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

North East Local Health Integration Network

Annual Business Plan 2017-18

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

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Cover photo:

Over the past two years, Sault Ste. Marie Police Service and the North East LHIN joined forces to improve access and care for residents living in marginalized areas of the city. North East LHIN Senior Officers Jennifer Wallenius and Robin Joanisse accepted a community recognition award at the 31st Annual Police Community Programs Night in March 2017. Further to a NE LHIN-funded Health Needs Assessment done by the Superior Family Health Team, a primary care clinic in the Gore Street Neighbourhood Resource Centre was set up. Along with the District of Sault Ste. Marie Social Services Administration Board, the LHIN then provided funding for a Coordinator and worked with local health service providers, including Algoma Public Health, to support mental health services within the Neighbourhood Resource Centre and improvements to its counselling area. The investment has provided much needed services to people in a targeted area of Sault Ste. Marie. Left to right: Police Chief Robert Keetch; Jennifer Wallenius, NE LHIN Rehabilitative Care Lead; Robin Joanisse, NE LHIN Senior Hub Officer; and Donna Hillsinger, Chair, Sault Ste. Marie Police Service Board.

TRANSMITTAL LETTER FROM THE NE LHIN BOARD CHAIR

June 16, 2017

Tim Hadwen
Assistant Deputy Minister
Health System Accountability and Performance Division
Ministry of Health and Long-Term Care
Hepburn Block, 5th Flr.
80 Grosvenor Street, 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 2017-2018 Annual Business Plan (ABP).

This ABP is the first to encompass the strategic directions of *Patients First Act 2016* and its transformative changes to improve the patient experience. It also focuses on the second year of our 2016-2019 Integrated Health Service Plan (IHSP) and continuing efforts to advance our three health care priorities: **improving access to care and wait times to receive quality care; enhancing the coordination of care;** and **strengthening the sustainability of the Northeastern Ontario health care system.**

Our 2017-18 ABP continues to focus on driving forward our vision of "***Quality health care, when Northerners need it,"*** and builds on progress to date with our valued partners while responding to the diverse cultural and linguistic needs of fellow Northerners.

Our LHIN is committed to meeting the priorities in the Minister's Mandate letter of May 1, 2017. We will work with the Ministry of Health and Long-Term Care and our many stakeholders to further develop the approaches needed to advance our efforts to: improve the patient experience; address the root cause of health inequities by strengthening the inclusion of social determinants of health in our planning; improve access to primary care and reduce wait times; break down silos between health care sectors and providers to ensure seamless transitions for patients; and support innovation by delivering new models of care and digital solutions. Evidence of our work underway to move these priorities forward is found throughout the following pages.

The collaborative work that went into planning for the transition of the NE CCAC to the NE LHIN has informed this ABP as we embark on our first year of delivering home and community care services. We remain committed to one of our key goals of ensuring continued quality services to patients, families and caregivers.

We have implemented a focused approach to our sub-region planning. Our extensive engagement outcomes over the past several years has informed our work which centres on advancing a common sub-region priority to deliver better integrated and patient-focused home/community care and primary care. This includes looking at the placement of home and community care providers in primary care settings.

We are strengthening the involvement of Northerners and will form a regional Patient and Family Advisory Committee while continuing to ensure patient voices are at the table of regional and sub-region efforts.

Please do not hesitate to discuss this ABP with either myself or our Acting Chief Executive Officer Kate Fyfe.

R.M. (Ron) Farrell
Board 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.

NE LHIN Strategic Directions

As we move forward this year, our approach in supporting both our sub-region and regional work will be guided by common strategic directions, including:

- A quality-driven health system focused on the patient experience.
- Engagement with patients and the public.
- Cultural safety and responsiveness.
- Leveraging technology to advance patient-centred care.
- Innovation and adoption of best practices.
- Performance monitoring and evaluation.
- Clinical leadership.

This plan reflects work the NE LHIN will undertake in 2017/18 to continue to move the **three priorities of our 2016-19 Integrated Health Service Plan (IHSP)** forward, including:

- Improve access and wait times
- Enhance care coordination
- Strengthen system sustainability

The NE LHIN supports the key objectives of Ontario's Patients First Action Plan for **Health Care: Access, Connect, Inform and Protect.**

Louise Paquette, NE LHIN Chief Executive Officer, (left), chats with Anne-Marie Brydge, the first client of PHARA's (Physically Handicapped Adults' Rehabilitation Association – Nipissing-Parry Sound) expanded transitional unit in North Bay. The unit offers 24-hour support for people needing extra care as they transition out of North Bay Regional Health Centre to their next home care setting. It also supports better patient flow at the hospital. With the NE LHIN's $3 million dollar annual investment, close to 300 people benefit from PHARA's services such as supportive housing for people with physical disabilities, personal support services, and care plans to help 75 high-risk seniors in their own homes.

This business plan is aligned with the priorities outlined in the NE LHIN's Mandate Letter as well as the key components of **Patients First Act 2016** and the goal of an improved patient experience for Ontarians:

- Expanded role for LHINs.
- Timely access to, and better integration of, primary care.
- More consistent and accessible home and community care.
- Stronger links to population and public health.
- Improving health equity and reducing health disparities.

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
- 44 Community Mental Health & Addictions Providers
- 70 Home and Community Care Providers
- 41 Long-Term Care Homes

Further to the Patients First Act 2016, the 2017-18 fiscal year saw the integration of the North East Community Care Access Centre (NE CCAC) to the NE LHIN. A priority of the expanded LHIN role is to ensure patient care in the delivery of home and community care services to more than 16,000 Northerners each day is maintained without interruption and continues to be enhanced.

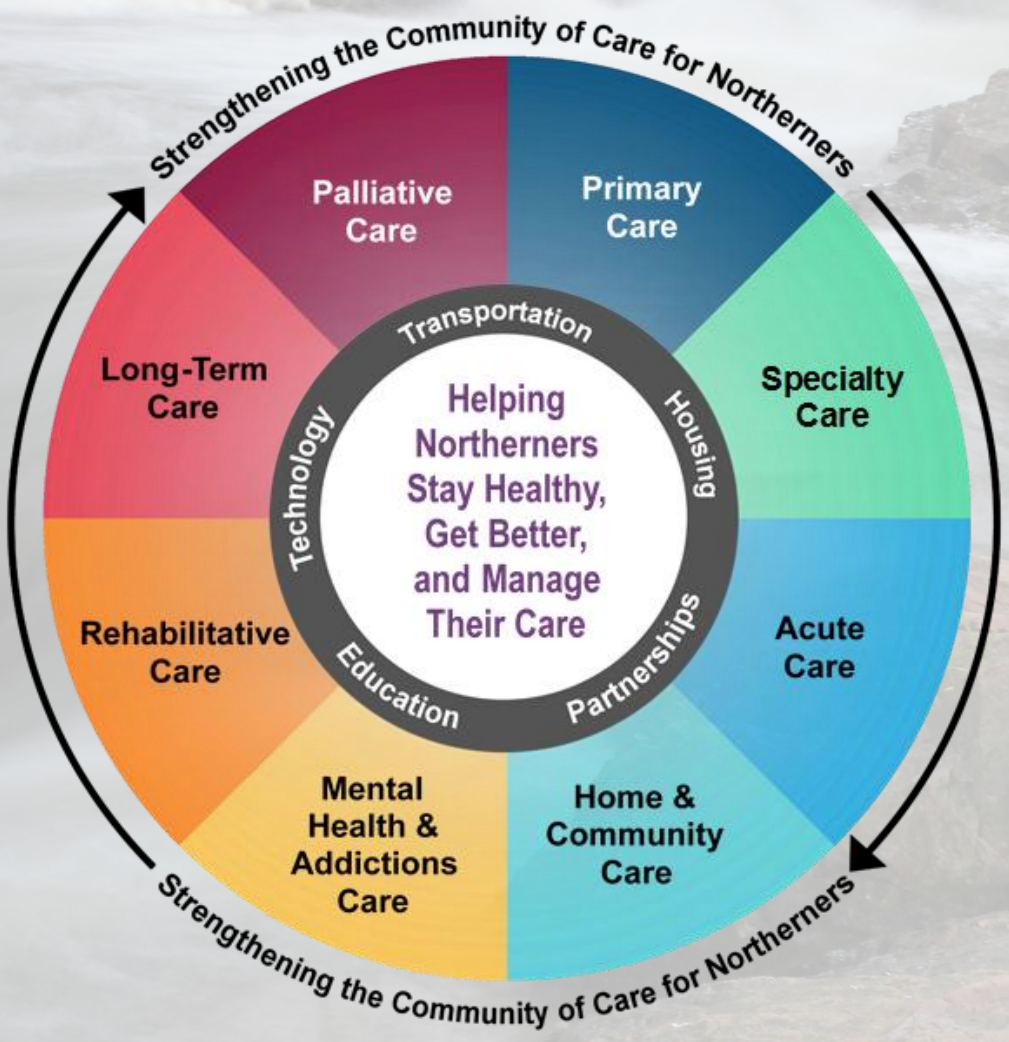
Through work to advance an integrated model of care in our five sub-regions, we are focusing on partnerships with Northern patients and leaders to drive system quality and a more integrated system of care. The NE LHIN's sub region focus this year is to better align primary care and home and community care so that patients benefit from a more seamless approach to their tailored care plans.

The Young Thunderbird Group perform at the launch of the *North East LHIN Aboriginal Health Care Reconciliation Action Plan* in September 2016 at Shkagamik-Kwe Health Centre in Sudbury. The centre is one of three Aboriginal Health Access Centres in the NE LHIN. The two others are Noojmowin Teg on Manitoulin Island, and Mamaweswen North Shore Tribal Council in Cutler. One of the Thunderbirds, 13-year-old Bronson Mclaughlin-Assinewai (photo right), spoke at the Action Plan launch event about unity. Bronson said: "Unity is the established bond between family members. Without this, we experience loss of culture, and our traditions are not passed down. United we support each other. We must be united in saving our culture for future generations."

NE LHIN Integrated Health Service Plan Priorities, 2016 - 2019

Improve Access and Wait Times	Increase Care Coordination	Strengthen System Sustainability

Areas of Care



The NE LHIN works with partners to drive system quality and value, enhance the patient experience, and improve population health while recognizing cultural diversity, particularly for Francophone and Indigenous Northerners.

