number of psychiatric consults completed; increase in number of education sessions completed.

Risks/barriers for successful implementation

- As use of this referral form is optional, risk will be inconsistent adoption. Incomplete implementation could see only partial adoption of tool and mini-site by health care professionals and consumers.

NE LHIN risk mitigation efforts

- Resourcing of phased-in implementation plan involving engagement with the system, evaluation of tools, and incorporation of feedback provided through engagements.

Key enablers

- Clear communication to all sectors with key messages.
- Use of OTN to demonstrate the applicability of the tools.
- RM&R (Resource Matching and Referral) staff to facilitate the full implementation.

Objective 8: Work with the French Language Health Planning Entity to increase access to services in French with a focus on increasing the number of health service providers developing designation plans and implementing an Active Offer approach.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Identify and support 10 additional HSPs to submit a designation plan.	Ongoing	60%	Ongoing	40%		
Action 2: Increase the number of HSPs that implement active offer strategies by 75%.	Ongoing	50%	Ongoing	50%		

How will we measure success?

Action 1: Number of HSPs that submit a designation plan to the NE LHIN.
Action 2: Number of HSPs that report using three or more strategies of active offer.

Risks/barriers for successful implementation

- Competing priorities.
- Lack of bilingual human resources for implementation of active offer.

NE LHIN risk mitigation efforts

- Educate HSPs on designation process and provide support with the assistance of the French Language Health Planning Entity.
- Share best practices for recruitment of bilingual staff.

Key enablers

- Integration/collaboration activities.
- Education of HSPs on French Language Services.

Objective 9: Increase access to community support services, diabetes outreach models, and traditional health and healing services for Aboriginal Northerners, particularly people living with complex chronic conditions.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Support health service providers to increase access to community support services delivered to elders in Aboriginal/First Nation/Métis communities.	In progress	33%	In progress	33%	In progress	33%
Action 2: Expand interdisciplinary diabetes outreach models, diabetes education, and foot care self-management programs to additional First Nations communities.	In progress	33%	In progress	33%	In progress	33%
Action 3: Work with providers to support planning and community development that will enhance the availability of traditional health services.	In progress	33%	In progress	33%	In progress	33%
Action 4: Support health service providers to enhance and improve access to mental health and addiction services to Aboriginal/First Nation/Métis people.	In progress	33%	In progress	33%	In progress	33%
Action 5: Work collaboratively with federal and provincial partners to develop a strategy to improve coordination of care that will increase access to care for rural and remote First Nations (Coast areas).	In progress	33%	In progress	33%	In progress	33%

How will we measure success?

Action 1: Through SAAs (Service Accountability Agreements) and quarterly/annual reports, develop a baseline and then measure and monitor the year-to-year service provisions (maintain service levels or increase).
Action 2: Through SAAs and quarterly/annual reports by developing a baseline and then measuring and monitoring.
Action 3: Through tracking meetings, creating plans with milestones/deliverables. Funded initiatives tracked through SAAs and quarterly/annual reports.
Action 4: Through SAAs and quarterly/annual reports by developing a baseline and then measuring and monitoring.
Action 5: Create a partnership committee to oversee this work and monitor the action plan.

Risks/barriers for successful implementation

- Vast geography of region and remoteness of some communities.
- Complex jurisdictional and governmental relationships direct First Nation policy, governance and health care delivery.
- Competing priorities for resources to expand or enhance services.

NE LHIN risk mitigation efforts

- Create baseline data by working closely with providers and encouraging quality data reporting.

- Share and communicate best practices, innovative service delivery models.
- Facilitate bringing federal and provincial partners together. .
- Develop communication and engagement plans which are shared with our partners.

Key enablers

- NE LHIN's Local Aboriginal Health Committee (LAHC).
- Education to enhance the skills of front line health service providers (e.g. advanced foot care for PSWs, best practice committees (Diabetes).
- Partnerships with mainstream health service providers, Aboriginal primary care providers (e.g. AHACs), networks and committees.
- Active involvement of Aboriginal health service providers in the roll-out of realignment plans and the implementation of Health Links to enhance access to health services, close gaps and remove barriers.
- Use of current resources in an innovative way such as through sharing of human resources and increased partnership and collaboration.
- In consideration of the remote locations of many First Nation communities, technology will continue to be leveraged to connect providers and bring care closer to home.

Objective 10: Increase timely access to rehabilitative care in home and community.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Align inpatient rehab and complex care programs with the standardized definitions framework for bedded levels of rehab care.	In progress	50%	In progress	30%	In progress	20%
Action 2: Develop and implement a process for identification, assessment and navigation of seniors at risk, directly to an inpatient rehab bed from community and/or continue to support in community (Assess and Restore Guideline Implementation).	In progress	75%	In progress	25%		
Action 3: Allocate/reallocate LHIN-funded community physio episodes of care to achieve optimal utilization and timely access.	In progress	50%	In progress	50%		
Action 4: Implement tele-rehabilitation program between acute care and repatriation facilities in order to support hospitals with gaps and vacancies in physiotherapy care.	In progress	50%	In progress	30%	In progress	20%
Action 5: Continue implementing the assess and restore pilot projects led by North East Specialized Geriatric Services (NESGS).	In progress and concludes	100%				

How will we measure success?

Action 1: Number of programs that fully align with definitions framework.
Action 2: Proportion of direct admissions from community and from ED to a rehab bed. Average wait time from referral to admission to a rehab care bed from community/ED.
Action 3: Percentage of funded episodes of care that are delivered. Average wait time from referral to assessment /intervention.

Action 4: Number of hub hospitals providing physiotherapy via video to patients at community hospitals following repatriation from acute care. Number of patients receiving virtual physiotherapy services via OTN.
Action 5: Pilot work begun in Sudbury and Sault Ste. Marie in 2015/16 continues and will be fully implemented in Timmins and North Bay in 2016/17.

Risks/barriers for successful implementation

- Gap between current and future ideal state.
- Availability of specialized geriatric services is limited in some hubs.
- Required inpatient capacity to receive direct admissions may exceed that which is available.
- Access in small communities due to limited resources.
- EoC (Episode of Care) reassignment process can be lengthy.