ENVIRONMENTAL SCAN

In 2017, the NE LHIN has 169 accountability agreements that hold HSPs accountable to deliver the NE LHIN's $1.4 billion annual investment in health care for people living in Northeastern Ontario. These agreements include: 110 Multi Sector Service Accountability Agreements (M-SAAs), 25 Hospital Service Accountability Agreements (H-SAAs), and 34 Long-Term Care Service Accountability Agreements (L-SAAs) covering 41 long-term care homes.

The NE LHIN structures its large geographic area (400,000 square kilometres) into five sub-regions to support local planning and realignment efforts. NE LHIN staff work out of 24 local offices and meet one-on-one with both providers and patients on a regular basis.

Access to Primary Care Health Services

The NE LHIN is home to about 460 family physicians delivering comprehensive primary care, one Group Health Centre in Sault Ste. Marie, 27 family health teams, six community health centres, three Aboriginal health access centres, six nurse practitioner-led clinics, and 16 nursing stations.

Access to Home and Community Care Services

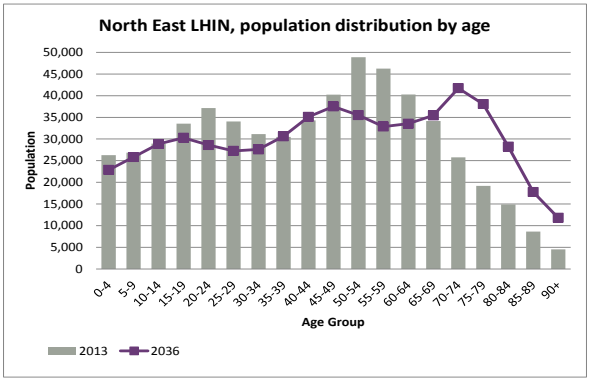
The NE LHIN funds about 110 community health service providers (i.e. Red Cross, March of Dimes, Alzheimer's Society, First Nations, Canadian Mental Health, etc.). In addition, as of June 1, 2017, the NE LHIN provides home and community care services to more than 16,000 people every day. This includes about 113,000 therapy visits per year, 39,000 school therapy visits per year, 379,000 nursing visits per year and more than 1.2 million personal support visits per year.

Life Span

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 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, and 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.

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 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 services.

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.[1]

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	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%

Sub-Region Statistics[1]

Sub-Region	Algoma	Cochrane	Nipissing/ Temiskaming	Sudbury/Manitoulin /Parry Sound
Demographic Highlights				
Population	102,000	80,300	144,000	228,000
People who identify as Francophone	7.1%	46.4%	25%	22.6%
People who identify as Indigenous	11.5%	12.7%	8.7%	10.8%
Seniors Aged 65+	21%	17.3%	20.7%	20%
Seniors Living Alone	28.1%	30.9%	28.9%	27.6%
Lone Parent Families	17.5%	14.3%	15.3%	16.3%
Youth Under 25	26.2%	28.1%	25.9%	26.3%
Low Income[2]	14.2%	13.2%	15%	13.5%
Hold Higher Education[3]	50.1%	46.9%	51.2%	52.5%
Health Service Provider Highlights				
Total Physicians	77	77	108	145
Health Links[4]	1	2	2	1
Hospitals	4	8	6	6
Home and Community Providers	17	18	18	31
Community Mental Health and Addictions Providers	9	9	6	9
Long-Term Care Homes	7	7	13	14
Aboriginal Health Access Centres	1	-	-	2
Community Health Centres	-	2	2	2
Nurse Practitioner-Led Clinics	2	-	1	3
Public Health Units	1	2	2	3

1. The NE LHIN has five Sub-Regions. Statistics for the James and Hudson Bay Coasts Sub-Region are not included due to unavailability of data.
2. Low income as defined by Statistics Canada as an income threshold at which families are expected to spend 20 percentage points more than the average family on food, shelter and clothing. (Statistics Canada CSD level download of NHS profile 2011)
3. Higher education is defined as education at a college or university where subjects are studied at an advanced level. (Statistics Canada CSD level download of NHS profile 2011)
4. A Health Link is a team of providers within a geographic area (primary care, hospital, home, community care, long-term care, community support agencies, community partners) working together to provide coordinated health care to patients with multiple complex conditions.

French Language Services (FLS)

In Northeastern Ontario, 23% (130,000) of the population is Francophone. Currently 42 health services providers are officially designated under the French Language Services Act, and 57 others are planning for a designation.

The NE LHIN works in partnership with the Réseau du mieux-être francophone du Nord de l'Ontario (Réseau) to help meet the needs and priorities of French speaking Northerners.

Engagement

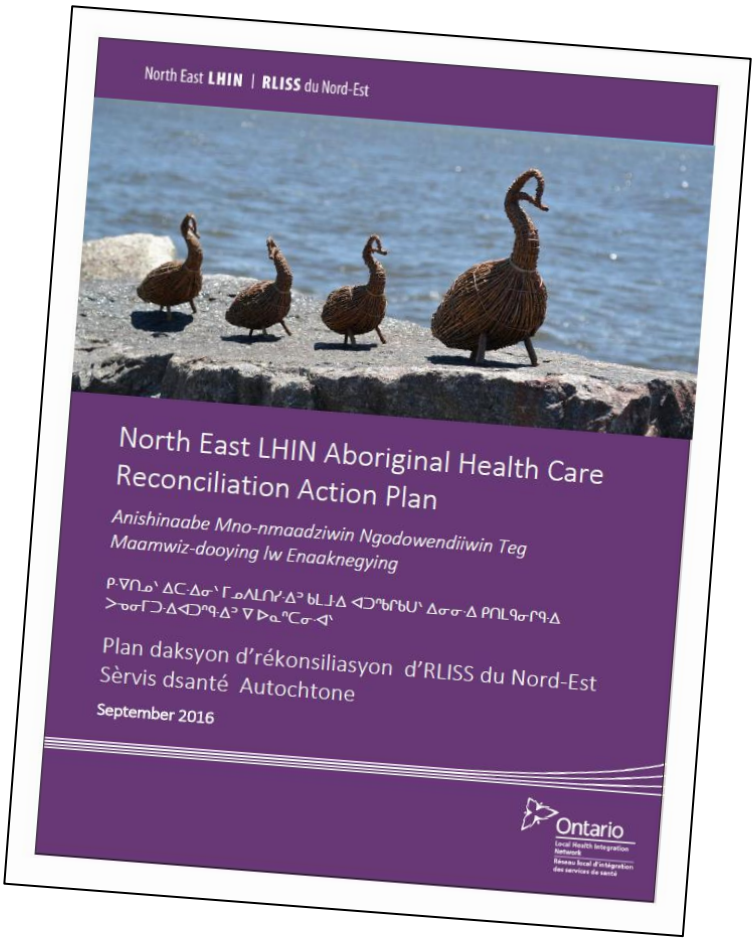
- The NE LHIN works collaboratively with the Réseau to increase access to services in French with a focus on increasing the number of providers developing designation plans and implementing an Active Offer approach.
- The Réseau and the LHIN developed a Joint Action Plan (2016-19) in alignment with the NE LHIN's IHSP (2016-19), and support the plan through: a LHIN-Réseau Liaison Committee; a LHIN-Réseau Working Group; and LHIN-Réseau Executive Director-Governance meetings.
- Réseau staff sit on LHIN planning tables and contribute to regional work plans to ensure the needs of Francophone communities are included in LHIN planning.
- The LHIN and Réseau work together to engage the Francophone community in planning work which helps inform the LHIN- Réseau Joint Action Plan and annual work plan.
- The LHIN works closely with the Réseau to establish FLS priorities and implementing actions to address the needs of Francophones.

FLS compliance with the French Language Services Act

- An online FLS toolkit (shown at right), collaboratively undertaken by the NE and NW LHINs and the Réseau, was launched in the spring of 2017 to help providers with their FLS planning.
- The LHIN and Réseau work together to identify HSPs whose FLS planning make them good candidates for designation. They also work to support a HSP in completing a designation plan, and evaluate designated HSPs to ensure they continue to meet designation criteria.
- The LHIN and the Réseau jointly promote the Active Offer approach for FLS.
- A key objective of the IHSP and the Joint Action Plan is to increase the number of providers that complete a submission for designation under the FLS Act.
- An FLS report is required by all HSPs to plan for the provision of FLS as required by their Service Accountability Agreements.
- Designated providers complete an evaluation every three years to confirm their compliance with the designation criteria.
- The NE LHIN, in collaboration with the Réseau, is engaged in primary care planning in Timmins through a Timmins Primary Care Collaborative Committee. Chaired by a member of the NE LHIN Board of Directors, the Collaborative is charged with developing a business case for a Francophone Community Health Centre to serve the area's Francophone population.
- As the NE CCAC was designated under the FLS act, the NE LHIN will monitor home and community care services on a yearly basis to ensure that care services continue to be provided in French throughout the North East in accordance with the French Language Services Act.

Indigenous Northerners

In Northeastern Ontario about 11% (62,000) of the population is Indigenous. In 2016, we worked with our Local Aboriginal Health Committee (LAHC) to develop Northeastern Ontario's first *North East LHIN Aboriginal Health Care Reconciliation Action Plan*. This plan is an important step in our journey to build a stronger system of care that addresses the profound inequities in the health of Indigenous Northerners. It is a plan that was created in the spirit of reconciliation, mutual understanding and respect.



A designated group of LHIN staff continue to work in partnership with federal and provincial partners, as well as health service providers, to strengthen the relationships and services needed to better support the needs of Indigenous Northerners.

Indigenous Northerners in health planning

- The need for an Aboriginal Health Care Strategy and Reconciliation Plan was identified as a result of LHIN-led engagements with Indigenous Northerners and the guidance of the LHIN's Local Aboriginal Health Committee.
- The NE LHIN works in partnership with the LAHC, an advisory committee to the Board, to guide its work in meeting the health needs of Indigenous Northerners. LAHC is comprised of senior representatives of Aboriginal health care organizations across the region. It advises the LHIN on health service priorities, opportunities for engagement, and ways to better the coordination of services within Indigenous urban and rural communities.