NE LHIN risk mitigation efforts

- Agree on the extent to which alignment will be pursued and develop a phased approach to close the gaps and achieve alignment.
- Consider option of reclassifying existing beds to meet the need prior to investment in additional capacity.
- Develop a plan which includes both increasing capacity in geriatric expertise, and accessing existing resources.
- Develop a NE LHIN Rehab Capacity Plan.
- Investigate aligning small communities with existing resources, giving consideration to partnerships, integration and/or use of technology.
- Develop standardized processes for reassignment to expedite process.
- Work with the MOHLTC as it is able to make approval process more efficient.
- Establish an internal performance monitoring process to ensure timely identification of underutilized EoCs (episodes of care).
- Leadership commitment.
- Collaboration among partners.

Key enablers

- Access to technology.
- Focused performance measurement and management.

Additional comments

Much of the work around the delivery of rehabilitative care is being done within the structures and frameworks of the Provincial Rehab Care Alliance. Further support by way of a provincial framework for capacity planning will further enhance the process of system transformation. Implementation of the Provincial Assess & Restore Guideline has identified the need for available and accessible geriatric capacity which is a challenge for some communities.

Objective 11: Improve access to long-term care beds.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Enhance opportunities for short stay convalescent care beds and respite beds that will alleviate pressure for LTC beds.	In progress	25%	In progress	75%		
Action 2: Establish programs that have potential to meet an unmet need of the LTC population and for people that are difficult to place in LTC.	In progress	50%	In progress	50%		
Action 3: Identify LTC home operators/ partners to incorporate unique short stay/DSU (Designated Specialized Unit) programs into redevelopment or existing home structure.	In progress	33%	In progress	33%	In progress	33%

How will you measure success?

Action 1:
- Number of respite beds available in each hub.
- Occupancy of respite beds greater than 55%.
- Number of convalescent care beds available in each hub.
- Occupancy of convalescent care beds greater than 90%.

Action 2:
- Increase in supportive programs/alternative destinations available.
- Decrease in refusals from LTC homes.
- Decrease in discharge by LTC home due to inability to manage condition.

Action 3:
- Number of LTC home operators planning to add a short stay/DSU program into redevelopment plans.
- Number of LTC home operators planning to incorporate short stay/DSU program into existing structure.

What are the risks/barriers for successful implementation?

- Operator willingness to implement short stay programs.
- Impact of converting existing long stay bed into a short stay bed.
- Competing expectations of identifying a solution from cross sectors.
- Impact of converting long stay beds to a new program.
- Competing priorities from stakeholders to ensure success of new program.

NE LHIN risk mitigation efforts

- LTC homes will be engaged in conversations through network and committee participation to ensure positive experience and interest.
- Analysis will be conducted to understand the full impact of conversion of beds.
- Wait list and ALC will closely be monitored to ensure desired impact achieved.
- Understand financial implications of proposed unit/program and associated cost savings in other areas.
- Consideration will be made to ensuring that the addition of a new program will not have a negative impact on wait list that outweighs the positive results of the program.

Key enablers

- Partnerships such as the active involvement from LTC Regional Network.
- Designated Specialized Unit working group, and establishing a cross-sector committee for solutions specific to each hub.
- Technology such as OTN and webinars to facilitate cross-sector meetings.
- Education which provides access to resources to guide informed decisions on opportunities identified.

NE LHIN Priority

Enhance the coordination of care

When more than 1,000 Northerners responded to a NE LHIN survey asking them what changes could be made to make their health experience better, 98% supported enhanced coordination of care as a Northeastern Ontario health care priority.

Improving a patient's journey within the health care system means:

- Better communication between providers.
- Focused efforts on the needs of patients as they transition from one part of the system to another.
- Programs and services that support people outside of an institution and in their setting of choice.

IHSP Priority: Enhance the coordination of care

Goal: Connecting care across the system to enhance patient-centred care.

Priority Objectives

1. Develop more coordinated care plans for patients with complex needs.
2. Work with providers to develop a more coordinated system of primary care and more seamless service delivery for Northerners.
3. Ensure the availability of quality acute care services when people need them.
4. Strengthen home and community care options for Northerners.
5. Enhance transportation services so people can get to and from the care they need.
6. Work with partners to implement strategies that ensure a more coordinated and client-centered approach to mental health and addictions services.
7. Establish a Regional Mental Health and Addictions Advisory Committee to support NE LHIN efforts, as well as the implementation of Ontario's Mental Health and Addictions Strategy and the work of the Mental Health and Addictions Leadership Advisory Council.
8. Develop plans and create opportunities to support providers in delivering services in a culturally sensitive manner.
9. Identify patient journey gaps and improve the transitions of care for Francophone and Aboriginal Northerners.
10. Develop coordinated care for patients at the end of their life's journey.

Current Status

The NE LHIN responds to the health care needs of Northerners by working with health care partners and community leaders to create a more closely aligned system of care across the full continuum, from birth to death. Efforts include increasing home and community care services in the region's small and large communities through services such as assisted living, adult day programs, system navigators so Northerners more easily get the care they need, community mobilization tables, more care for older adults with dementia, and more.

More than 19,000 Northerners have been assessed at a Joint Assessment Centre since 2010. Centres in five communities (Sault Ste. Marie, Sudbury, Timmins, North Bay and Parry Sound) are working to reduce wait times and improve transitions of care. Other LHIN-led programs improving transitions of care between different points in the health care system include the Priority Assistance to Transition Home (PATH) program, which has helped 1,800 seniors in the past two years; 300 free exercise and falls prevention classes; eight volunteer visiting palliative care programs; and more enhanced transportation services to get Northerners to and from the care they need.

Consistency with Government Priorities

Care that is connected is one of the goals in the *Patients First: Action Plan for Health Care* (February 2015). The objectives in this business plan for enhanced care coordination are also aligned with the *Bringing Care Home: Report of the Expert Group on Home & Community Care* (March 2015) and *Living Longer, Living Well* (December 2012).

Objective 1: Develop more coordinated care plans for patients with complex needs.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action: Implement Health Links to provide 100% of NE LHIN eligible patients access to coordinated care plans.	In progress	33%	In progress	33%	In progress	33%

How will we measure success?

- Increase the number of coordinated care plans for patients eligible for Health Links.
- Increase the number of complex patients with regular and timely access to a primary care provider.
- Increase the percentage of acute care patients who have had a follow-up with a physician within 7 days of discharge.
- Decrease the rate of emergency visits for conditions best managed elsewhere.
- Decrease the hospitalization rate for ambulatory care sensitive conditions.

Risks/barriers to successful implementation?

- Readiness of communities to implement a Health Links approach.
- Physician participation in Health Links.