Plans to deliver services

- The *NE LHIN Aboriginal Health Care Reconciliation Action Plan* outlines goals in four strategic directions that are aligned with the Medicine Wheel's quadrants. Goals for the four areas – opportunities, relationships, knowledge and understanding, and sustainability and evaluation – include 25 specific actions, timelines, and measurable targets, that the NE LHIN is committed to deliver on over the next three years.
- Within the first nine months since its launch, the NE LHIN has provided cultural safety training for more than 400 Northerners through an eight-week online training course designed to broaden understanding of the history of Aboriginal Canadians, and strengthen the skills of practitioners working with Aboriginal people. In addition, it has appointed an Indigenous Co-Chair to its Mental Health and Addictions Advisory Council and re-aligned its internal resources to ensure a designated group of LHIN staff work in partnership with federal and provincial partners, as well as health service providers, to strengthen the relationships and services needed to better support the needs of Aboriginal Northerners.
- Reconciliation Plan progress will be reviewed biannually at LAHC meetings and annually at a meeting of the NE LHIN Board of Directors

Priority: Improve Access and Wait Times to Receive Quality Care

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

The following are objectives outlined in the LHIN's 2016-2019 IHSP to meet this goal:

- Support primary and specialty providers to ensure more timely access to services.
- Improve wait times for surgical / diagnostic procedures and emergency department visits.
- Enhance the availability of coordinated home and community care services and programs.
- Improve older adults' access to falls prevention strategies.
- Enhance dementia/behavioural support services for seniors and their caregivers.
- Work with partners to increase housing opportunities and associated supports for older adults, people with mental health and addiction issues, and other vulnerable populations.
- 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.
  ** Done in fiscal 2016-17.*
- 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.
- 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.
- Increase timely access to rehabilitative care in home and community.
- Improve access to long-term care beds.

Current Status

When it comes to accessing health care services – from primary care to home and community care – Northerners face greater challenges due to a large geography, dispersed population, and health professional recruitment challenges.

A few examples of how the LHIN is working to improve access to primary care include: encouraging primary care providers to switch to electronic medical records for their patients' information (now more than 500 family doctors, specialists and all nurse practitioner-led clinics have adopted); the Virtual Critical Care program in all hospitals, and more than 2,000 people benefiting from Telehomecare to better self-manage their COPD or heart failure.

Over the past three years, the NE LHIN has invested in programs to improve access and wait times for people suffering from mental health or addiction related illnesses, such as a harm reduction home now offering clients community care and supports in Sudbury rather than in a hospital emergency department, transitional housing for people to be cared for in community rather than hospital, a 24/7 telephone line people can call to speak to a counsellor, to name a few.

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 defined in the *Patients First Act* (December 2016).
- The Ministry's *10-Year Mental Health and Addictions Strategy* sets out five pillars for achieving better mental health and addictions recovery, and home care improvements were noted in *Bringing Care Home*: Report of the Expert Group on Home & Community Care (March 2015).

Support primary and specialty providers to ensure more timely access to services.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
New VP Clinical will focus on efforts of the five sub-region Clinical Leads and activities to better align primary care with home and community care and engage primary care providers in system improvements.	40%	100%	
Work with North East Specialized Geriatric Centre (NESGC) to implement its strategic plan.	33%	100%	
Monitor and address issues related to the implementation of Critical Care Services Ontario's (CCSO) Critical Care Life or Limb policy.	50%	100%	
Expand telemedicine adoption to primary care providers and patients.	30%	60%	100%
Improve access to primary care services by promoting an improved Health Care Connect program (for unattached patients).	30%	60%	100%
Develop capacity assessments for primary care in 28 Primary Care Groups, to determine the gap between patient need for service and current ability to provide service.	50%	100%	
Support the implementation of a provincial eConsult platform by promoting implementation, adoption, and use.	30%	60%	100%

Measurements of Success

- Increased percentage of patients referred to a primary care provider through Health Care Connect.
- Percentage of people attached in the NE LHIN (Health Care Experience Survey done by York University).
- Percentage of people able to see a primary care provider when they were sick on the same or next day (Health Care Experience Survey).
- Expansion of the NESGC team in Sudbury and multi-disciplinary SGS teams in Timmins and Sault Ste. Marie.
- Reduction or elimination of critical care life or limb consultation refusals by sub-specialists in the North East.
- Increased number of physicians utilizing tele-dermatology, increased total consultations annually, increased in number of physicians utilizing tele-psychiatry, increased total number of consultations annually, and increased OTN visits annually.

Risks/Barriers for Successful Implementation

- Primary care physician participation

NE LHIN Risk Mitigation Efforts

- Primary care engagement and involvement in system improvement work.
- Communications plan for implementation of an updated Health Care Connect program to physicians.
- NESGC consolidated regional program sponsorship and governance to support increased coordination and oversight.
- NE LHIN Critical Care Network to address and manage life or limb related issues.

Key Enablers

- Closer alignment of primary care with home and community care
- Sub-region Primary Care Clinical Leads.
- Support and alignment with OTN.

Improve wait times for surgical/diagnostic procedures and emergency department visits.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Complete value for money assessment of Pay for Results funding to inform the utilization strategy for future initiatives.	100%		
Implement LHIN CEO Council's five recommended actions to support improved access to MRI.	30%	60%	100%
Complete population-based analysis of QBP Cataracts to inform volume allocation to surgical hospitals.	100%		
Complete a population-based analysis of QBP Hip and Knee to inform volume allocation to surgical hospitals.	100%		

Measurements of Success

- ED length of stay for complex patients will improve to meet 8-hour target.
- Improve patient access to MRIs.
- Cataract surgery performance maintained at/above the target of 90%.
- Hip and knee replacement surgery improves wait times.

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 to improve patient flow.
- Population-based allocation of cataract, and hip and knee replacement surgeries.

Key Enablers

- 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. NE LHIN's ED Network will support ongoing monitoring of ED performance and third-party review of Pay for Results performance will enhance delivery of the program in 2017/18 and after.
- 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. A key enabler for improved MRI performance is the Local Partnership's leadership on adopting the LHIN CEO Council's five recommendations on MRI including Choosing Wisely Canada for diagnostic imaging (focus on MRI) in 2017-18. These efforts will be completed through 2019-20.

Enhance the availability of coordinated home and community care services and programs.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Integrate home and community care (HCC) into one sector.	25%	75%	100%
Localize, align and implement strategies within the Patients First Roadmap.	40%	80%	100%
Develop and implement IT tools that improve flow across all sub-regions.	30%	60%	100%
Collaborate on health human resource initiatives to strengthen capacity and service coordination.	35%	70%	100%

Measurements of Success

- Percentage of home care patients with complex needs who receive their first personal support visit within 5 days.
- Percentage of home care patients who receive their first nursing visit within five days.
- Decrease in wait times from community for in-home home and community care services.
- Decrease in wait times from hospital discharge to service initiation for home and community care.
- Strengthened relationships across home and community care work streams.
- Implementation Framework; self-directed care models established for home and community care; caregiver support expanded; and home maintenance reviewed, evaluated and realigned across NE LHIN.
- Existing IT assets (such as Client Health and Related Information System and Health Partner Gateway, eNotification) are enhanced and more accessible in the Home and Community Care Sector.
- Best practices are shared across all sectors.
- Implementation of provincial dashboards.

Risks/Barriers for Successful Implementation

- Successful collaboration and integration necessary for seamless patient service delivery.
- Limited availability of health human resources.

NE LHIN Risk Mitigation Efforts

- Work collaboratively with partners to build upon current and new resources.
- Build a collaborative culture and approach to review and ensure informed decisions/solutions are achieved.

Key Enablers

- Expanded LHIN mandate for home and community care.
- Enabling technology to support enhanced coordination.

Improve older adults' access to falls' prevention strategies.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Build multi-sector partnerships across the health continuum focused on falls' prevention.	40%	100%	
Increase falls prevention knowledge base among multi-sector service providers.	40%	100%	
Increase awareness among older adults and caregivers of the risks and ways to reduce risks.	40%	100%	
Maximize the reach of exercise classes and falls' prevention classes.	50%	100%	
Support and build healthy public policies on falls' prevention and healthy aging.	25%	100%	
Establish a standard fall risk screen/ assessment and community referral protocol with all primary care providers.	25%	100%	

Measurements of Success

- Decrease in emergency room visits and hospitalizations due to falls among older adults.
- Percentage of: sectors engaged in Stay on Your Feet (SOYF); sectors implementing fall prevention programming; primary care providers who integrate standard falls' risk screen and assessment into their practice; service providers providing education on fall risks and prevention strategies.
- Reach of education and awareness components of SOYF.
- Number of policies supported and implemented.

Risks/barriers for Successful Implementation

- Our three-year memorandum of understanding with the five Public Health Units related to falls' prevention work and resources expires March 31, 2018. Strengthening community capacity is underway; however, this is a long-term process.
- Limited capacity within the health and other sectors to engage in SOYF.

NE LHIN Risk Mitigation Efforts

- Build on the strengths that exist within each district for falls' prevention.
- Identify ways to incorporate falls' prevention into existing practices.
- Strengthen local population and public health planning with other health services.
- Work with physicians and pharmacies to raise awareness of the role of medication management in falls' prevention.

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.

Enhance dementia/behavioural support Ontario (BSO) services for seniors and their caregivers.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Realign existing BSO services to ensure larger coverage	50%	100%	
Enhance BSO investments and programs available in NE LHIN.	100%		
Support the development of a North East Dementia Strategy.	100%		
Develop behavioural management in LTC facilities to reduce ALC pressures.	50%	100%	

Measurements of Success

- Increase in number of referrals for appropriate clients to receive BSO services.
- Increase in number of LTC homes with embedded BSO teams; enhanced BSO supports available in acute care, community, LTC.
- Complete dementia strategy.

Risks/barriers for Successful Implementation

- Willingness of providers to incorporate BSO program into existing services; providing adequate support in rural/remote communities.
- Competing priorities of stakeholders.

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 challenges of providing services in rural settings and ensure all partners are engaged throughout the process.
- Review data and analyze gaps in current dementia services for identification of partnerships.

Key Enablers

- Partnerships and ongoing engagements.
- Technology including OTN and 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 BSO training opportunities.

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:	2017/18	2018/19	2019/20
	Percentage Complete		
Support implementation of recommendations in the *Innovative Housing with Health Supports in Northeastern Ontario Strategic Plan: 2016-2019.*	50%	75%	100%
Market the strategy among partners: non-profit, profit, and government.	50%	100%	

Measurements of Success

- Development of scorecard to measure implementation of housing report.
- Roles and responsibilities are aligned to recommendations within scorecard; recommendations implemented.

NE LHIN Risk Mitigation Efforts

- 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 to improve access and decrease wait times for housing.

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:	2017/18	2018/19	2019/20
	Percentage Complete		
Continued implementation of a provincial bed registry.	33%	100%	
Strategies in *North East LHIN Aboriginal Health Care Reconciliation Action Plan.*	30%	60%	100%
Ongoing use of Central Access Point in Algoma Sub-region for addictions and mental health services.	30%	100%	
Health Sciences North community mental health and addictions programs/Canadian Mental Health Association – Sudbury/ Manitoulin/ Northern Initiative for Social Action using same client data software system.	50%	75%	100%
Nipissing Common Referral Working Group to oversee the referral process and triage table for community mental health support services in the District of Nipissing.	30%	60%	100%
Implement standardized referral form.	100%		
Implement on-line health information site.	100%		

Measurements of Success

- Decrease in repeat unscheduled emergency room visits within 30 days for mental health conditions.
- Enhanced access to care.

- Stakeholder engagements to measure the outcomes of programs.

Risks/barriers for Successful Implementation
- Privacy and confidentiality.
- Buy-in for programs that might need to be more culturally aware/safe.

NE LHIN Risk Mitigation Efforts
- Education on the sharing of client data.
- Resourcing of phased-in implementation plan involving feedback provided through engagements.

Key Enablers
- Clear communication to all sectors with key messages.
- Strengthened partnerships with Indigenous leaders and stakeholders.

Work with the French Language Health Planning Entity to increase access to services in French with a focus on increasing the number of HSPs developing designation plans and implementing an Active Offer approach.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Identify and support 10 additional HSPs to submit a designation plan.	60%	100%	
Increase the number of HSPs that implement active offer strategies by 75%.	50%	100%	

Measurements of Success.
- Number of HSPs that submit a designation plan to the NE LHIN.
- Number of HSPs that adopt an Active Offer approach.
- Number of activities by the NE LHIN and the Réseau to promote active offer (presentations, workshops, training, resource materials).
- Home and Community Care services continue to meet designation criteria.

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 Planning Entity.
- Share and promote best practices for recruitment of bilingual staff and provision of FLS.

Key Enablers
- Integration/collaboration activities.
- Education of HSPs on FLS.

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:	2017/18	2018/19	2019/20
	Percentage Complete		
Support HSPs to increase access to community support services delivered to elders in Indigenous communities.	30%	60%	100%
Expand interdisciplinary diabetes outreach models, diabetes education, and foot care self-management programs to additional First Nations communities.	30%	60%	100%
Work with providers to support planning and community development that will enhance of traditional health services.	30%	60%	100%
Support HSPs to enhance and improve access to mental health and addiction services to Indigenous people.	30%	60%	100%
Work collaboratively with federal and provincial partners to develop a strategy to improve coordination of care to increase access to care for rural and remote First Nations.	30%	60%	100%

Measurements of Success

- Monitor achievements of the 25 calls for action in the *NE LHIN Aboriginal Health Care Reconciliation Action Plan* through a scorecard/dashboard.
- HSPs align their culturally proficient practices with the *NE LHIN Aboriginal Health Care Reconciliation Action Plan.*
- Formalize partnership with Health Canada to ensure funding and programs are coordinated.

Risks/barriers for Successful Implementation

- Vast geography, remoteness and unique aspects of some communities.
- Complex jurisdictional relationships within First Nation policies, governance and health care delivery options.
- Competing priorities for resources to expand or enhance services.

NE LHIN Risk Mitigation Efforts

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

Key Enablers

- Strategies and actions outlined in *North East LHIN Aboriginal Health Care Reconciliation Action Plan*. Partnerships with NE LHIN's Local Aboriginal Health Committee (LAHC) and mainstream health service providers, Aboriginal primary care providers (e.g. AHACs), networks and committees.
- Strengthened resources and increased partnership and collaboration.
- Technology (such as telemedicine and eConsult)

Increase timely access to rehabilitative care in home and community.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Complete a North East region-wide Capacity Plan for diagnostic groups that would benefit from bedded levels of rehabilitative care and community rehab.	100%		
Implement outcomes of capacity plan to sub-regions.	33%	100%	
Align inpatient rehab and complex care programs with standardized definitions framework for bedded levels of rehab care.	50%	100%	
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).	25%	100%	

Measurements of Success

- Successful implementation of the Rehab Capacity Planning Report at the sub-region level.
- Number of programs that align with definitions framework.
- Proportion of direct admissions from community and/or ED to a rehab bed.
- Average wait time from referral to admission to a rehab care bed from community/ED.
- Percentage of funded episodes of care that are delivered.
- Average wait time from referral to assessment /intervention.
- Percentage of home care patients with complex needs who receive their first personal support visit within 5 days.
- Percentage of home care patients who receive their first nursing visit within five days.
- Decrease in wait times from community for in-home home and community care services

NE LHIN Risk Mitigation Efforts

- 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 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.
- Development of NE LHIN Rehab Capacity Plan by sub-region.
- Consider option of reclassifying existing beds to meet the need prior to investment in additional capacity.
- Aligning small communities with existing resources, giving consideration to partnerships, integration and/or use of technology.
- Leadership commitment. Collaboration among partners.

Key Enablers

- Access to technology and focused performance measurement and management.

Improve access to long-term care beds.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Enhance opportunities for short stay convalescent care beds and respite beds to alleviate pressure for LTC beds.	25%	100%	
Establish programs that have potential to meet an unmet need of LTC population and for people that are difficult to place in LTC.	100%		
Identify LTC home operators/ partners to incorporate unique short stay/Designated Specialized Unit (DSU) programs into redevelopment or existing home structure.	33%	100%	

Measurements of Success

- 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%.
- Increase in supportive programs/alternative destinations available.
- Decrease in refusals from LTC homes.
- Increase allocation of designated beds to meet needs of patients with significant behaviours.
- 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.

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.
- Loss of Long Stay beds to replace with Short Stay beds
- Operators unwillingness to continue operation of short stay programs.

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.
- 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 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 to provide access to resources to guide informed decisions on opportunities identified.

The NE LHIN's regional Mental Health and Addictions Advisory Council met for the first time in late 2016 at a Knowledge Exchange Day, held in collaboration with the Centre for Addiction and Mental Health (CAMH). The Council was struck to develop a plan to implement the recommendations of Dr. Brian Rush's Review of Addiction Services in Northeastern Ontario, commissioned by the NE LHIN, as well as a mental health Blueprint undertaken by Health Sciences North and North Bay Regional Health Centre. As per the NE LHIN's Reconciliation Action Plan, the Council is Co-Chaired by Pam Williamson, Executive Director of Noojmowin Teg Health Centre (right), and Carol Philbin-Jolette, NE LHIN Director, Coast Sub-Region and Population Equity (left). Pictured in this photo is NE LHIN CEO Louise Paquette (middle).

IHSP Priority: Enhance the coordination of care

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

The following are objectives outlined in the LHIN's 2016-2019 IHSP to meet this goal:

- Develop coordinated care plans for patients with complex needs.
- Work with providers to develop a more coordinated system of primary care and more seamless service delivery for Northerners.
- Ensure the availability of quality acute care services when people need them.
- Strengthen home and community care for Northerners.
- Enhance transportation services so people can get to and from the care they need.
- Work with partners to implement strategies that ensure a more coordinated and client-centered approach to mental health and addictions services.
- Establish a Regional Mental Health and Addictions Advisory Council 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.
- Develop plans and create opportunities to support providers in delivering services in a culturally sensitive manner.
- Identify patient journey gaps and improve the transitions of care for Francophone and Aboriginal Northerners.
- Develop coordinated care for patients at the end of their life's journey.

Current Status

Much of the NE LHIN's focus has been to create a unified home and community care sector. Examples of this work include the roll-out across the region of the Priority Assistance to Transition Home (PATH) program which has helped more than 6,000 seniors get home safely from hospital with the services, food and medication in place needed to recuperate; the implementation of the Personal Support Services Regulatory changes and the successful transitioning of more than 350 low acuity clients from the NE CCAC to other community support service providers; and working collaboratively with system partners to develop a common referral form and an enhanced website the connects Northerners to home and community care or mental health and addictions services (www.connect.northeasthealthline.ca).

With the legislative changes arising out of the Patients First Act, this transformation into one sector will be further strengthened, as will increased primary care coordination and linkages between primary care and other sectors.

Consistency with Government Priorities

- Care that is connected is a goal in the *Patients First: Action Plan for Health Care* (February 2015).
- Alignment with the *Patients First Act* (December 2016), *Bringing Care Home: Report of the Expert Group on Home & Community Care* (March 2015), and *Living Longer, Living Well* (December 2012).

Develop coordinated care plans for patients with complex needs.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Implement Health Links to provide 100% of NE LHIN eligible patients access to coordinated care plans.	30%	60%	100%

Measurements of Success

- Decrease rate of emergency visits for conditions best managed elsewhere.
- Decrease hospitalization rate for ambulatory care sensitive conditions.
- Increase number of coordinated care plans for patients eligible for Health Links to approximately 3,300 patients in the NE LHIN.
- Increase number of complex patients with regular and timely access to a primary care provider.
- Increase percentage of acute care patients who have had a follow-up with a physician within seven days of discharge.

Risks/Barriers for Successful Implementation

- Readiness of communities to implement a Health Links approach.
- Physician participation in Health Links.
- James and Hudson Bay Coasts may require additional support and a unique approach to care coordination that is reflective of the culture and language.
- Scalability of models implemented, and spread amongst all primary care providers.
- Digital health solution to enable the coordinated care plan to be shared electronically amongst providers.

NE LHIN Risk Mitigation Efforts

- Involvement of primary care clinical leads in sub-regions.
- Community engagement and community building efforts.
- NE LHIN representation on LHIN Health Links Provincial Working Group.
- Work to embed Care Coordinators in Primary Care Settings, review of Care Coordination models to recommend an approach for Health Links, and review of non-CCAC funded case management/care coordination/navigation activities.
- Leverage technology for electronic sharing of coordinated care plans amongst HSPs.

Key Enablers

- Digital health solution for sharing Health Links coordinated care plans amongst HSPs.
- Timely support for project management teams to implement coordinated care plans into eight new Health Links.