NE LHIN risk mitigation efforts

- Coordinated care plans for patients.
- Support for Health Links and coordinated care models that reflect our largely rural and remote geography.
- NE LHIN continued work and support of primary care clinical leads.
- Work with Health Link steering committees to ensure that a sustainable model to provide complex care is developed.

Key enablers

- Technological solutions to support the care coordination/care transition process (automate certain functions that are resource intensive).

Objective 2: Work with providers to develop a more coordinated system of primary care and more seamless service delivery for Northerners.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Ensure primary care providers receive timely information on patient admission and discharge from hospital for timely follow-up, particularly patients with complex needs.	In progress	33%	In progress	33%	In progress	33%
Action 2: Ensure primary care providers have access to coordinated care plans for complex patients as part of Health Links.	In progress	33%	In progress	33%	In progress	33%
Action 3: Support and strengthen the role of primary care providers in chronic disease prevention and management.	In progress	33%	In progress	33%	In progress	33%
Action 4: Facilitate linkages between primary care and community services, including home and community care.	In progress	33%	In progress	33%	In progress	33%

How will we measure success?

Actions 1 and 2:

- Sustained uptake of Physician Office Integration (POI), including lab reports via OLIS, by primary care providers.
- Increasing number of reports sent via POI.
- Sustained uptake and support for eNotification by hospitals and primary care providers.
- Increase in percentage of acute care patients who have had a follow-up with a physician within 7 days of discharge.

Action 3:

- Decrease readmissions within 30 days for Selected HIG conditions.
- Increase the number of diabetes education programs with collaborative practice agreements with local primary care providers, including the provision of outreach/programming directly in primary care settings.

Action 4:

- Work with home and community care coordinators to ensure better linkages with primary care organizations.

Risks/barriers to successful implementation?

- Physician uptake of electronic medical records and use of POI.
- Technology costs, notably for smaller hospitals.

NE LHIN risk mitigation efforts

- Collaboration between Primary Care and eHealth to engage primary care providers and promote adoption of eHealth solutions.
- Engage stakeholders to identify sustainment costs for higher rates of implementation.
- Further adoption of Health Links.

Key enablers

- EMR adoption by 100% of primary care physicians and specialists.
- eNotification in place from all hospitals to primary care physicians, primary care organizations, and Health Links agencies.

Objective 3: Ensure the availability of quality acute care services when people need them.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Establish Regional Quality Table.	In progress	50%	Completed and continues	100%		
Action 2: Determine Hub cross-sector quality improvement priorities, targets, and improvement initiatives.	In progress	50%	In progress	50%	Fully implemented	100%
Action 3: Develop NE LHIN quality framework which supports the IHSP.	In progress	50%	Complete	100%		
Action 4: Increase capability for quality improvement through collaboration with HQO to expand use of quality framework.	In progress	60%	In progress	40%	Completed and continues	100%
Action 5: Establish process for HSPs to implement quality standards as they are introduced by HQO (start with mental health quality standards).	In progress	40%	In progress	60%		

How will we measure success?

Action 1: Regional Table established in first quarter of 2016/17. Work plan developed by second quarter of 2016/17. Quality focus determined by second quarter of 2016/17 to inform QIP development.
Action 2: Two cross-sector indicators with initiatives from each organization agreed upon in one hub area by end of Q2, evaluate the process and then roll out to other Hubs by Q4.
Action 3: NE LHIN quality framework linking quality and performance management developed and approved by end of Q3.
Action 4: Hold two educational sessions annually together with HQO. Evidence of success would be QIPs with targets.
Action 5: Process for implementation of quality standards is working well and standard uptake by HSPs is 100% by 2018/19.
Actions 1 to 5: Coordination of quality improvement efforts across HSPs to assist with achieving the LHIN MLAA targets on ED length of stay for admitted patients (25 hrs), ALC (12.7%) and 30 day readmission rates for specific HIG (15.5%) for 2016/17 at or better than provincial targets by 2018/19.

Risks/barriers to successful implementation?

- Multiple priorities for the HSPs and LHIN officers.
- Resistance of partners to collaborate.

NE LHIN risk mitigation efforts

- Make quality part of the roll-out of new initiatives and changes.
- Use existing indicators rather than adding new ones and focus on activities which support the IHSP.
- Insert the indicators and commitments for quality initiatives into the SAAs.

Key enablers

- Education for all HSPs regarding the quality agenda.
- Strong partnership with HQO.
- Partnership between performance and quality.

Objective 4: Strengthen home and community care options for Northerners.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Expand a locally developed early adopter model responding to PSS (Personal Support Services) regulatory amendments which builds on best practices currently in place (i.e. Health Links).	In progress	60%	In progress	40%		
Action 2: Provide LHIN-funded home and community care providers with access to quality improvement tools and training to ensure access to consistent standardized approaches for care coordination.	In progress	20%	In progress	40%	In progress	40%
Action 3: Collaborate on health human resource initiatives regarding PSW training and volunteer management to assist in stabilizing and building capacity within the workforce, helping to improve access and wait times.	In progress	30%	In progress	35%	In progress	35%

How will we measure success?

Action 1: Ensure LHIN-wide implementation of the PSS Regulatory Amendments and Policy by Spring 2017.
Action 2: Operational quality improvements and practices in place and aligned with the Excellent Care for All Act.
Action 3: More coordinated PSW training through Annualized Program Criteria which will be provided to all PSWs and evolve into Train the Trainer models. Training will be provided annually until the full workforce achieves certification in 2017-2018. Review current service delivery best practices by the volunteer workforce.

Risks/barriers to successful implementation

- Ongoing challenge of massive geography and travel necessary to provide service to clients, along with the volume of clients requiring support.
- Continued support for programs requiring cultural shift.

NE LHIN risk mitigation efforts

- Alignment and inclusion with the Regional Quality Table work plan.
- Home and community care investments.

Key enablers

- Five streamlined referral pathways to Community Support Services (CSS) established including: acute care to CSS, primary care to CSS, all home and community care providers, CSS to CSS , mental health and addiction services to CSS.
- Common CSS referral form implemented.
- CSS mini-site established for use by HSPs and public.
- Support and collaboration of regional System Navigators.

Objective 5: Enhance transportation services so people can get to and from the care they need.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Finalize the multi-year non-urgent patient transportation (NUPT) strategy to support the implementation of a restructured NUPT model in the North East.	In progress	50%	In progress	25%	In progress	25%
Action 2: Implement the recommended NUPT service and governance model.	In progress	50%	In progress	50%		

How will we measure success?