Work with providers to develop a more coordinated system of primary care and seamless service delivery for Northerners.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Ensure primary care providers receive timely information on patient admission and discharge from hospital for timely follow-up, particularly patients with complex needs.	30%	60%	100%
Ensure primary care providers have access to coordinated care plans for complex patients as part of Health Links.	30%	60%	100%
Embed CCAC Care Coordinators into Primary Care settings.	20%	100%	
Facilitate linkages between primary care and community services, including home and community care.	30%	100%	

Measurements of Success

- Increase in percentage of acute care patients who have had a follow-up with a physician within seven days of discharge.
- Decrease readmissions within 30 days for Selected HIG conditions.
- Work to place home and community care coordinators to ensure better linkages with primary care organizations.
- Sustained uptake of Physician Office Integration (POI) which includes lab, diagnostic imaging and hospitals reports; Ontario Laboratories Information System (OLIS), by primary care providers.
- Number of new hospitals to join OLIS.
- Increasing number of reports sent via POI.
- Uptake and support for eNotification by hospitals and primary care providers.
- Increase the number of diabetes education programs with collaborative practice agreements with local primary care providers, including the provision of programming directly in primary care settings.

Risks/Barriers for Successful Implementation

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

NE LHIN Risk Mitigation Efforts

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

Key Enablers

- Expanded LHIN mandate with primary care and leverage of new LHIN VP Clinical.
- Development and implementation of a NE LHIN-region hospital information system for data collection and management, currently in progress with 24 acute care hospital boards committing in 2016 to achieve this goal.
- Electronic medical record 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.

Ensure the availability of quality healthcare services when people need them.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Regional Quality Table established.	100%		
Determine sub-region cross-sector quality improvement priorities, targets, and improvement initiatives.	50%	100%	
Develop NE LHIN quality framework to support the IHSP.	100%		
Increase capability for quality improvement through collaboration with Health Quality Ontario (HQO) and expand use of quality framework.	40%	100%	
Establish process for HSPs to participate in the development and implementation of quality standards as introduced by HQO.	30%	100%	
Implement clinical and non-clinical standards.	20%	40%	100%

Measurements of Success

- Regional Table established in second quarter of 2016-17. Work plan is developed for fiscal 2017-18. Quality focus utilized to inform Quality Improvement Plan (QIP) development moving forward.
- Track two cross-sector indicators with initiatives from each organization agreed upon in one sub-region area by end of 2017-18. Evaluate the process and then roll out to other sub-regions in 2019-20.
- NE LHIN quality framework linking quality and performance management implemented by March 31, 2018.
- Quality-focused educational session(s) held annually with HQO with engagements in sub-regions and cross sector QIP development.
- Process for implementation of quality standards is established and working well by 2019-20. Uptake of quality statements within standards by HSPs is 100% by 2019-20 for initial release.
- Quality improvement efforts are coordinated 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 2017-18 at or better than provincial targets by 2018-19.

Risks/Barriers for Successful Implementation

- Multiple priorities for HSPs.
- Resistance of partners to collaborate.
- Limited availability of health human resources, especially in rural areas.

NE LHIN Risk Mitigation Efforts

- Make quality part of the roll-out of new initiatives.
- Use existing indicators rather than adding new ones and focus on activities that support the IHSP.
- Ensure alignment between Quality Improvement Plans and SAA indicators.

Key Enablers

- Clinical Quality Lead Physician for NE LHIN, and new VP Clinical.
- Education for all HSPs on the quality agenda.
- Strong partnership with HQO.
- Partnership between performance and quality.
- Advancement of patient-centred care through e-health solutions that support patient and family access to health information and services.
- Advancement of recommendations of the Hospital Information System Renewal Advisory Panel.

Strengthen home and community care for Northerners.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Implement the provincial "Statement of Values for Home and Community Care."	70%	100%	
Implement care coordination models that supports Northerners.	60%	100%	
Create a coordinated region-wide waitlist for Personal Support Services (PSS).	80%	100%	
Implement the PSS regulatory amendments across the NE LHIN.	40%	100%	
Provide quality improvement tools and training.	40%	100%	

Measurements of Success

- Percentage of home care patients with complex needs who receive their first personal support visit within 5 days.
- Percentage of home care patients who receive their first nursing visit within five days.
- Decrease in wait times from community for in-home home and community care services
- Decrease in wait time from hospital discharge to service initiation for home and community care.
- Decrease in rate of emergency room visits for conditions best managed elsewhere.
- Statement of Values adopted and implemented across the NE LHIN.
- Care coordination models are developed.
- Coordinated/centralized waitlist in place.
- Equitable access to PSS delivered by community support services for low acuity clients across NE LHIN.
- Progress made on integration of quality improvement plans within the home and community care sector.

Risks/Barriers for Successful Implementation

- Transition year with expanded mandate for home and community care.
- Demand for services given aging population with reliance on home and community care services.
- Limited availability of health human resources.

NE LHIN Risk Mitigation Efforts

- Alignment with Patients First vision, transparency of accountability, and leveraging of partnerships.
- Home and community care sharing of best practices across sub-regions.

Key Enablers

- Expanded LHIN mandate with home and community care.
- CSS mini-site/Healthline website for home and community care services and resources in place.

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

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Finalize multi-year non-urgent patient transportation (NUPT) strategy.	100%		
Implement Phase 1 of the recommended NUPT service and governance model.	50%	100%	

Measurements of Success

- Delivery of more than 12,000 hours of dedicated NUPT services across the region (Phase 1).
- Non-urgent waiting areas implemented at Health Sciences North and Timmins and District Hospital.

NE LHIN Risk Mitigation Efforts

- Municipal, health service provider and Ministry of Health and Long-term Care support of a new vision for NUPT in the North East.

Key Enablers

- Partnerships aligned with vision across the region.

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:	2017/18	2018/19	2019/20
	Percentage Complete		
Implement Ontario Perception of Care (OPOC) tool in mental health and addiction (MH&A) treatment services.	30%	60%	100%
Implement the use of Staged Screening and Assessment tools across the LHIN.	30%	60%	100%
Implement Dual Diagnosis Framework across the NE LHIN.	50%	100%	
Implement the NE LHIN's Action Plan on Ontario Common Assessment of Need (OCAN)/Integrated Assessment Record (IAR) adoption.	75%	100%	

Measurements of Success

- Decrease in repeat unscheduled emergency room visits with 30 days for mental health conditions.
- Decrease in repeat unscheduled emergency room visits with 30 days for substance abuse conditions.
- 85% adoption of OPOC tool by community MH & A service providers; training for use of the Staged Screening and Assessment tool is rolled out across the LHIN, and the tool is used with all addictions providers.
- Reduction of Dual Diagnosis individuals reporting to emergency departments and individuals in conflict with criminal justice system.
- Increase in the number of OCAN assessments shared between health service providers via the IAR.

Risks/Barriers for Successful Implementation

- Lack of consistent model of centralized access.
- Geographical barriers and diversity that challenge a regional centralized model.
- Support and human resources required for implementation.

NE LHIN Risk Mitigation Efforts

- Collaboration with partners.
- Work with Ministry of Children and Youth Services and MOHLTC to engage with Dual Diagnosis sector to ensure a smooth implementation of Dual Diagnosis guidelines.

Key Enablers

- Use of technology to keep participants engaged in implementation and planning process.
- Establishment of the NE LHIN Community of Interest for OCAN to work in collaboration with the Centre for Addiction and Mental Health's Evidence Exchange Network for Mental Health and Addictions.

Establish a Regional Mental Health and Addictions Advisory Council 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.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Develop terms of reference for Regional Mental Health and Addictions Advisory Council.	100%		
Develop and implement two-year work plan.	50%	100%	
Advisory Council to set priorities and provide input into NE LHIN addictions and mental health system development as per Dr. Brian Rush's Report (2016) and the Blueprint for Mental Health and Addiction (Health Sciences North and North Bay Regional Health Centre).	30%	60%	100%

Measurements of Success

- Decrease in repeat unscheduled emergency room visits with 30 days for mental health conditions.
- Decrease in repeat unscheduled emergency room visits with 30 days for substance abuse conditions.
- Establish and/or strengthen sub-region mental health and addiction planning tables.
- Completion of two-year work plan.
- Regional agreement on system priorities.

Risks/Barriers for Successful Implementation
- Resistance to change.
- Partner participation and engagement.

NE LHIN Risk Mitigation Efforts
- Apply a change management approach to redefine how mental health and addiction services are delivered in
- the NE LHIN.
- Ongoing collaboration and consultation with partners and Regional Advisory Council.

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

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

Actions to meet the objective:	**2017/18**	**2018/19**	**2019/20**
	Percentage Complete		
Create, distribute and promote FLS (French Language Services) toolkit for health service providers (HSPs) to assist in FLS planning and provision.	80%	100%	
Create opportunities to support health service providers to deliver health services in a culturally safe manner.	30%	60%	100%
Expand Personal Support Worker training along the James Bay Coast.	30%	60%	100%

Measurements of Success
- Evaluation of implementation of Reconciliation Action Plan (via scorecard/dashboard).
- Completion of FLS toolkit.
- Number of health service providers that receive education session on the FLS toolkit.

Risks/Barriers for Successful Implementation?
- Lack of awareness of the importance of FLS in health care service delivery.
- Health service provider support of Reconciliation Plan.

NE LHIN Risk Mitigation Efforts
- Involve HSPs in a comprehensive promotion plan.
- Monitor implementation and adjust toolkit content as needed; identify opportunities to promote the toolkit.
- Leverage the connections and expertise of the NE LHIN's Local Aboriginal Health Committee; continue to offer cultural safety training to HSPs.

Key Enablers
- Education, awareness and partnerships.
- Coordinated efforts by LHINs and MOHLTC to promote cultural safety training.
- Technology for training.

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

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Explore the Francophone patient journey and experience to identify gaps and improve transitions of care.	65%	100%	
Continue to develop relationships and partnerships with federal/provincial agencies to support coordinated health care in Aboriginal communities.	30%	60%	100%
Develop mutual communication processes and systems to minimize gaps in transitions of care for Aboriginal people.	50%	80%	100%

Measurements of Success

- Documented Francophone patient experiences that contribute to initiatives to improve transitions for Francophones.
- Increase the number of activities to improve access and patient experience for the Francophone population (focus groups, surveys, experienced-based design activities, patient journey mapping exercises).
- Percentage achievement of initiatives.
- Evaluation of implementation of Reconciliation Action Plan (via scorecard/dashboard).

Risks/Barriers for Successful Implementation

- HSP resources and time to participate.
- Complex jurisdictional relationships that impact First Nation policy, governance and health care delivery.
- Fragmented use of electronic medical records and inconsistent linkages between Aboriginal and mainstream providers.

NE LHIN Risk Mitigation Efforts

- Engage HSPs to ensure collaboration and continually build on successes and outcomes**.**
- Leverage *NE LHIN Aboriginal Health Care Reconciliation Action Plan*, and federal and provincial commitment to the implementation of the *Truth and Reconciliation Commission of Canada: Calls to Action* recommendations.

Key Enablers

- Education and awareness.
- Experience-based design to collect Francophone patient experiences.
- Use of technologies to enhance collaboration across stakeholders.

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

Actions to meet the objective: (*Note that these actions correspond to the NE Palliative Care Network Regional Steering Committee's three-year work plan which concludes in fiscal 2018-19)*	**2017/18**	**2018/19**	**2019/20**
	Percentage Complete		
Develop residential hospice services (in hospice, hospital and long-term care).	30%	100%	
Set a regional strategy for palliative education for all sectors.	30%	100%	
Develop community palliative expert teams to support primary care providers and assist with care planning for complex patients identified through Health Links.	30%	100%	
Standardize hospice volunteer visiting services, integrate volunteers into community.	30%	100%	
Promote advance care planning and identification of persons who could benefit from a palliative approach to care.	30%	100%	
Enhance grief, loss and bereavement services to improve caregiver support.	40%	100%	

Measurements of Success

- Percentage of palliative patients discharged from hospital with home support.
- Increase in:
  - number of residential hospice beds.
  - number of staff trained by professional designation.
  - number of teams; patients served; and length of stay at home.
  - number of people who complete an Advance Care Plan upon admission to hospital, long-term care home or assisted living facility.
- Improved caregiver experience as measured through a caregiver voice survey.

Risks/Barriers for 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.
- Regional education collaborative to 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 the Réseau and the LAHC to ensure that services are culturally appropriate.
- Optimize the knowledge and connections that exist through the local palliative planning tables.
- 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.
- Community education on advanced care planning.

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.

The following are objectives outlined in the LHIN's 2016-2019 IHSP to meet this goal:

- Implement the recommendations of the Regional Addictions Services Review.
- Work with communities to ensure their hospitals continue to evolve to meet current and future health needs.
- Improve strategies to better support frail seniors and their caregivers in community.
- Work with partners to improve the patient experience through a relentless focus on quality.
- Implement standardized addictions screening/ assessment tools.
- Conduct an evaluation of all designated health service providers every three years to ensure they continue to meet designation criteria.
- Work with providers to ensure quality data collection for Aboriginal and Francophone population groups.
- Work in partnership with the NE LHIN's Local Aboriginal Health Committee to develop a NE LHIN Aboriginal Health Care Strategy that includes the Northeastern Ontario Reconciliation Action Plan (launched in 2016).
- Adopt standardized rehabilitative care best practices.
- Support redevelopment of long-term care homes to meet the highest safety and design standards.
- Work with partners to improve patients' timely follow-up from a primary care practitioner after discharge from hospital.

Current Status

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.

Challenges as outlined in the Environmental Scan (pages 7 to 8) include population risk factors, an aging population with a higher percentage of people over the age of 65 (20%) compared to the rest of the province (16%), and the resource-based economy of the North East region.

Some examples of work to strengthen system sustainability include work with 24 of the region's hospitals to create the Northern Supply Chain (encompassing most of the hospitals in the North East and North West); collaborating with system partners to implement the three-year *North East Patient Flow/Alternate Level of Care Strategy;* and commissioning Dr. Brian Rush to undertake a review of addiction providers in the North East region to help guide our work over the coming years.

The *Patients First Act 2016* and its transformative changes expand the LHIN's role to strengthen our health system and improving the patient experience. Its directives will continue to further align primary care and home and community care. Protecting the sustainability of our health care system for generations to come is key to the Act.

Consistency with Government Priorities

- *Patients First: Action Plan for Health Care (*February 2015).
- *Bringing Care Home*: Report of the Expert Group on Home & Community Care (March 2015).

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Work with Regional Mental Health and Addiction Advisory Council to prepare work plan.	100%		
Implement year one of plan.	25%	100%	

Measurements of Success

- Decrease in repeat unscheduled emergency room visits within 30 days for mental health conditions.
- Decrease in repeat unscheduled emergency room visits within 30 days for substance abuse conditions.
- Number of actionable items implemented.
- Number of health service providers involved in planning and implementation.

Risks/Barriers for Successful Implementation

- Capacity of HSPs to support recommendations.

NE LHIN Risk Mitigation Efforts

- Work with Regional Advisory Council to provide support for implementation plan.

Key Enablers

- Partnerships and ongoing engagement efforts with the sector.

Work with communities to ensure their hospitals continue to evolve to meet current and future health needs.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Implementation of the NE Patient Flow / Alternate Level of Care Strategy.	30%	60%	100%
Implementation and evaluation of the rural health strategy model.	50%	75%	100%
Continued implementation of quality-based procedures (QBPs).	25%	50%	100%
Capacity Planning exercise for rehabilitative care (described on Page 20).	30%	60%	100%

Measurements of Success

- Continued reduced ALC rate in NE LHIN hospitals.
- Expansion of rural health strategy implementation (currently within two areas -- Blind River and Espanola).
- QBPs implemented as scheduled.

Risks/Barriers for Successful Implementation

- Participation and commitment from all 25 hospitals.

NE LHIN Risk Mitigation Efforts

- Full risk management framework.
- Education with hospitals and communities and community engagements.

Key Enablers

- Engagement education and partnerships.

Improve strategies to better support frail seniors and their caregivers in community.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Develop innovative Home and Community Care (HCC) delivery models to support Northern communities.	50%	75%	100%
Ensure equitable, accessible and sustainable services by building on existing resources.	50%	75%	100%
Ensure implementation of standardized reporting of key performance indicators in HCC.	33%	70%	100%
Implement recommendations from Assisted Living Review (2016).	50%	75%	100%
Collaborate on health human resource initiatives, including PSW training, to strengthen capacity and reduce wait times.	33%	70%	100%

Measurements of Success

- Percentage of home care patients with complex needs who receive their first personal support visit within 5 days.
- Percentage of home care patients who receive their first nursing visit within five days.
- Decrease in wait times from community for in-home home and community care services.
- Decrease in wait time from hospital discharge to service initiation for home and community care.
- Standardized service delivery frameworks for assisted living and caregiver respite across all NE LHIN sub-regions.
- Rural Health Hubs implemented in two sub-regions.

Risks/Barriers for Successful Implementation

- Adoption of technology.
- Vast geography, dispersed population and shortage of health care professionals in some communities.

NE LHIN Risk Mitigation Efforts

- Work with planning tables at the sub-region level to develop local work plans to support regional priorities.

Key Enablers

- Expanded LHIN mandate for home and community care to support system improvements for seniors and caregivers.

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

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Foster best practices in the development, accountability and empowerment of a Patient and Family Advisory Council.	33%	100%	
Implement the quality practices described under “Quality Healthcare Services” on page 25	30%	60%	100%

Measurements of Success

- Patient and Family Advisory Council established and continued patient engagement to achieve better system outcomes.
- See additional measurements of success outlined on page 25.

Risks/Barriers for Successful Implementation

- Geographical considerations in assembling an advisory council.

NE LHIN Risk Mitigation Efforts

- NE LHIN education and awareness of patient involvement opportunities.

Key Enablers

- Partnerships.
- Education to help with development of dissemination of best practices.

Implement standardized addictions screening assessment tools.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Continue to work with The Centre for Addiction and Mental Health (CAMH) to help train and certify service providers to use the assessment tools.	30%	60%	100%
Broad adoption of screening and assessment tools and adjustment of multi-sector service accountability agreements to include use of tools for affected agencies.	30%	60%	100%

Measurements of Success

- Decrease in unscheduled emergency room visits within 30 days for substance abuse conditions.
- Implementation plan rolled out in 2016-17.
- Identified trainers in the region.
- Number of addiction health service providers that have adopted the tools.
- Number of clients screened using the GAIN SS (short screener) since implementation.

Risks/Barriers for Successful Implementation

- Ongoing support from CAMH.
- Participation of targeted health service providers.
- Tools aligned with needs of region's diverse cultural groups.

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.

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:	2017/18	2018/19	2019/20
	Percentage Complete		
Lead and implement a designation evaluation process developed by the Office of Francophone Affairs.	100%		

Measurements of Success

- Number of evaluations completed.

NE LHIN Risk Mitigation Efforts

- Collaboratively work with French Language Health Planning Entity to provide support to HSPs.

Key Enablers

- Ongoing education and communication efforts with HSPs and Entity collaboration.

Work with providers to ensure quality data collection for Indigenous and Francophone population groups.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Educate HSPs on the importance of Francophone data collection.	50%	100%	
Increase the number of HSPs that capture language data using linguistic variable questions.	60%	100%	
Increase the number of Indigenous health service providers completing Inter RAI assessments and uploading data to the IAR.	50%	75%	100%
Enhance training and education to support improved quality of health service provider data reporting.	50%	80%	100%

Measurements of Success

- Percentage of HSPs that capture language data using the linguistic variable questions as best practice.
- Number of HSPs that are made aware of the importance of Francophone data collection from the NE LHIN and the Réseau.
- Completion of Inter RAI assessments and uploading to the IAR.
- Quarterly and annual reporting with accurate data.

Risks/Barriers for Successful Implementation

- Inconsistent data collection methodologies.
- Information systems not having the capacity to capture language data.
- Capacity for consistent HSP reporting.
- Understanding how the data will be stored and used.

NE LHIN Risk Mitigation Efforts

- Monitoring and reporting of FLS data to communicate importance of data collection.
- Leverage the NE LHIN's Local Aboriginal Health Committee.
- Conduct an analysis of current usage, technology resources and development of a plan based on the current state information.
- Develop a culturally safe approach to monitor accountability agreement with Indigenous HSPs.

Key Enablers

- Education, awareness.
- Use of technology to collect data.
- Leverage relationship with Health Canada to jointly promote the use of the Inter RAI assessment tools.

Work in partnership with the NE LHIN's Local Aboriginal Health Committee (LAHC) to develop a NE LHIN Aboriginal Health Care Strategy.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Engage with Aboriginal health leaders, service providers and stakeholders to identify the components for a NE LHIN Aboriginal Health Care Strategy.	100%		
Guidance of LAHC in implementing the NE LHIN Reconciliation Action Plan.	30%	80%	100%

Measurements of Success

- Implementation of Reconciliation Plan and semi-annual reporting to LAHC.
- NE LHIN developed *NE LHIN Aboriginal Health Care Reconciliation Action Plan* in 2016, and will build upon it to develop a Health Care Strategy.