- Delivery of more than 19,000 hours of dedicated NUPT services across the region.
- Delivery of a minimum of 5,000 inter-facility patient transfers per year in the region.

NE LHIN risk mitigation efforts

- Municipal, HSP and MOHLTC support of a new vision for NUPT in the North East.

Key enablers

- Partnerships aligned with vision across the region.

Objective 6: Work with partners to implement strategies that ensure a more coordinated and client-centred approach to mental health and addictions services.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Implement Dual Diagnosis (DD) Framework across the NE LHIN.	Commence fall 2016	50%	In progress	50%		
Action 2: Implement Ontario Perception of Care (OPOC) tool in MH & A treatment services.	In progress	50%	In progress	50%		
Action 3: Work with Regional MH & A planning group to develop work plan for region-wide centralized access model.	Commence fall 2016	25%	Complete March 2018	75%		

How will we measure success?

Action 1: Reduction of DD individuals reporting to emergency departments and individuals in conflict with criminal justice system.
Action 2: 100% adoption of OPOC tool by community MH & A service providers.
Action 3: Work plan in development.

Risks/barriers to successful implementation

- Lack of consistent model of centralized access.

NE LHIN risk mitigation efforts

- The NE LHIN will work with MCYS (Ministry of Children and Youth Services) and MOHLTC to engage with DD sector to ensure a smooth implementation of DD Guidelines.

Key enablers

- Use of OTN to keep all participants engaged in implementation and planning process.

Objective 7: Establish a Regional Mental Health and Addictions Advisory Committee to support NE LHIN efforts, as well as the implementation of Ontario's Mental Health and Additions Strategy and the work of the Mental Health and Addictions Leadership Advisory Council.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Develop terms of reference (TOR) for Regional Advisory Group and invite interest.	Commence spring 2016	100%	Complete			
Action 2: Develop and implement three-year work plan.	Commence fall 2016	25%	In progress	75%		
Action 3: Set priorities and provide input into NE LHIN Addictions and Mental Health system development.	Commence fall 2016	25%	In progress	75%		

How will we measure success?

Action 1: Completion of TOR & committee membership.
Action 2: Completion of three-year work plan.
Action 3: Regional agreement of system priorities.

Risks/barriers to successful implementation

- Partner participation and engagement.

NE LHIN risk mitigation efforts

- NE LHIN will provide support to help complete necessary work.
- Ongoing collaboration and consultation with partners.

Key enablers

- OTN utilization and LHIN supports to ensure regional advisory council develop and implement three-year work plan.
- Input from partners and ongoing engagement.

Objective 8: Develop plans and create opportunities to support providers in delivering services in a culturally sensitive manner.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Create and distribute FLS (French Language Services) toolkit for HSPs to assist in FLS planning and provision.	In progress	50%	Complete	100%		
Action 2: Create opportunities to support health service providers to deliver health services in a culturally safe manner.	In progress	33%	In progress	33%	In progress	33%
Action 3: Expand PSW training along the James Bay Coast.	In progress	33%	In progress	33%	In progress	33%

How will we measure success?

Action 1:

- Toolkit completed and posted on NE LHIN website for HSPs.
- Number of HSPs that receive education session on the FLS toolkit.

Actions 2 and 3:

- Monitor creation of opportunities and ensure continual adoption.
- Track number of people trained on cultural safety for Aboriginal people.
- Number of PSW graduates.

Risks/barriers to successful implementation?

Action 1:

- Lack of awareness of the importance of FLS in health care service delivery.

Action 2:

- Reporting mechanism to capture number of people trained.
- HSP support of investments in training.

Action 3:

- Ongoing support for expansion of program.

NE LHIN risk mitigation efforts

Action 1:

- Involve HSPs in the development and implementation of a comprehensive promotion plan; monitor implementation and adjust plan as needed.

Actions 2 and 3:

- Leverage the connections and expertise of the NE LHIN's Local Aboriginal Health Committee to advise on indicator development and capture of appropriate data.
- Promote OTN and online distance education platforms to broaden delivery of training.

Key enablers

- Education and awareness.
- Partnerships.
- Coordinated efforts by LHINs and MOHLTC to promote cultural safety training.
- Technology – Multiple training options through various modes of delivery (online, in person) and utilizing NE LHIN website to promote and inform.

Objective 9: Identify patient journey gaps and improve the transitions of care for Francophone and Aboriginal Northerners.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Map Francophone patient journey in three Northeastern communities.	In progress	35%	In progress	65%		
Action 2: Capture Francophone patient experiences to contribute to the mapping.	In progress	35%	In progress	65%		
Action 3: Develop targeted initiatives to improve services for Francophones.	In progress	35%	In progress	65%		
Action 4: Continue to develop relationships and partnerships with federal/provincial agencies to support coordinated health care in Aboriginal communities.	In progress	25%	In progress	75%		
Action 5: Develop mutual communication processes and systems to help minimize gaps in the transitions of care for Aboriginal people.	In progress	25%	In progress	50%	In progress	30%

How will we measure success?

Actions 1, 2, and 3:

- Number of mapping exercises; documented patient experiences; improvement projects.
- Percentage achievement of targeted service improvements.

Actions 4 and 5:

- Track plans with milestones/deliverables.

Risks/barriers to successful implementation

Actions 1, 2, and 3:

- HSP resources and time to participate.
- Follow-through on improvement projects.

Actions 4 and 5:

- Complex jurisdictional relationships have an impact on First Nation policy, governance and health care delivery.
- Identifying relevant stakeholder agencies and ensuring inclusive participation of federal partners (Health Canada) and various provincial ministries.
- Federal or other ministry mandates or strategies that are not aligned with MOHLTC/NE LHIN.
- Fragmented use of electronic medical records and inconsistent linkages between Aboriginal and mainstream health service providers.

NE LHIN risk mitigation efforts

Actions 1, 2, and 3:

- Engage HSPs early in the planning process to ensure collaboration.
- Continually build on successes.

Action 4 and 5:
- Leverage federal and provincial commitment to the implementation of the *Truth and Reconciliation Commission of Canada: Calls to Action* recommendations.

Key enablers

Actions 1, 2, and 3:
- Education and awareness.
- Use experience-based design to collect Francophone patient experiences.

Actions 4 and 5:
- Leverage use of communication technologies to enhance collaboration across stakeholders and expansive geography.
- Leverage virtual health care technologies to provide health care services to clients with family members and helpers, respecting language and culture preferences.

Objective 10: Develop coordinated care for patients at the end of their life's journey.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Develop residential hospice services (in hospice, hospital and long-term care).	In progress	30%	In progress	30%	In progress	40%
Action 2: Set a regional strategy for palliative education for all sectors.	In progress	60%	In progress	30%	In progress	10%
Action 3: Develop community palliative expert teams to support primary care providers and assist with care planning for complex patients identified through Health Links.	In progress	40%	In progress	30%	In progress	30%
Action 4: Standardize hospice volunteer visiting services and integrate volunteers into community teams.	In progress	50%	In progress	30%	In progress	20%
Action 5: Promote advance care planning and identification of persons who could benefit from a palliative approach to care.	In progress	40%	In progress	30%	In progress	30%
Action 6: Enhance grief, loss and bereavement services to improve caregiver support.	In progress	30%	In progress	40%	In progress	30%

How will we measure success?

Action 1:
- Increase in number of residential hospice beds.

Action 2:
- Increase in number of staff trained, by professional designation.
- Improved satisfaction with cultural safety of curriculum.

Action 3:
- Increase in number of teams; patients served; and length of stay at home.

Action 4:
- Improved caregiver experience.

Action 5:
- Increase in number of people who complete an Advance Care Plan upon admission to hospital, long-term care home or assisted living facility.

Action 6:
- Improved caregiver experience as measured through a caregiver voice survey.

Risks/barriers to successful implementation

- Eight agencies currently receive funding for hospice volunteer visiting but variations exist in their policies.
- Public perception of death and dying and comfort level with discussing palliative and end-of-life issues.
- Grief, loss and bereavement services often overlooked within the continuum.

NE LHIN risk mitigation efforts

- Involve the broader community in planning for residential services to mitigate the financing and sustainability challenges.
- A regional education collaborative will shift the focus to a regional strategy and ensure more support by all involved parties.
- Identify necessary investments required in districts and work with the local palliative planning tables to optimize existing resources.
- Eight agencies currently receive funding for hospice volunteer visiting and have committed to standardizing their processes to ensure equity of access.
- Optimize the linkages that exist through the local palliative planning tables to promote advance care planning and help normalize death and dying conversations.

Key enablers

- Optimize existing resources within each district to develop local solutions.
- Leverage support from Réseau du mieux-être francophone du Nord de l'Ontario to ensure that services are culturally appropriate.
- Optimize the knowledge and connections that exist through the local palliative planning tables.

Additional comments (i.e. additional information that supports the implementation/success of the goal)

- The MOHLTC will launch the Ontario Palliative Care Network which will support the work already happening at the local level with more standardized capacity planning, data collection and measurement and clinical policies.

NE LHIN Priority

Strengthen sustainability of the health care system

A sustainable Northeastern Ontario health care system is one that reflects a multi-level commitment to improving the lives of Northerners today and for generations to come.

It is a system that is driven by what is right for patients and improving quality and efficient care while being financially responsible. It is a system that focuses on health, not just health care, and one that invests in keeping people healthy, out of hospital, and living with quality of life in community.

The NE LHIN is taking steps to ensure Northeastern Ontario's health care system is held accountable to deliver better results for patients, now and into the future.

IHSP Priority: Strengthen the sustainability of the health care system

Goal – Protecting the Northeastern Ontario health care system so Northerners can receive quality care today and tomorrow.

Priority Objectives

1. Work with partners to improve a patient's timely follow-up from a primary care practitioner after discharge from hospital.
2. Work with communities to ensure their hospitals continue to evolve to meet current and future health needs.
3. Improve strategies to better support frail seniors and their caregivers in their homes and/or in community.
4. Implement standardized addictions screening/ assessment tools.
5. Implement the recommendations of the Regional Addictions Services Review as appropriate.
6. Work with partners to improve the patient experience through a relentless focus on quality.
7. Conduct an evaluation of all designated health service providers every three years to ensure they continue to meet designation criteria.
8. Work with providers to ensure quality data collection for Aboriginal and Francophone population groups.
9. Work in partnership with the NE LHIN's Local Aboriginal Health Committee to develop a NE LHIN Aboriginal Health Care Strategy that includes a Northeastern Ontario reconciliation action plan.
10. Adopt standardized rehabilitative care best practices.
11. Support redevelopment of long-term care homes to meet the highest safety and design standards.

Current Status

Northeastern challenges that have an impact on health care system sustainability include:

- **An aging population:** NE LHIN has a higher proportion of people over the age of 65 compared to Ontario (20% vs. 16%).

- **Population risk factors:** Compared to the province, the NE LHIN has a higher percentage of smokers (23% vs. 18%), people who report heavy drinking (22% vs. 17%), adults who are overweight or obese (62% vs. 54%), and percentage of residents with multiple chronic conditions (21% vs. 15%). Northeastern Ontario also has a lower proportion of people who rate their health as "very good or excellent" (55% vs 60%) and residents who report lower levels of physical activity (43% vs. 46%).

- **Complex Health:** The top 5% of high users of the healthcare system account for two-thirds of health care spending in Ontario. Three out of four of these patients will visit more than six doctors in a year. A quarter of these patients will see up to 16 different physicians in a year. The NE LHIN continues to work on a range of integrated models of care for such patients, such as Health Links and Health Hubs, to make their care more efficient and effective.

- **Economic environment:** A resource-based economy which suffers from population loss is having an impact on the region's long-term sustainability across a number of sectors.

Consistency with Government Priorities

Protecting the sustainability of our health care system for generations to come is one of the goals in the *Patients First: Action Plan for Health Care (*February 2015). The importance of making decisions based on value and quality, to sustain the system, also aligns with *Bringing Care Home*: Report of the Expert Group on Home & Community Care (March 2015).

Objective 1: Work with partners to improve a patient's timely follow-up from a primary care practitioner after discharge from hospital.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: eNotification implemented in all hospitals and primary care providers.	In progress	33%	In progress	33%	In progress	33%
Action 2: Physician Office Integration (POI) implemented from all hospitals to primary care providers.	In progress	33%	In progress	33%	In progress	33%
Action 3: Primary care providers committed to ensure discharged hospital patients have follow up within seven days.	In progress	33%	In progress	33%	In progress	33%

How will we measure success?

Action 1: Increase number of primary care physicians receiving eNotifications from hospitals for patients.
Action 2: Increase number of primary care physicians with Physician Office Integration (POI).
Action 3: Increase percentage of acute care patients who have had a follow-up with a physician within 7 days of discharge; and decrease readmissions within 30 days for Selected HIG (HBAM Inpatient Group) conditions.