Risks/Barriers for Successful Implementation

- Collaboration for system-wide implementation.

NE LHIN Risk Mitigation Efforts

- Continued work with LAHC and education efforts on Reconciliation Plan.
- Leverage the commitment of federal and provincial governments on LHIN plan and the Truth and Reconciliation Commission recommendations.

Key Enablers

- *Reconciliation Action Plan*, LAHC and HSPs.
- Engagement, communication and ongoing education efforts.

Adopt standardized rehabilitative care best practices.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Align care with the definitions framework for bedded levels of rehab care.	50%	100%	
Align care with the definitions framework for community levels of rehab care.	50%	100%	
Adopt best practices pathway for post-acute phase rehab for total joint replacement and hip fracture QBPs.	40%	100%	

Measurements of Success

- Number of programs delivering care according to the definitions framework.
- Gap between current state and future ideal state which will be informed by the capacity planning exercise i.e. framework.
- Adopt Rehab Care Alliance process indicators to monitor performance.
- 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 for Successful Implementation

- Access to human resources to deliver care.
- Availability of resources to monitor indicators on a regular basis.

NE LHIN Risk Mitigation Efforts

- Develop a phased approach to investment and/or consideration of reclassification of beds according to sub-region capacity planning.
- 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.
- Performance measurement and management.
- Rehabilitation services provided by telemedicine.
- Work of the Provincial Rehab Care Alliance.

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

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
Participate in redevelopment discussions with operators and MOHLTC to support early redevelopment plans that are reflective of needs in NE LHIN.	50%	75%	100%
Collaborate with MOHLTC to develop a bed licence framework that addresses issues in the NE LHIN.	50%	25%	100%
Engage with eligible operators and stakeholders to complete steps/tasks necessary to move forward with redevelopment in the first three years.	75%	25%	100%

Measurements of Success

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

- Challenges with licence movement.
- Operator willingness to redevelop.

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 conversations with operators, Ministry of Health and Long-Term Care.
- Technology such as OTN to facilitate discussions.
- Education specific to bed licence framework and funding policies/limitations.

Work with partners to improve patients' timely follow-up from a primary care practitioner after discharge from hospital.

Actions to meet the objective:	2017/18	2018/19	2019/20
	Percentage Complete		
eNotification implemented in all hospitals and primary care providers.	30%	60%	100%
Physician Office Integration (POI) implemented in hospitals for primary care providers.	30%	60%	100%
Increased adoption of Physician Practice Reports through Health Quality Ontario (HQO) for NE LHIN primary care physicians.	10%	20%	50%

Measurements of Success

- Decrease in percentage of home care patients who receive their first nursing visits within 5 days.
- Increase in percentage of acute care patients who have follow-up visit with physician within 7 days of discharge.
- Increased number of primary care physicians receiving eNotifications from hospitals for patients.
- Increased number of primary care physicians with POI. (Note: this initiative is under review to be transitioned or merged with OntarioMD's Hospital Report Manager).
- Decreased readmissions within 30 days for Selected HIG (HBAM Inpatient Group) conditions.

Risks/Barriers for Successful Implementation

- Physician uptake of EMRs; physicians using POI and receiving eNotifications.
- Physician participation in HQO Practice Reports is voluntary.

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

- NE LHIN's VP Clinical will assist in improving collaboration between primary care and digital health teams, engage primary care providers and promote adoption of digital health solutions.
- Work with eHealth Ontario to support its mandate on regional connecting projects.
- Engage stakeholders to identify sustainment costs at time of implementation.

LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2016/17 Actuals	2017/18 Allocation	2018/19 Planned Expenses	2019/20 Planned Expenses
Salaries and Wages	$ 3,011,276.00	$ 3,436,648.00	$ 3,436,648.00	$ 3,436,648.00
Employee Benefits				
HOOPP	$ 263,635.00	$ 350,133.00	$ 350,133.00	$ 350,133.00
Other Benefits	$ 302,378.00	$ 417,967.00	$ 417,967.00	$ 417,967.00
Total Employee Benefits	$ 566,013.00	$ 768,100.00	$ 768,100.00	$ 768,100.00
Transportation and Communication				
Staff Travel	$ 151,262.00	$ 142,235.00	$ 142,235.00	$ 142,235.00
Governance Travel	$ 25,191.00	$ 12,000.00	$ 12,000.00	$ 12,000.00
Communications	$ 118,127.00	$ 135,191.00	$ 135,191.00	$ 135,191.00
Other Benefits	$ 4,290.00	$ 3,750.00	$ 3,750.00	$ 3,750.00
Total Transportation and Communication	$ 298,870.00	$ 293,176.00	$ 293,176.00	$ 293,176.00
Services				
Accommodation	$ 208,160.00	$ 186,582.00	$ 186,582.00	$ 186,582.00
Advertising	$ 5,053.00	$ 5,000.00	$ 5,000.00	$ 5,000.00
Banking	$ 2,659.00	$ 750.00	$ 750.00	$ 750.00
Consulting Fees	$ 52,959.00	$ 24,770.00	$ 24,770.00	$ 24,770.00
Equipment Rentals	$ 9,475.00	$ 7,692.00	$ 7,692.00	$ 7,692.00
Board Chair Per Diems	$ 12,810.00	$ 12,600.00	$ 12,600.00	$ 12,600.00
Governance Per Diems	$ 36,745.00	$ 14,500.00	$ 14,500.00	$ 14,500.00
Insurance	$ 6,719.00	$ 6,897.00	$ 6,897.00	$ 6,897.00
LSSO Shared Costs1+E	$ 251,579.00	$ -	$ -	$ -
LHIN Collaborative	$ 47,500.00	$ -	$ -	$ -
Other Meeting Expenses	$ 33,117.00	$ 28,000.00	$ 28,000.00	$ 28,000.00
Other Governance Costs	$ 6,890.00	$ 5,000.00	$ 5,000.00	$ 5,000.00
Other Governance Groups	$ -	$ 2,000.00	$ 2,000.00	$ 2,000.00
Printing & Translation	$ 80,857.00	$ 94,000.00	$ 94,000.00	$ 94,000.00
Staff Development	$ 53,212.00	$ 27,230.00	$ 27,230.00	$ 27,230.00
Total Services	$ 807,735.00	$ 415,021.00	$ 415,021.00	$ 415,021.00
Supplies and Equipment				
IT Equipment	$ 43,943.00	$ 29,400.00	$ 29,400.00	$ 29,400.00
Office Supplies & Purchased Equipment	$ 15,904.00	$ 19,951.00	$ 19,951.00	$ 19,951.00
Total Supplies and Equipment	$ 59,847.00	$ 49,351.00	$ 49,351.00	$ 49,351.00
LHIN Operations: Total Planned Expense	$ 4,743,741.00	$ 4,962,296.00	$ 4,962,296.00	$ 4,962,296.00
Total CCAC expenditure/allocation	$ 147,506,336.00	$ 151,099,085.00	$ 151,099,085.00	$ 151,099,085.00
Total LHIN and CCAC planned expense/allocation	$ 152,250,077.00	$ 156,061,381.00	$ 156,061,381.00	$ 156,061,381.00
LHIN Program expenses				
Diabetes RCC	$ 1,065,809.00	$ 1,065,809.00	$ 1,065,809.00	$ 1,065,809.00
French Language Services	$ 296,800.00	$ 296,800.00	$ 296,800.00	$ 296,800.00
eHealth PMO	$ 510,000.00	$ 510,000.00	$ 510,000.00	$ 510,000.00
Aboriginal Planning	$ 100,000.00	$ 100,000.00	$ 100,000.00	$ 100,000.00
ER/ALC	$ 100,000.00	$ 100,000.00	$ 100,000.00	$ 100,000.00
FLS Entity	$ 796,159.00	$ 796,159.00	$ 796,159.00	$ 796,159.00
Physician Lead	$ 225,000.00	$ 275,000.00	$ 275,000.00	$ 275,000.00
Transition Lead	$ 291,720.00	$ 202,500.00	$ -	$ -
Total LHIN Programs	$ 3,385,488.00	$ 3,346,268.00	$ 3,143,768.00	$ 3,143,768.00
Grand Total LHIN Expenses	$ 8,129,229.00	$ 8,308,564.00	$ 8,106,064.00	$ 8,106,064.00
Annual Funding Target	$ 8,129,229.00	$ 8,308,564.00	$ 8,106,064.00	$ 8,106,064.00
Variance Surplus/Deficit	$ -	$ -	$ -	$ -

Note: As of March 31, 2017, the LHIN Operations Spending Plan reflects the transfer of LHIN Shares Services Office and LHIN Collaborative Funding to Health Shared Services Ontario.

LHIN Staffing Plan (Full-Time Equivalents)*

Positions	2016/17 Actual as of Mar. 31/17 FTEs	2017/18 Forecast FTEs	2018/19 Forecast FTEs	2019/20 Forecast
Chief Executive Officer	1	1	1	1
Executive Assistant and Board Liaison	2	2	2	2
Vice President of Home and Community Care	0	1	1	1
Vice President of Clinical	1	1	1	1
Senior Management Team	4	4	4	4
Project Coordinators	4	5	5	5
Administration Clerks	3	2	2	2
Corporate Services – HR and Controller	1	1	1	1
Analysts – Data, Finance & Performance	3	4	4	4
Communications Officers/Coordinator	4	3	3	3
Senior Officers	6	6	6	6
Hub Officers	3	4	4	4
Outreach Officers	3	4	4	4
Officers – CSS & Assisted Living, Chronic Disease/Diabetes Management, Rehabilitation & Complex Continuing Care, Primary Care, NE Falls Prevention, Mental Health & Addictions, Performance & Decision Support, Finance & Performance, Project Management, Long-Term Care	14	13	13	13
Total LHIN FTEs	**49**	**51**	**51**	**51**
Total CCAC FTEs	**620**	**646**	**646**	**646**
Total LHIN and CCAC FTEs	**669**	**697**	**697**	**697**

Integrated Communications Strategy

Business Objectives

The NE LHIN's 2017/18 Annual Business Plan operationalizes the priorities outlined in our *Integrated Health Service Plan: A Plan for the Health and Well-being of Northerners Living in Northeastern Ontario*, (IHSP 2016-19), specifically:

- Improve access to and wait times for services.
- Increase the coordination of care Northerners need.
- Strengthen system sustainability so Northerners can rely on a strong health care system today and tomorrow.