Risks/barriers to successful implementation?

- Physician uptake of EMRs; physicians using POI or receiving eNotifications.

NE LHIN risk mitigation efforts

- Evidence to support physician changes to practice.
- Support of Primary Care Clinical Leads to implement HQO's Advanced Access program, and support evidence from hospitals.

Key enablers

- Collaboration between primary care and eHealth teams to engage primary care providers and promote adoption of eHealth solutions.
- Engage stakeholders to identify sustainment costs at time of implementation.

Objective 2: Work with communities to ensure their hospitals continue to evolve to meet current and future health needs.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Implementation of the three-year NE Patient Flow / Alternate Level of Care Strategy (approved by the NE Health System Advisory Committee in January 2016).	In progress	33%	In progress	33%	In progress	33%
Action 2: Implementation and evaluation of the rural health HUB model in Northeastern Ontario.	In progress	25%	In progress	50%	In progress	25%
Action 3: Continued implementation of quality-based procedures (QBPs).	In progress	50%	In progress	25%	In progress	25%

How will we measure success?

Action 1: Reduced ALC rate in NE LHIN hospitals.
Action 2: Expansion of rural health strategy implementation (currently within two areas -- Blind River and Espanola).
Action 3: QBPs implemented as scheduled.

Risks/barriers to successful implementation?

- Participation and commitment from all 25 hospitals in NE LHIN.
- Shared governance models.

NE LHIN risk mitigation efforts

- Full risk management framework.
- Education efforts with hospitals and Northeastern Ontario communities.
- Continual NE LHIN support to move plans forward in the interest of better patient care and system sustainability.
- Community engagements.

Key enablers

- Engagement and education efforts.
- Partnerships.

Objective 3: Improve strategies to better support frail seniors and their caregivers in their homes and/or in community.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Review the 26 Community Support Services (CSS) Functional Centres to ensure standardized reporting and interpretation of Key Performance Indicators (KPI).	Initiate	33%	In progress	33%	In progress	33%
Action 2: Build on assisted living (AL) review to analyze current AL capacity and develop a decision framework to support future investments.	Implement	90%	In progress	10%		
Action 3: Collaborate on health human resource initiatives, including PSW training, to strengthen capacity and improved access/wait times.	Ongoing	30%	In progress	35%	In progress	35%

How will we measure success?

Action 1: Establish best practices and KPI. Review functional centres annually.
Action 2: Develop and share a decision framework to ensure AL investments are aligned with need and equity.
Action 3: Build on annualized PSW training programs and volunteer management practices

Risks/barriers to successful implementation

- Geography and resources/organizational culture to support KPI work.
- Resource alignment to support potential recommendations.

NE LHIN risk mitigation efforts

- Work with local planning tables to develop local work plans to support regional priorities.

Key enablers

- CSS System Navigators to support system improvements at the HSP level.

Objective 4: Implement standardized addictions screening assessment tools.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Work with CAMH to form implementation working group, identify and train trainers, build implementation plan.	In progress	50%	Complete	50%		
Action 2: Work with CAMH to identify early adopters, train and certify staff.	Spring 2016	50%	Complete	50%		
Action 3: Broad adoption of screening and assessment tools and adjust MSAA.	In progress	50%	Complete	50%		

How will we measure success?

Action 1: Development of implementation plan.
Action 2: Completion of identification and training with at least eight trainers in the region.
Action 3: Number of addictions HSPs that have adopted the tools; number of clients screened using the GAIN SS (short screener) since implementation.

Risks/barriers to successful implementation?

- Ongoing support from CAMH.
- Participation of targeted HSPs.
- Tools aligned with needs of region's diverse cultural groups.
- Use of IT solutions by HSPs.

NE LHIN risk mitigation efforts

- Continual work with CAMH, the MOHLTC and service providers on implementation.
- Collaborative efforts with regional trainers group and implementation working group.

Key enablers

- Technology such as Datis/Catalyst and OTN and the use of Adobe Connect for training.
- Partnerships

Objective 5: Implement the recommendations of the Regional Addictions Services Review as appropriate.						
Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Receive, revise and accept final report.	Complete	100%				
Action 2: Work with Regional Planning Table to review and prioritize actionable items.	Start fall 2016	50%	Complete	50%		
Action 3: Develop implementation plan and implement year one actionable items.	Start fall 2016	25%	In progress	25%	Complete	50%

How will we measure success?

Action 1: Final report accepted by April 2016.
Action 2: Number of actionable items implemented; number of HSPs involved in planning and implementation.
Action 3: Number of items implemented.

Risks/barriers to successful implementation

- Pace of implementation.

NE LHIN risk mitigation efforts

- Work with regional advisory council to develop work plan for implementation of priority recommendations from addictions services report.
- Budget for actionable items yearly, and aim to complete a number of priorities each year.

Key enablers

- Partnerships and ongoing engagement efforts with the sector.

Objective 6: Work with partners to improve the patient experience through a relentless focus on quality.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action: Foster best practices in the development, accountability and empowerment of patient/client advisory councils.	In progress	33%	In progress	33%	In progress	33%

How will we measure success?

- Newly established Patient Advisory Councils and increase in patient engagement practices.

Risks/barriers to successful implementation

- Sector commitment to development of patient advisory councils and additional patient engagement practices.

NE LHIN risk mitigation efforts

- NE LHIN education and awareness of importance of patients first.
- LHIN sharing of survey outcomes which indicate Northerners' commitment to system changes focused on patient's needs and inclusion in decision making processes.

Key enablers

- Partnerships such as HQO, Change Foundation. LHIN/health service providers.
- Education to help with development of dissemination of best practices.

Objective 7: Conduct an evaluation of all designated health service providers every three years to ensure they continue to meet designation criteria.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Provide direction and support to designated HSPs to complete the designation evaluation tool.	In progress	40%	In progress	60%		
Action 2: Review evaluation submissions and provide recommendations for improvement.	In progress	40%	In progress	60%	Complete	100%
Action 3: Provide support to HSPs in implementing the recommendations in the evaluation submission.	In progress	40%	In progress	60%	Complete	100%

How will we measure success?

Action 1: Number of designation evaluation tools completed and submitted to the NE LHIN.
Action 2: Number of designation evaluation tools reviewed with recommendations by the NE LHIN.

Action 3: Number of recommendations implemented by HSPs.

NE LHIN risk mitigation efforts

- Engage and work collaboratively with French Language Health Planning Entity.
- Inclusion of FLS language within HSP accountability agreements.

Key enablers

- Ongoing education and communication efforts with HSPs.

Objective 8: Work with providers to ensure quality data collection for Aboriginal and Francophone population groups.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Educate HSPs on FLS indicators.	In progress	50%	In progress	50%		
Action 2: Increase the number of HSPs that capture language data using linguistic variable questions.	In progress	25%	In progress	75%		
Action 3: Increase the number of Aboriginal health service providers completing Inter RAI assessments and uploading data to the IAR.	In progress	25%	In progress	50%	In progress	25%
Action 4: Enhance training and education to support improved quality of health service provider data reporting.	In progress	25%	In progress	50%	In progress	25%

How will we measure success?

Actions 1 and 2:

- Percentage of HSPs participating in FLS education sessions.
- Percentage of HSPs that capture language data using linguistic variable questions.

Actions 3 and 4:

- Completion of Inter RAI assessments and uploaded to the IAR to provide better data to assist HSPs and the NE LHIN with planning and priority setting.
- Quarterly and annual reporting with accurate data.

Risks/barriers to successful implementation

Actions 1 and 2:

- Inconsistent data.
- Information systems not having the capacity to capture language data.

Actions 3 and 4:

- Capacity for consistent HSP reporting.
- Understanding of how the data will be stored and used.

NE LHIN risk mitigation efforts

Actions 1 and 2:

- Monitoring and reporting of FLS indicators.

Actions 3 and 4:

- Leveraging the Local Aboriginal Health Committee to help promote the benefits of implementing Inter RAI assessment tools.
- Conducting an analysis of current usage, technology resources and development of a plan based on the current state information.

Key enablers

Actions 1 and 2:

- Education, awareness.
- Use of technology to collect data.

Actions 3 and 4:

- Use of technology to identify gaps and set health priorities, share assessments across providers to ensure seamless continuum of care for clients.
- Leveraging relationship with Health Canada to jointly promote the use of the Inter RAI assessment tools.

Objective 9: Work in partnership with the NE LHIN's Local Aboriginal Health Committee (LAHC) to develop a NE LHIN Aboriginal Health Care Strategy that includes a Northeastern Ontario reconciliation action plan.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	
Action 1: Engage with Aboriginal health leaders, service providers and stakeholders to identify the components for a NE LHIN Aboriginal Health Care Strategy.	In progress and completed	100%				
Action 2: LAHC support for the strategy and system implementation.	In progress	75%	In progress	25%		

How will we measure success?

- Development of strategy and support received by LAHC, NE LHIN, and health service providers.

Risks/barriers to successful implementation

- Timelines for strategy development and subsequent system-wide implementation.

NE LHIN risk mitigation efforts

- Continued work with LAHC and awareness efforts to all NE LHIN stakeholders on importance of strategy development and implementation.
- Leverage the commitment of federal and provincial governments on the Truth and Reconciliation Commission recommendations.

Key enablers

- NE LHIN partnership with LAHC and HSPs.
- Engagement, communication and ongoing education efforts.

Objective 10: Adopt standardized rehabilitative care best practices.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Align care with the definitions framework for bedded levels of rehab care.	In progress	50%	In progress	50%	Complete	100%
Action 2: Align care with the definitions framework for community levels of rehab care.	In progress	50%	In progress	50%	Complete	100%
Action 3: Adopt best practices pathway for post-acute phase rehab for TJR (total joint replacement) and hip fracture QBPs.	Not yet started	60%	In progress	40%	Complete	100%

How will we measure success?

Action 1 and 2:

- Number of programs delivering care according to the framework.
- Gap between current state and future ideal state i.e. framework.
- Adopt Rehab Care Alliance process indicators to monitor performance.

Action 3:

- Number of programs that have implemented the post acute rehab care pathway.
- Number of programs that are delivering post acute care as per the pathway.
- Implement tele-rehabilitation program between acute care and repatriation facilities in order to support hospitals with gaps and vacancies in physiotherapy care.

Risks/barriers to successful implementation

- Access to human resources to deliver care.
- Not all programs have decision support capacity for monitoring of indicators.
- LHIN-wide rehab capacity plan.

NE LHIN risk mitigation efforts

- Develop a phased approach to investment and/or consideration of reclassification of beds.
- Explore alternative options for maintaining access to required resources e.g. use OTN, partnerships.
- Explore shared resources, regional decision support.
- Seek opportunity to leverage work done across the province in rehab capacity planning.
- HSPs to develop policy regarding use of pathway.
- Collaboration efforts with HSPs.

Key enablers

- Technology
- Focused performance measurement and management.
- Rehabilitation services provided by telemedicine.
- Work of the Provincial Rehab Care Alliance.

Objective 11: Support redevelopment of long-term care homes to meet the highest safety and design standards.

Actions to meet the objective:	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Action 1: Participate in redevelopment discussions with operators and MOHLTC to support early redevelopment plans that are reflective of needs in NE LHIN.	In progress	25%	In progress	75%		
Action 2: Collaborate with Ministry of Health and Long-Term Care to develop a bed licence framework that addresses issues in the NE LHIN.	In progress	50%	In progress	50%		
Action 3: Engage with eligible operators and stakeholders to complete steps/tasks necessary to move forward with redevelopment in the first three years.	In progress	25%	In progress	75%		

How will we measure success?

Action 1:

- Implementation of work arising from joint Ministry/LHIN/operator meetings.
- Number of operators moving forward early in redevelopment.
- Number of operators moving forward early that are willing to adjust accommodation mix for redeveloped home.

Action 2:

- Number of licences leaving NE LHIN; coming into the NE LHIN; and relocated within NE LHIN to manage areas with high need and poor system flow.

Action 3:

- Increased awareness of stakeholders on redevelopment process.
- Number of applications submitted to the Ministry for acceptance into the program; number of operators accepted into the program; number of operators with an accepted development agreement.

Risks/barriers to successful implementation

- Challenges with licence movement.

NE LHIN risk mitigation efforts

- Early and ongoing engagement with stakeholders in mutually respectful environment to maintain confidentiality.
- Collaborative efforts with Ministry and operators on key financial policy components.
- Open dialogue with all stakeholders in bed licence discussions.
- Understanding of funding to support viability of projects, particularly for support of increasing basic accommodation and redevelopment of small homes.