Listening to the voices of Northerners continues to be a core value of the NE LHIN and we will continue to focus on integrating the voices of the patient and family into our initiatives through robust community engagement and the creation of a Patient and Family Advisory Council in 2017.

We will continue to work with partners to drive system quality and value, improving population health while recognizing cultural diversity, particularly for Francophone and Indigenous Northerners.

Communications Objectives

Given the changes to the health care system as a result of the *Patients First Act* (2016) and ongoing strengthening of the Northeastern Ontario health care system with the implementation of our IHSP 2016-2019, a communications and community engagement strategy is critical to support the initiatives contained in this Annual Business Plan. The communications strategy will:

- Ensure the voice of patients and their families is captured and reflected in the implementation of initiatives.
- Build confidence among fellow Northerners that:
    - Progress is being made to improve access and coordination of health care services;
    - The system is sustainable, being effectively managed, providing value for tax dollars;
    - Progress is being made to improve the patient experience;
    - The system is transparent.
- Support the *Patients First* goals so that public confidence in the local health care system remains stable, patient care remains seamless and uninterrupted, and fellow Northerners are both informed and provided the opportunity to be actively involved in the work needed to strengthen the continuum of care.
- Support the implementation of our strategic priorities through ongoing communication and engagement with the key stakeholders and Health Service Providers who have a pivotal role in moving these priorities forward – and inspiring them to future action.
- Promote LHIN investments in new programs and enhancements, helping people to navigate the system through an increased awareness of the health care options that are available to them.

Context

The *Patients First: Action Plan for Health Care* is Ontario's plan to transform the health care system into one that puts the needs of patients at its centre. It sets out clear 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: increasing access, connecting services, informing patients and protecting our health care system.

On December 7, 2016, Ontario passed the Patients First Act, 2016, an important step forward in the *Patients First: Action Plan for Health Care*. It holds five key components to achieve an improved patient experience for Ontarians:

- Expanded role for LHINs.
- Timely access to, and better integration of, primary care.
- More consistent and accessible home and community care.
- Stronger links to population and public health.
- Improving health equity and reducing health disparities.

LHINs continue to have a critical role to play in key provincial initiatives and ensuring the system is meeting the needs of Ontarians. LHINs will ensure that any changes are seamless and that they simplify and improve patient experience. There will be no added bureaucracy and financial savings will go to patient care.

LHINs are further guided by the mandate letter from the Honourable Dr. Eric Hoskins that reinforces the *Patients First Action Plan* to deliver integrated and comprehensive health services across primary and specialist care, home and community care, hospitals, and other health care settings.

In the NE LHIN, our 2016-2019 IHSP and the initiatives laid out in this Annual Business Plan are strategically aligned with government direction and priorities and recognize the joint accountability of the MOHLTC and LHINs to serve the public interest and effectively oversee the use of public funds.

The evolution of the sub-region planning construct will be a key communication opportunity for the NE LHIN. Sub-regions will be further advanced by working with Health Service Providers to co-design a more integrated care delivery model to strengthen the patient experience.

Target Audiences

Internal

- Board of Directors, clinical leads, advisory groups and committees, staff.

External

- Public (citizens, patients/clients, and family members)
- Health Service Providers (HSPs)
    - Hospitals, home and community providers, community mental health and addictions services, long-term care homes, community health centres
    - Physicians, primary care organizations, emergency services (EMS), Ontario Telemedicine Network (OTN), provincial networks (i.e. Cancer Care Ontario and others), public health units
- Ministry of Health and Long-term Care, other Ministries and Policy Makers
    - 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, MPPs, Municipal Government, Councils, Mayors, Reeves and CEOs.

- Academic Institutions
- Partner Organizations
    - Réseau du mieux-être francophone du Nord de l'Ontario; District Social Service Administration Boards (DSSABs); Police Services, College of Physicians and Surgeons of Ontario, Ontario College of Family Physicians, Ontario Medical Association, Ontario Public Health Association.
- Special Population Groups - Francophone, Aboriginal/First Nations/Métis
- Media

Strategic Approach

To support our business and communication objectives, the NE LHIN communications strategy will continue to:

- Ensure patients, clients and caregivers have quick and easy access to the information they need to best navigate the health care system and find the care they need.
- Integrate the voice of the patient and caregiver into our communications whenever possible – using their stories and experiences to inspire action and keep our system grounded in our vision for what is possible.
- Position the enhanced NE LHIN as a valued key player within the transformation of Ontario's health care system and as the lead in health system transformation in the NE LHIN region.
- Foster an understanding of the need for health system transformation both internally and externally.
- Seek out initiatives to demonstrate how the NE LHIN:
    - Adds system-wide value
    - Aligns local solutions to provincial priorities
    - Supports, mobilizes and engages Health Service Providers, system partners and other key stakeholders to improve the health care system.
- Manage and respond to ongoing issues with efficiency, transparency, responsibility and integrity.
- Provide accurate and timely information to all audiences.
- Demonstrate how patients/caregivers/general public can participate in improving their own health and support the development of plans to support care delivery in the LHIN's five LHIN sub-regions.
- Provide information on performance and progress on the implementation – document successes and share it.

Key Messages – Provincial

- The *Patients First: Action Plan for Health Care* is Ontario's plan to transform the health care system into one that puts the needs of patients at its centre.
- The *Patients First: Action Plan for Health Care* sets clear goals for Ontario's health care system to put patients at the centre of our health care system by improving the health care experience: increasing

access, connecting services, informing patients and protecting our health care system. Progress has been made in all four priority areas, but we can do more to put patients first.

- By putting patients first in everything we do, we will provide faster access to the care patients need today and make the necessary investments to ensure our health system will be there for patients for generations to come.

- On December 7, 2016, Ontario passed the Patients First Act, 2016, an important step forward in the *Patients First: Action Plan for Health Care*.

- Once fully implemented, changes supported by the Patients First Act will make local health care more responsive to local needs:
  - Patients will benefit from improved access to primary care, including a single number to call when they need health information or advice on where to find a new family doctor or nurse practitioner.
  - Primary care providers, inter-professional health care teams, hospitals, public health units and home and community care providers will be better able to communicate and share information, to ensure a smoother patient experience and transitions. Our goal is that patients will only have to tell their story once.
  - Administration of the health care system will be streamlined and reduced, with savings put back into improving patient care.
  - The voices of patients and families in their own health care planning will be strengthened.
  - There will be an increased focus on cultural sensitivity and the delivery of health care services to Indigenous peoples and French speaking people in Ontario.

- LHINs will ensure that any changes are seamless and that they simplify and improve patient experience. There will be no added bureaucracy and financial savings will go to patient care.

Key Messages – Local

- **The NE LHIN is a key partner in transforming the health system to provide quality care that meets the needs of Northerners today and into the future.**

- **The voices of Northerners are the bedrock of the NE LHIN's work** to strengthen the Northeastern Ontario health care system.

- **Transformation requires a collective call to action**. The NE LHIN is working with partners and fellow Northerners to shift an old system designed to treat people once sick to a more coordinated, value-driven model that promotes wellness, and is patient focused.

- **Status quo is neither acceptable nor sustainable**. The NE LHIN has already brought about significant and positive change in the way health services are delivered, and we will continue that work.

- **The health care system belongs to all of us.** Everyone has an important role to play in making healthy change happen, including health service providers, patients/families and caregivers, the LHINs, public health, primary care providers, community leaders and the public.

- **Improving the patient experience is key.** By planning service through a tailored sub-region lens, services will be strengthened and more coordinated.

Tactics

- Patient/Family/Caregiver information is widely available: www.nelhin.on.ca; www.northeasthealthline.ca ; Facebook, Twitter/ printed materials
- Media sends, blast emails, newsletters
- Healthy Change Champions – named by NE LHIN as champions of health care change
- Clinical Lead Columns – regular updates on their NE LHIN roles/work
- Videos to tell personalized stories of health system transformation
- Website postings/alerts
- Social media – Twitter, Facebook
- Stakeholder events – presentations
- Outreach to local government stakeholders
- Engagement with specific stakeholders – provincial associations, community groups, etc.
- Participation in information-sharing events – workshops, conferences, community tables
- NE LHIN Annual Report
- Board Meetings

Evaluation

Identifying and tracking critical communication success factors enables the NE LHIN to identify whether communication activities have been successful. These factors may include:

- Annual evaluation of the Patient and Family Advisory Committee.
- 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.
- Northerners with a clear understanding of the "*Quality Health Care When Northerners Need It*" transformation. At each engagement opportunity, feedback is tracked.
- HSPs and Northerners can see how their participation is impacting implementation/transformation.
- Evaluate engagement of stakeholders across the NE LHIN – are they engaged early and frequently and how is their participation impacting the implementation of the future state?
- Feedback mechanisms and ongoing assessments are in place to monitor the effectiveness of communication vehicles and messages, and the LHIN has the ability to make quick modifications based on shifts and lessons learned as activities are carried out.

Community Engagement

In accordance with Community Engagement Guidelines (Revised June 2016) and in keeping with the expectations of the Local Health System Integration Act (LHSIA 2006), all LHINs undertake engagement to ensure the voices of the people served are reflected in decision-making.

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

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

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

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

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

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

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

Engagement of Indigenous Peoples

In addition to other engagements, the NE LHIN consults at least twice a year with its Local Aboriginal Health Committee on key issues and challenges faced by indigenous people in the region. The NE LHIN also works to ensure there are Indigenous people on its other committees and advisory groups. For instance, the NE LHIN's Regional Mental Health and Addiction Advisory Council is chaired by Pam Williamson, who is also the Executive Director of the Noojmowin Teg Health Centre and a member of LAHC.

Engagement of NE LHIN Francophone Community

The NE LHIN works closely with the Réseau du mieux-être francophone du Nord de l'Ontario in designing engagements to ensure the voices of Francophones are also present and captured. The NE LHIN, NW LHIN and the Réseau have a joint three-year health action plan on French Language Services aimed at enhancing care coordination, improving the patient experience, increasing access to services in French and reducing inequities, and strengthening the sustainability of French Language Services. The plan is available online on the NE LHIN website here or on the Réseau's website here.

Sources

1. 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.

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