Key enablers

- Partnerships such as early conversations with operators, Ministry and LTC.
- Technology such as OTN to facilitate discussions.
- Education specific to bed licence framework and funding policies/limitations.

LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2015/16 Actuals	2016/17 Planned Expenses	2017/18 Planned Expenses	2017/18 Planned Expenses
Salaries and Wages	3,256,005	3,054,465	3,054,465	3,054,465
Employee Benefits				
HOOPP	295,501	308,805	308,805	308,805
Other Benefits	403,421	378,556	378,556	378,556
Total Employee Benefits	***698,921***	***687,361***	***687,361***	***687,361***
Transportation and Communication				
Staff Travel	135,273	142,235	142,235	142,235
Governance Travel	24,693	13,000	13,000	13,000
Communications	135,160	110,191	110,191	110,191
Other	1,972	3,750	3,750	3,750
Total Transportation and Communication	***297,098***	***269,176***	***269,176***	***269,176***
Services				
Accommodation	216,846	204,651	204,651	204,651
Advertising	6,051	5,000	5,000	5,000
Banking	656	360	360	360
Consulting Fees	45,795	30,400	30,400	30,400
Equipment Rentals	9,792	9,344	9,344	9,344
Board Chair Per Diems	17,500	12,600	12,600	12,600
Other Governance Per Diems	20,637	14,500	14,500	14,500
Insurance	6,287	6,762	6,762	6,762
LSSO Shared Costs	260,956	266,413	266,413	266,413
LHIN Collaborative	47,500	47,500	47,500	47,500
Other Meeting Expenses	35,643	28,000	28,000	28,000
Other Governance Costs	7,095	5,000	5,000	5,000
Printing & Translation	80,739	52,000	52,000	52,000
Staff Development	18,123	31,000	31,000	31,000
Total Services	***773,620***	***713,530***	***713,530***	***713,530***
Supplies and Equipment				
IT Equipment	15,267	25,000	25,000	25,000
Office Supplies & Purchased Equipment	30,055	25,000	25,000	25,000
Total Supplies and Equipment	***45,322***	***50,000***	***50,000***	***50,000***
Capital Expenditures	-	-	-	-
LHIN Operations: Total Expenses	5,070,965	4,774,533	4,774,533	4,774,533
LHIN Program Expenses				
Diabetes RCC	1,065,809	1,065,809	1,065,809	1,065,809
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	8,164,733	7,868,301	7,868,301	7,868,301
Annual Funding Target	8,164,733	7,868,301	7,868,301	7,868,301
Variance Surplus/(Deficit)	-	-	-	-

LHIN Staffing Plan (Full-Time Equivalents)

Positions	2015/16 Actual as of Mar. 31/15 FTEs	2016/17 Forecast FTEs	2017/18 Forecast FTEs	2018/19 Forecast
Chief Executive Officer	1	1	1	1
Executive Assistant and Board Liaison	1	1	1	1
Senior Management Team	4	4	4	4
Project Coordinators	4	4	4	4
Administration Clerks	2	2	2	2
Corporate Services – HR and Controller	2	2	2	2
Analysts – Data, Finance & Performance	2	2	2	2
Communications Officers/Coordinator	4	4	4	4
Senior Officers	4	4	4	4
Hub Officers	4	4	4	4
Outreach Officers	6	8	8	8
Field Officers	10	10	10	10
Total FTEs	**44**	**46**	**46**	**46**

Integrated Communications Strategy

Objectives

Business Objective:

To implement the first year of the NE LHIN's 2016-2019 IHSP and the initiatives contained in this ABP to develop a regional system of patient-centred, integrated health care across the continuum by:

- improving access to care and wait times to receive quality care;
- enhancing the coordination of care;
- strengthening the sustainability of the health care system so that it is here for Northerners today and tomorrow;
- educating Northerners on the importance of priority enablers: housing, partnerships, education, technology, transportation;
- working with partners to drive system quality and value, enhancing the patient experience, and improving population health while recognizing cultural diversity, particularly for Francophone & Aboriginal people;
- providing information on performance and progress – documenting successes and sharing them; and
- focusing on health system transformation that is centred on patients first.

Communications Objectives:

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

- coordinating corporate communications and community engagement activities, particularly related to possible structural changes in the Patients First Discussion Paper of Dec. 17, 2015 that would expand services at home and in community;
- 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 2016-2019 and increasing awareness of transformation and integration successes in the NE LHIN;
- building awareness of the NE LHIN's role in advancing local health care priorities;
- 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.
- *Patients First Discussion Paper (Dec. 17, 2015) – A Proposal to Strengthen Patient-Centred Health Care in Ontario*, which invites comment on an expanded role for LHINs in Ontario.
- The NE LHIN's 2016-2019 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.
- *Patients First: Roadmap to Strengthen Home and Community Care* (May 2015) is a plan to strengthen home and community care. 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
  - Réseau du mieux-être francophone du Nord de l'Ontario (RMEFNO) – the French Language Health Planning Entity (FLHPE); 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*, the related Discussion Paper of December 2015, and the NE LHIN's IHSP 2016-2019.

- 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

- Patients First means a caring, integrated experience for patients and faster access to quality health services for all Ontarians.

- The *Patients First: Action Plan for Health Care* sets clear and ambitious goals for Ontario's health care system in order to put patients at the centre of our health care system by improving the health care experience:
    - Access
        - Improve access - providing faster access to the right care.
    - Connect
        - Connect services - delivering better coordinated and integrated care in the community closer to home; providing better home and community care.
    - Inform
        - Support people and patients - providing the education, information and transparency Ontarians need to make the right decisions about their health.
    - Protect
        - Protect our universal public health care system - making decisions based on value and quality, to sustain the system for generations to come.
- As the next logical step in the *Patients First Action Plan*, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* proposes a path toward providing better access to care no matter where you live by better connecting health care services.

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 2016-2019 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

- 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 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 2016/17.

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 the various communication vehicles and methods previously described.

NE LHIN Engagements

Throughout the year, the NE LHIN holds engagements with both fellow Northerners and HSPs. For current information about our engagement acitivites, please see our website www.nelhin.on.ca. In the past three years, Northerners have provided input to the NE LHIN at more than 500 engagements. In the month of February 2016 alone, more than 1,000 Northerners offered their opinions to the NE LHIN through surveys and face-to-face engagements held across the region on the discussion paper *Patients First; a Proposal to Strengthen Patient-Centred Health Care in Ontario* (December 2015).